



**SPRC**

**SUICIDE PREVENTION RESOURCE CENTER**

# **Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth**

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## Executive Summary

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This paper highlights the higher risk of suicidal behavior among lesbian, gay, and bisexual (LGB) youth. This higher risk may well extend to transgender (T) youth. Additionally, the paper provides recommendations to reduce this risk by addressing stigma and prejudice at the institutional and individual level; by forming partnerships across youth-serving, suicide prevention, and LGBT youth agencies; by building on recent advances in research; and by responding to the issues of LGBT youth. To write the paper, the authors reviewed relevant up-to-date literature and researched current services for LGBT youth. Youth, for the purposes of this paper, is defined as between ages 15 and 24. Drafts of the paper were reviewed by LGBT youth and experts with relevant interests.

LGB youth as a group experience more suicidal behavior than other youth. A variety of studies indicate that LGB youth are nearly one and a half to three times more likely to have reported suicidal ideation than non-LGB youth. Research from several sources also revealed that LGB youth are nearly one and a half to seven times more likely than non-LGB youth to have reported attempting suicide. These studies do not include transgender youth.

For several reasons, little can be said with certainty about suicide deaths among LGB people. Most mortality data do not include sexual orientation. However, based on the higher rate of suicide attempts among LGB youth and the relative seriousness of their suicide attempts, it is likely that LGB youth experience higher rates of suicide deaths than their non-LGB peers. While limited information is available on suicidal behavior among transgender youth, it is plausible to hypothesize that transgender youth, in common with LGB youth, have elevated risk and lower protective factors and higher rates of suicidal behavior.

Risk and protective factors help explain suicidal behavior and inform program and practitioner approaches to reducing suicidal behavior. LGB youth generally have more risk factors, more severe risk factors, and fewer protective factors than heterosexual youth. For example, LGB youth often lack important protective factors such as family support and safe schools, and more LGB young people appear to experience depression and substance abuse. In addition, there is risk unique to LGB youth related to the development of sexual orientation, for example, disclosure at an early age raises risks.

It would be difficult to overstate the impact of stigma and discrimination against LGBT individuals in the United States. Stigma and discrimination are directly tied to risk factors for suicide. For example, discrimination has a strong association with mental illness, and heterosexism may lead to isolation, family rejection, and lack of access to culturally competent care.

While LGB youth are at higher risk for suicidal behavior, some groups of LGB youth are at particular risk: those who are homeless and runaway, living in foster care, and/or involved in the juvenile justice system. Although all youth in these settings are vulnerable, many LGBT youth experience multiple risk factors and have fewer supports than other youth.

Suicide prevention programs can be effective in diminishing risk factors and especially in building protective factors, yet few target risk and protective factors relevant to LGBT youth. Gatekeepers – those who have contact with youth and are trained to recognize at-risk youth and refer them to services – as well as staff of screening programs and crisis lines, need to understand LGBT risk for suicidal behavior, know particular issues for these youth, and develop cultural effectiveness to serve them. Gatekeepers and staff need to be aware of LGBT-inclusive providers to use for referrals.

Other programs, whether they serve all youth or specifically LGBT youth, may not explicitly address suicide prevention, but may reduce suicidal behavior by strengthening protective factors, such as connecting youth with supportive adults, and reducing risk factors, such as preventing violence and harassment. Organizations serving LGBT youth can partner with statewide suicide prevention groups to increase their expertise in suicide prevention and to ensure that suicide risk among LGBT youth is addressed effectively.

Three venues for providing services to youth can make vital differences in the lives of LGBT youth – schools, mental health and social services, and health care services – by increasing safety and inclusion. This is accomplished not only by having knowledgeable and culturally effective staff, but by having an environment – including the setting, policies, and board – that supports safety and inclusion comprehensively.

The authors assert the following recommendations to strengthen or increase protective factors and to reduce risk factors among LGBT youth. Agencies that serve youth – schools, health practices, suicide prevention programs, and youth services – as well as funders, can help to reduce suicidal behavior among these youth. The authors recommend that these agencies and individuals:

- Implement training for all staff members to effectively serve LGBT youth by including recognition and response to warning signs for suicide and the risk and protective factors for suicidal behavior in LGBT youth
- Include information about higher rates of suicidal behavior in LGBT youth in health promotion materials

- Assess and ensure that youth services and providers are inclusive, responsive to, and affirming of the needs of LGBT youth, and refer youth to these services and providers
- Develop peer-based support programs
- Include the topic of coping with stress and discrimination and integrate specific activities for LGBT youth in life skills training and programs to prevent risk behaviors
- Support staff advocacy for LGBT youth
- Incorporate program activities to support youth and their family members throughout the development of sexual orientation and gender identity, including awareness, identity, and disclosure. These programs must address young children and adolescents.
- Promote organizations that support LGBT youth, such as Gay-Straight Alliances and Parents, Families, and Friends of Lesbians & Gays (PFLAG)
- Institute protocols and policies for appropriate response if a client or student is identified as at risk of self-harm, has made a suicide attempt, or has died by suicide
- Make accurate information about LGBT issues and resources easily available
- Use an LGBT cultural competence model that enables individuals and agencies to work effectively with LGBT youth cultures
- Include LGBT youth in program development and evaluation
- Institute, enforce, and keep up to date non-discrimination and non-harassment policies for all youth
- Implement confidentiality policies that are clear, comprehensive, and explicit
- Assume that clients or students could be any sexual orientation or gender identity and respond accordingly
- Address explicitly the needs of LGBT youth in school-based programs and policies to prevent violence and bullying

Researchers and program developers, as well as funders, also play a role in reducing suicidal behavior in LGBT youth. The authors recommend that they:

- Use evaluation results, surveillance data, and research conclusions to develop evidence-based programs to build protective factors and to prevent suicide among LGBT youth
- Undertake large-scale epidemiological studies that include complex measures of sexual orientation and gender identity and include research on discrimination and mental illness
- Include LGBT youth in research development and evaluation
- In developing programs, emphasize protective factors for LGBT youth
- Develop research projects and funding for research on risk and protective factors for suicidal behavior for youth generally and for LGBT youth specifically and work with program staff to encourage getting research results into program design

These recommendations will help not only to reduce the disparate rate of suicidal behavior of LGBT youth but to promote the health, safety, and inclusion of LGBT youth as visible and empowered members of our communities.



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## Introduction

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Every year, suicide claims the lives of more than 800,000 people worldwide (Peden, McGee, & Krug, 2002) and about 32,000 people in the United States alone. Suicide is the third leading cause of death for people 15 to 24 years old, with more than 4,000 youth dying by suicide each year (Centers for Disease Control and Prevention, 2007). Many more youth consider suicide, make plans to kill themselves, or attempt suicide.

In recent years, major national and international reports have drawn attention to this tragedy. These reports include the World Health Organization's *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* (United Nations, 1996), *The Surgeon General's Call to Action to Prevent Suicide* (U.S. Public Health Service, 1999), *National Strategy for Suicide Prevention: Goals and Objectives for Action* (U.S. Department of Health and Human Services, 2001), and the Institute of Medicine's *Reducing Suicide: A National Imperative* (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

Although all of these reports identify groups at risk for suicidal behavior, none address in any depth issues relevant to one group generally thought to be at higher risk for suicidal behavior: youth who are lesbian, gay, bisexual, or transgender (LGBT). For example, *National Strategy for Suicide Prevention* (U.S. Department of Health and Human Services, 2001) includes only a brief appendix that refers to LGB youth as a special population at risk.

Fortunately, the field of suicide prevention is beginning to turn its attention to LGBT youth. For example, the application guidelines for youth suicide prevention programs authorized under the federal Garrett Lee Smith Memorial Act ask that applicants address issues of sexual orientation and gender in at-risk populations.

The focus of this paper is on what is known about suicidal behavior among LGBT youth. As defined in *National Strategy for Suicide Prevention*, suicidal behavior includes suicidal thinking, suicide attempts, and completed suicides (U.S. Department of Health and Human Services, 2001). For the purposes of this paper, the term *youth* is roughly defined as people age 15 through 24. In developing this paper, the authors reviewed the relevant literature published from 1996 through 2007, spoke with individuals in suicide prevention and mental health promotion programs, and researched services for LGBT youth. After summarizing research findings about the higher risk of suicidal behavior for LGBT youth, the paper explores risk and protective factors for this group and provides recommendations to the field that we hope will reduce suicidal behavior among LGBT youth.

Drafts of this paper were reviewed by LGBT youth and experts in sexual and gender minority issues, suicide, and suicide prevention.

## Terminology

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The terms *lesbian*, *gay*, *bisexual*, and *transgender* are often used with minimal consideration of the complexities of sexuality and gender. How and why sexual orientation – affection and/or sexual attraction towards males, females, or both – develops and changes over time remains the subject of both research and debate. The relationships among sexual orientation, gender identity (whether a person identifies as male or female), and gender conformity (whether a person displays the emotional and behavioral characteristics culturally associated with a particular gender) are extremely complex.

The term *transgender* refers to persons whose gender identity and/or expression is inconsistent with cultural norms about their biological sex. Transgender is not a sexual orientation; however, transgender people are sometimes included in research on LGB people. Occasionally included in research are young people identified as questioning – that is, those who are in the process of exploring the nature of their sexual orientation or gender identity. Questioning often occurs during adolescence, the developmental stage when many young people struggle with issues of sexuality, gender, and identity. This struggle can be especially difficult and prolonged for people exploring LGBT sexual orientations and gender identities.

The somewhat ambiguous nature of these definitions and perhaps of human sexuality in general complicates research about health problems associated with sexual orientation and gender identity. For the most part, this paper will use the terms *lesbian*, *gay*, *bisexual*, and *transgender* in their everyday sense. While the authors acknowledge that these terms cannot reflect individuality, and sexuality and gender may be more fluid than research can accommodate, this paper does not attempt to reconcile these issues. However, it is important to remember the diversity that exists within sexual orientations and gender identities. Additionally, the underlying cultural conceptions of sexual and gender identity, not just the terms used to describe these identities, change over time.

This paper uses the common abbreviation LGBT to refer to lesbian, gay, bisexual, and transgender people. In discussing the research, the paper defers to each study's definitions and reports the results accordingly. For example, if the research includes only lesbian, gay, and bisexual youth, we will use the abbreviation LGB, not LGBT.

## **Scope of the Problem: Suicide Deaths Among LGB Youth**

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Suicide is the eleventh leading cause of death overall in the United States, and the third leading cause of death for youth age 15 through 24, following unintentional injuries and homicide. However, data on suicide rates – the number of suicide deaths per 100,000 of population – reveal that the rate for this age group is 10 per 100,000, below the national rate of 11.01 per 100,000 for people of all ages (Centers for Disease Control and Prevention, 2007).

Little can be said with any certainty about the extent of suicide deaths among LGB youth. Sexual orientation is not usually included in a cause of death report or on a death certificate. Even if information on sexual orientation was included in a police or a medical examiner's report, the National Vital Statistics System that aggregates these reports at the state and national levels does not include this information. This is a significant omission: the National Vital Statistics System is a primary source of data for public health researchers studying any cause of mortality, including suicide.

Newspaper obituaries rarely make reference to the sexual orientation of the deceased or to the cause of death when suicide is involved. Families and friends may not know – or be willing to discuss – the sexual orientation of a person who died, especially by his or her own hand (Lebson, 2002).

Although hard data on suicide rates for young LGB people are lacking, research has established that the most reliable indicators of suicide risk are suicidal ideation and prior suicide attempts (American Psychiatric Association, 2003; Beautrais, 2001; Beautrais, 2004; Borges et al., 2006; Gibb, Beautrais, & Fergusson, 2005).

### **Citation of Scientifically Questionable Statements**

A report on suicide among gay and lesbian youth provides a powerful illustration of how statements derived from very limited hard data can acquire the aura of fact. In 1989 the U.S. Department of Health and Human Services published *Report of the Secretary's Task Force on Youth Suicide*. The section "Gay and Lesbian Youth Suicide" includes two often-quoted statements:

- Homosexual youth may represent up to 30 percent of youth suicide deaths.
- Suicide is the leading cause of death for LGBT youth.

Ryan and Futterman (1998) have pointed out criticisms that these statements were based on a review by Paul Gibson (1989) of non-random studies and agency reports on diverse lesbian and gay populations. Unfortunately, the statements have often been quoted as factual even though the scientific grounding behind them is questionable.

## **Scope of the Problem: Suicide Attempts Among LGB Youth**

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A suicide attempt is a “potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself” (U.S. Department of Health and Human Services, 2001, p.203). One of the strongest predictors of suicide is one or more prior suicide attempts. Data from the National Comorbidity Survey of people 15 through 54 years of age show a lifetime suicide attempt rate of 4.6 percent (Kessler, Borges, & Walters, 1999) – that is, nearly one in twenty people reported having attempted suicide at some point in their lives. The Youth Risk Behavior Survey (YRBS) results from October 2004 to January 2006 indicated that 8.4 percent of all students in grades 9 through 12 reported having attempted suicide at least once in the 12 months before the survey (Eaton et al., 2006).

## **Overview of the Data on Suicide Attempts Among LGB Youth**

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Studies that compare the rate of suicide attempts among LGB youth with those among heterosexual youth show significantly higher rates for LGB youth:

- Remafedi and colleagues (Remafedi, French, Story, Resnick, & Blum, 1998) found that 28.1 percent of gay or bisexual males in grades 7 through 12 had attempted suicide at least once during their lives, while only 4.2 percent of heterosexual males in those grades had attempted suicide. The corresponding percentages for females were 20.5 percent for lesbian or bisexual females and 14.5 percent for heterosexual females.
- The Massachusetts Youth Risk Behavior Survey reported that LGB high school students in Massachusetts were more than four times as likely as the state’s non-LGB students to have attempted suicide in the last year (Massachusetts Department of Education, 2006b).
- Safren and Heimberg (1999) reported that 30 percent of LGB youth versus 13 percent of heterosexual youth (mean age of about 18) had attempted suicide at some point.
- Garofalo and colleagues (1999) found that high school students identifying as either LGB or not sure of their sexual orientation were 3.4 times as likely to have attempted suicide within the last 12 months as their heterosexual peers.
- D’Augelli and Hershberger (1995) found that LGB youth were three times as likely to have attempted suicide as heterosexual youth.

- Russell and Joyner (2001) found that the risk of attempting suicide was twice as high among LGB youth as among heterosexual youth.
- Eisenberg and Resnick (2006) found that LGB students in grades 9 and 12 were significantly more likely to have attempted suicide than their heterosexual peers. 52.4 percent of LB females and 29.0 percent of GB males had attempted suicide. The percentages of non-GLB females and males who had attempted suicide were 24.8 and 12.6 percent respectively.
- A study in New Zealand found that 32.1 percent of LGB youth through age 21 had attempted suicide, whereas only 7.1 percent of same-age heterosexual youth had made such an attempt (Fergusson, Horwood, & Beautrais, 1999).

Several other studies reported dramatic suicide attempt rates among young LGB people, but these studies do not include comparison groups. In such cases, it is useful to compare the data with a range: population studies suggest that a range of 4 to 8 percent of all young people have attempted suicide by age 20 (Beautrais, 2003). In contrast, non-comparison studies of LGB youth found that the following percentages of lesbian, gay, and/or bisexual youth had attempted suicide at some point over the life course:

- 40.3 percent of LGB people up to age 21 (Proctor & Groze, 1994)
- 37 percent of LGB youth ages 14 to 21 (D'Augelli, 2002)
- 33 percent of GB males ages 15 to 25 (Remafedi, 2002)
- 30 percent of GB males ages 14 to 21 (Remafedi, Farrow, & Deisher, 1991)

The majority of literature reviews on LGB suicide attempts conclude that LGB youth have a significantly higher rate of attempting suicide than heterosexual youth. Furthermore, most suicide attempts among LGB people occur during adolescence and young adulthood (Kulkin, Chauvin, & Percle, 2000; Proctor & Groze, 1994; Remafedi et al., 1991). (The same holds true for people of all sexual orientations; national hospital data show self-harm rates are highest for youth age 15 through 19 years old (Centers for Disease Control and Prevention, 2007)).

Some researchers have compared the seriousness of suicide attempts by LGB and heterosexual youth by asking people about their intent to end their lives. Safren & Heimberg (1999) found that 58 percent of LGB people who had attempted suicide reported that they had really hoped to die. In contrast, only 33 percent of heterosexuals who had attempted suicide reported that they had really hoped to die. Another measure of seriousness is the lethality of the means used to attempt suicide. For example, people who use firearms in a suicide attempt have a higher

rate of suicide deaths than people who use other means, simply because firearms are more lethal than other means (Brent et al., 1991; Conwell et al., 2002; Brent & Bridge, 2003; Shenassa, Catlin, & Buka, 2003; Miller, Azrael, Hepburn, Hemenway, & Lippman, 2006). Remafedi and colleagues (1991) found in interviews with GB males 14 through 21 years of age that 54 percent of suicide attempts in this group could be classified as moderately to highly lethal. The study also reported that one fifth of LGB youth who attempted suicide needed hospitalization, and three-fifths were least or moderately rescuable (a measure of the seriousness of the attempt).

It is important to note that all suicide attempts should be taken seriously by those responsible for the care of young people, including parents, school staff, and health care providers.

### **Limitations of the Data on Suicide Attempts Among LGB Youth**

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The data on suicide attempts have limitations. Medical records seldom include information on the sexual orientation of a patient, and often lack data on the cause, much less the intent, of the injury. Many people who attempt suicide do not receive medical or other health services. Much of the research on suicide attempts depends on surveys in which people self-report both suicidal behavior and sexual orientation. Given the stigma - widespread social disapproval and negative attitudes - associated with both homosexuality and suicide, research participants may be reluctant to answer questions about these issues honestly, even in a confidential or anonymous survey.

Many studies on suicide among LGB young people ask participants to self-identify as lesbian, gay, or bisexual. Some researchers add the category "questioning" (or, less frequently, "not sure") to describe adolescents who are still coming to terms with their sexual identity (see, for example, Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Medeiros, Seehaus, Elliott, & Melaney, 2004; Morrison & L'Heureux, 2001; Savin-Williams & Ream, 2003). Asking participants to self-identify in a survey assumes that they define their sexual orientation by one of the categories offered by the survey and that these categories are meaningful in terms of the range of sexual behavior, identity, and expression among young people. Some researchers try to avoid these definitional questions by asking survey respondents about their sexual behavior rather than their sexual orientation (see, for example, Bontempo & D'Augelli, 2002; Botnick et al., 2002; Cochran & Mays, 2000b; DuRant, Krowchuk, & Sinal, 1998; Remafedi, 2002). Surveys using this methodology might, for example, ask men if they have had sex with men in the past year and ask women if they have had sex with women in the past year. This approach assumes that sexual behavior is consistent with sexual identity and that the respondents are sexually active.



Although many researchers postulate that studies underestimate the rate of suicide attempts among young LGB people because of their low self-reporting of both sexual orientation and suicidal behavior, some researchers speculate that self-reports of these variables may inflate the reported rate of suicide attempts among LGB youth. Cochran and Mays (2000b) suggest that LGB people willing to disclose their sexual orientation in research studies may also be more willing to admit to other socially stigmatized attributes – suicide attempts or mental health problems – than LGB people who are reluctant to disclose their sexual orientation. Savin-Williams (2001) contends that much of the discrepancy between the suicide rates of LGB youth and their heterosexual peers can be attributed to the fact that LGB youth tend to exaggerate the seriousness of their suicide attempts, “to communicate the hardships of [their] lives or to identify with a gay community.”

Despite these limitations, the data on suicide attempts can be extremely useful in investigating suicide risk. For further insight into this risk, researchers and practitioners commonly turn to the third area of suicidal behavior, suicidal thinking.

## **Scope of the Problem: Suicidal Ideation Among LGB Youth**

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Suicidal ideation has been defined as “self-reported thoughts of engaging in suicide-related behavior” (U.S. Department of Health and Human Services, 2001, Appendix E, Glossary). Ideation can range in severity from passing thoughts about suicide to a detailed plan for attempting suicide. Suicidal ideation is often used as an indicator of suicide risk in studies, based on the fact that many people who seriously consider suicide go on to attempt or die by suicide. Suicidal ideation is more widespread than either attempts or suicides, and its recognition can provide an opportunity to intervene before more serious suicidal behavior develops.

Although not all youth with suicidal ideation go on to attempt or die by suicide, ideation is disruptive to the individual and a matter for serious concern. Youth considering suicide need emergency or outpatient mental health services or other support (Gary Diamond, personal communication, November 21, 2007).

## **Overview of the Data on Suicidal Ideation Among LGB Youth**

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The National Comorbidity Survey reported that 13.5 percent of the U.S. population (all gender identities and sexual orientations) ages 15 through 54 responded “yes” to the question “Have you seriously thought about committing suicide?” (Kessler et al., 1999). For youth, suicidal ideation is relatively common: the Youth Risk Behavior Survey found that 16.9 percent of all students in grades 9 through 12 reported that they had “seriously considered attempting suicide” in the 12 months

before the survey was given (Eaton et al., 2006). Although this represents a minority of youth, one in nearly six youth facing this risk is a significant share.

Research results generally confirm that LGB youth have much higher levels of suicidal ideation than their heterosexual peers:

- Cochran and Mays (2000a) found that 41.2 percent of gay men ages 17 to 39 reported suicidal ideation, compared to only 17.2 percent of heterosexual men of similar ages.
- The Massachusetts Youth Risk Behavior Survey reported that youth who self-identified as gay, lesbian, or bisexual or who reported any same-sex sexual contact were more than three times as likely as their heterosexual peers to have seriously considered suicide in the last year (34 percent compared to 11 percent) (Massachusetts Department of Education, 2006b).
- Eisenberg and Resnick (2006) found that 47.3 percent of GB adolescent boys and 72.9 percent of LB adolescent girls reported suicidal ideation, compared with 34.7 percent of non-GB adolescent boys and 53 percent of non-LB adolescent girls.
- Remafedi et al. (1998) reported that 31.2 percent of GB male high school students and 36.4 percent of LB female students reported suicidal ideation. The proportions for heterosexual students were 20.1 percent and 34.3 percent respectively.

Comparable outcomes have been reported in international studies:

- A study of LGB people in New Zealand through age 21 found that 67.9 percent reported suicidal ideation, compared to 28 percent of similarly aged heterosexuals (Fergusson et al., 1999).
- A study in Belgium found that suicidal ideation among LGB youth was double that of heterosexual youth (van Heeringen & Vincke, 2000).

### **Limitations of the Data on Suicidal Ideation Among LGB Youth**

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Data on the prevalence of suicidal ideation are based on surveys in which participants self-report. Thus, data on suicidal ideation among LGBT youth are subject to many of the same limitations that apply to surveys on the frequency of suicide attempts, including the following:

- respondent reluctance to admit suicidal thinking
- respondent reluctance to disclose sexual orientation or gender identity

- possible respondent exaggeration of suicidal ideation
- difficulty in ascertaining the seriousness of suicidal thinking
- differences in definitions of sexual orientation

Differences in the results of these surveys may result from methodological issues including the age of the sample, how respondents are recruited, and how *ideation* is defined. It is also difficult to distinguish suicidal thoughts that put people at risk of suicide or a suicide attempt from thoughts that do not.

## **Conclusions About Suicidal Behavior Among LGB Youth**

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Research indicates that LGB youth have significantly higher rates of suicide attempts and suicidal ideation than their heterosexual peers. Data limitations make it difficult to draw conclusions about higher rates of death by suicide among LGB youth; however, the higher number of suicide attempts, as well as the seriousness of attempts among LGB youth, make it probable that this group of youth has a higher rate of suicide deaths than their heterosexual counterparts.

## **Risk and Protective Factors for Suicidal Behavior Among LGB Youth**

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Risk and protective factors help explain suicidal behavior – including suicidal ideation, suicide attempts, and suicide deaths. According to *National Strategy for Suicide Prevention*, risk factors “make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment” (U.S. Department of Health and Human Services, 2001, p. 202). Risk factors include mental disorders, a lack of social support, a sense of isolation, stigma associated with seeking help, loss of a relationship, and access to firearms and other lethal means, along with many other factors. Protective factors, such as access to effective care, restricted access to lethal means, community support, coping skills, and strong family connections, make it less likely that individuals will consider or attempt suicide (U.S. Department of Health and Human Services, 2001).

Risk factors affect the likelihood of suicidal behavior in ways both dynamic and synergistic – that is, a factor’s significance can change for an individual over time, and the effect of a single factor is increased when an individual has additional risk factors. Berman et al. (2006) grouped risk factors into themes such as mental illness, negative personality attributes (such as aggression and impulsivity), negative personal history (including previous self-harm and parental mental illness), isolation and alienation, and availability of a method. Beautrais (2003)

reviewed the literature on risk factors for suicidal behavior in youth. She identified a complex interplay of factors including adverse events (such as family discord, abuse, and neglect), stresses (relationship losses or conflicts and legal or disciplinary crises), personality traits (such as low self-esteem, impulsivity, and hopelessness), and mental health problems. She found that youth who demonstrated suicidal behavior may have had not only more stresses but also more severe stresses and that a majority of youth attempting suicide has some form of mental disorder at the time of the attempt (Beautrais, 2003).

The risk factors that apply to youth overall also apply to LGB youth. Kitts's review of the research literature (2005) confirms this. Kitts concludes that the elevated risk of suicide attempts among LGB adolescents is a consequence of the psychosocial stressors associated with being lesbian, gay, or bisexual, including gender nonconformity, victimization, lack of support, dropping out of school, family problems, suicide attempts by acquaintances, homelessness, substance abuse, and psychiatric disorders. While heterosexual adolescents also experience these stressors, they are more prevalent among LGB adolescents (Kitts, 2005).

In addition, stresses related to the awareness, discovery, and disclosure of being gay – which researchers refer to as “gay-related stress” – are unique risk factors for LGB youth (Bontempo & D'Augelli, 2002). Research indicates that LGB youth are more at risk for suicide attempts if they acknowledge their sexual orientation at an early age (Remafedi et al., 1991). Remafedi and his colleagues speculate that “compared with older persons, early and middle adolescents may be generally less able to cope with the isolation and stigma of a homosexual identity” (p. 874).

## **Social Environment**

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Although the social environment itself has not been defined as a risk factor for suicide, widespread discrimination against LGBT people, heterosexist attitudes, and gender bias can lead to risk factors such as isolation, family rejection, and lack of access to care providers. Risk factors may interact in unhealthy ways – for example, internalized homophobia or victimization may lead to stress, which is associated with depression and substance abuse, which can contribute to suicide risk. This risk may be compounded by a lack of protective factors that normally provide resilience, such as strong family connections, peer support, and access to effective health and mental health providers.

In the United States prejudice and discrimination against LGB people are widespread among individuals, and in fact, supported by many religious, social, and government institutions. Homophobia and heterosexism are terms that refer to prejudice against LGB people and reflect prevalent social attitudes that most people have internalized (McDaniel et al., 2001).

Morrow (2004) points out that “GLBT adolescents must cope with developing a sexual minority identity in the midst of negative comments, jokes, and often the threat of violence because of their sexual orientation and/or transgender identity” (p. 91-92) and that, given the pervasive homophobia in our culture and in the families of LGBT youth, “the internalization of homophobic and heterosexist messages begins very early – often before GLBT youth fully realize their sexual orientation and gender identity” (p. 92). Morrow also says that positive role models for LGBT youth are hard to find.

Herek and colleagues (2007) describe a framework to understand the social environment for sexual minorities. The framework integrates the sociological idea of stigma with the psychological idea of prejudice. Through stigma, society discredits and invalidates homosexuality relative to heterosexuality. Institutions embodying stigma results in heterosexism, and heterosexual individuals internalizing stigma results in prejudice. The United States legal system has faced challenges by sexual minorities and sympathetic heterosexuals that have led to significant changes. However, the legal system continues to reinforce stigma through discriminatory laws and the absence of laws protecting sexual minorities from discrimination in employment, housing, and services. A minority of states had antidiscrimination laws as of 2005, and most of these only referred to employment and not to housing or services. Most religious denominations continue to condemn homosexuality as sinful and provide a rationale for marginalizing LGB people.

Researchers suggest that this social environment puts stresses on LGBT people that elevate the risk of substance abuse, depression, anxiety, and other emotional problems. One study (with participants in their mid-twenties) found that internalized homophobia was correlated with depression, although not directly correlated with suicide (Igartua et al., 2003). Mays and Cochran (2001) found growing evidence that experiences of discrimination can result in mental health and general health disorders. Analyzing data from the National Survey of Midlife Development in the United States (MIDUS), they compared LGB and heterosexual people’s mental health and experiences with discrimination. The MIDUS asked about the frequency of lifetime and day-to-day experiences of perceived discrimination including being denied a scholarship, being denied a bank loan, receiving poorer services at stores, and being called names. Mays and Cochran found that homosexual and bisexual individuals reported more frequently than heterosexual individuals both day-to-day and lifetime discrimination, and 42 percent attributed the discrimination at least in part to their sexual orientation. LGB individuals were twice as likely as heterosexuals to have experienced discrimination in a lifetime event and were five times more likely to indicate that discrimination had interfered with having a full and productive life. Perceived discrimination had a relatively robust association with mental disorders.

Meyer (2003) describes a social environment that is hostile and stressful for LGB people. His review of research demonstrates that social stressors are significantly associated with mental disorders and supports a model of minority stress that theorizes the higher prevalence of mood, anxiety, and substance use disorders among LGB people as “caused by excess in social stressors related to stigma and prejudice” (p. 691). Another study relates minority stressors to suicidal behavior: a study of gay men (with an average age of 38) found that three stressors – internalized homophobia, stigma (related to expectations of rejection and discrimination), and experiences of discrimination – were significantly associated with five outcomes indicating psychological distress, including suicidal ideation and behavior (Meyer, 1995).

Other studies find that internalized homophobia and conflict about sexual orientation appear to contribute to suicide risk among LGB youth. One study reported that LGB youth are at higher risk of suicide if they report high levels of internal conflict about their sexual orientation (Savin-Williams, 1990). Another study of gay men (with a median age in the twenties) found that internalized homophobia was associated with depression and anxiety, which increased suicide risk (Igartua, Gill, & Montoro, 2003). A third study indicated that positive role models and high self-esteem are protective factors against suicide in young gay men (Fenaughty & Harre, 2003).

#### **A Research Agenda**

Research on discrimination and sexual minority social stress (see Mays and Cochran, 2001; Meyer, 2003; Meyer, 2007) suggest the need for large-scale epidemiological studies that focus on discrimination and social stressors and negative mental health outcomes in the LGB population. Meyer (2003) suggests that this research must use random sampling, sophisticated measures of sexual orientation, a large number of respondents, and hypotheses related to prevalence of disorders and their causes and the process through which stressors work.

### **Family Support**

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Aspects of family dynamics – such as lack of support, conflict, and rejection as well as connectedness – play an important role in suicide risk for LGB youth. Abuse within the family (whether psychological, verbal, physical, or sexual) elevates the risk of suicidal behavior by LGB young people (Gibson & Saunders, 1994; McBee-Strayer & Rogers, 2002). Forty percent of the callers to the Trevor Helpline for LGBTQ youth reported that they had difficulty with their families because of their

sexual orientation (Charles Robbins, personal communication, April 9, 2008). Family conflict is also a contributing factor to homelessness of LGBT youth, discussed below.

Family support plays an important role for LGB youth during the period in which they identify and “come out,” or disclose their sexual orientation to their families. LGB youth experience a rise in suicide attempts and ideation around the time of disclosure (D’Augelli & Hershberger, 1993; Igartua et al., 2003; Remafedi et al., 1991). D’Augelli, Hershberger, & Pilkington (1998) found that LGB youth who had disclosed to their families were more than four times as likely to have attempted suicide as LGB youth who had not disclosed. Researchers speculate that this is related to the stress caused by coming out and fear of – or actual – rejection by members of their families. A substantial proportion of youth who disclose an LGB sexual orientation to their families are assaulted by members of their family, while many others are threatened or verbally and emotionally abused (D’Augelli et al., 1998).

Research findings generally agree that family and parental support are important protective factors against adolescent suicide for LGB youth (Kidd et al., 2006; Proctor & Groze, 1994). Eisenberg and Resnick (2006) measured protective factors – specifically, family connectedness, other adult caring, and school safety – based on youth self-reports. They found that lower levels of these protective factors in LGB youth account for much of the increased risk of suicidal ideation and attempts. In particular, family connectedness plays a vital role for LGB youth: those with strong family connectedness are half as likely to experience suicidal ideation as those with low family connectedness. They concluded:

Family connectedness, support from other adults, and school safety are all characteristics that are amenable to change, and would be appropriate targets for interventions aimed at protecting young people from self-harm. Improving the ability of parents and other influential adults to connect with and support adolescents grappling with issues of sexual identity may be a critical component of mental health promotion and protection for these young people (p. 667).

## **Internet Use**

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Use of the Internet by young people has grown astronomically in recent years, and concerns about the potential benefits and harm of this technology have been raised. More than half of all online American youth ages 12 to 17 use an online social networking site (Lenhart & Madden, 2007). Public attention has focused on social networking sites for potential unwanted sexual solicitation and harassment of youth; however, the majority of youth who are online are not victimized, and

online victimization seems to occur less frequently on social networking sites than in other Internet applications such as instant messaging. (Ybarra & Mitchell, 2008). About half of teens use social networking sites at least once a day. Nine-tenths use the sites to stay in touch with friends they see frequently, while half use the sites to make new friends (Lenhart & Madden, 2007).

Internet use by youth also raises questions about targeted messages to influence suicidal behavior. Sites that promote suicide and describe specifics of methods, as well as chat rooms that may facilitate suicide pacts, exist in cyberspace alongside health- promoting and suicide prevention sites. The influence of the Internet on suicidal behavior is not well understood (Biddle et al., 2008) although the influence of other media reporting of suicides – particularly specific content about methods – has been shown to raise the risk of suicide clusters or contagion (Biddle et al., 2008; Gould, Petrie, Kleinman, & Wallenstein, 1994; Gould, Wallenstein, & Davidson, 1989; Gould, Wallenstein, Kleinman, 1990; Gould, Wallenstein, Kleinman, O’Carroll, & Mercy, 1990; Gould, 2001; Gould, Jamieson, & Romer, 2003).

LGBT youth rely on the Internet and related technologies to a greater degree than their peers in order to find an accepting peer group and social support (Hillier, Kurdas, & Horsley, 2001; McFarlane et al., 2002; Brown, Maycock, & Burns, 2005). This reliance has been attributed to the relative social isolation of these youth, the privacy that these media are perceived to provide, and the ready access to a supportive environment (Hillier et al.). Social networking sites such as MySpace and Facebook have been rapidly embraced by adolescents and young adults and particularly by young LGBT individuals (Hillier et al.; Koblin, 2006; Egan, 2000). Virtual and online spaces are seen as sites where youth can explore their identities and interact with others (Maczewski, 2002).

Not enough is known yet about the potential protection or risks posed by online social networking among LGBT youth. Online contacts may decrease isolation and build positive relationships. Such networks offer the potential to disseminate suicide prevention or other targeted health messages to audiences of LGBT individuals. Further research is needed on how social networking and other Internet applications can raise – or lower – risks of suicide among LGBT and other adolescents.

## **AIDS/HIV Prevalence**

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Little research exists on the relationship of HIV and AIDS status to suicide. Most research on the topic does not target LGB people per se, although studies of HIV/AIDS and suicide tend to include a substantial portion of gay men. Some research indicates that being infected with HIV or having AIDS may elevate the



risk of suicide. A study of Swiss homosexual and bisexual males found that a sample of HIV seropositive gay men (all ages) had significantly higher suicide risk than did the HIV seronegative sample (Cochand & Bovet, 1998). A study of a very small sample of HIV seropositive gay men in New York City found that 17 percent either had made plans or had given serious consideration to ending their own lives because of their HIV status (Goggin et al., 2000). A study of HIV seropositive men in Texas over the age of 18 (80 percent of whom identified as gay) revealed that 59 percent had thought about suicide and 30 percent had attempted it (Shelton et al., 2006). A study of HIV seropositive men and women in North Carolina (64 percent were gay) found that two thirds had exhibited suicidal ideation at some point since their diagnosis and one-third were currently exhibiting ideation. Half of the individuals in the sample had made suicide plans and one quarter had attempted suicide (Robertson, Parsons, Ven Der Horst, & Hall, 2006). A study of primarily ethnic minority women in New York City (all ages and sexual orientations) found those who were HIV seropositive were significantly more likely to have experienced suicide attempts or ideation (Cooperman & Simoni, 2005).

HIV seropositive status has also been found to be associated with elevated rates of depression, a risk factor for suicide, among gay men (Hedge & Sherr, 1995) as well as among men and women of all sexual orientations (Williams et al., 2005).

At least one review of the literature on HIV/AIDS and suicide points out that this research is compromised by the fact that many of the participants in these studies are GB men and people who have abused substances – two groups at elevated risk for suicidal behavior (Komiti et al., 2001). The research on the relationship of HIV/AIDS and suicide is also complicated by the fact that people with HIV/AIDS who attempt suicide tend to have additional risk factors that can confound the relationship between HIV/AIDS and suicide (including younger age, a family history of suicidal behavior, and depression) (Roy, 2003).

## **Depression and Substance Abuse**

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Although the majority of young people who are clinically depressed or who abuse alcohol or other drugs do not attempt or die by suicide, both depression and substance abuse are risk factors for suicide among people of all ages, sexual orientations, and gender identities. Among LGB youth, suicide and suicidal ideation are associated with depression (Proctor & Groze, 1994; Russell & Joyner, 2001; Savin-Williams & Ream, 2003; van Heeringen & Vincke, 2000) and with substance abuse (Remafedi et al., 1991; Russell & Joyner, 2001; Savin-Williams & Ream, 2003). LGB young people have an elevated risk for both depression (Gilman et al., 2001; Russell & Joyner, 2001; Safren & Heimberg, 1999) and substance abuse (Bagley & Tremblay, 2000; DuRant et al., 1998; Garofalo et al., 1999; Gilman et al., 2001; Russell & Joyner, 2001). Safren and Heimberg (1999) found that when

substance abuse, depression, and related psychosocial factors are taken into account, the difference in suicide rates between LGB and heterosexual people is greatly reduced.

Recent research from Silenzio and others found that some risk factors for suicidal ideation and attempts differed for LGB and non-LGB youth responding to the National Longitudinal Study of Adolescent Health. Consistent with earlier findings, LGB youth had higher rates of suicidal ideation and attempts than non-LGB youth. There was a surprising finding, however: drug use was *not* associated with increased risk of ideation for LGB respondents, and problem drinking, drug use, and depression were *not* associated with increased risk of suicide attempts for LGB respondents. The authors call for further research on other mediating risk and protective factors for LGB youth (Silenzio et al., 2007).

## **Gender Nonconformity**

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Fitzpatrick, Euton, Jones, and Schmidt (2005) conclude that cross-gender role (often called gender nonconformity) – that is, “personality traits associated with the opposite sex” (p. 35) – accounts for almost all of the variation in suicidal behavior between heterosexuals and LGB people. An earlier study identified that gender nonconformity in gay and bisexual males was predictive of self harm (Remafedi et al., 1991). Some research – for example, the review of the literature in Lippa (2000) – indicates that gender nonconformity is more prevalent among LGBT people than among heterosexuals. Although research on the issue is lacking, the social disapproval of gender nonconformity<sup>1</sup> might result from its association (whether real or perceived) with an LGB sexual orientation.

## **Ethnicity**

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Research indicates that some ethnic and cultural groups (such as first-generation immigrants from Latin America) are less accepting of children who do not conform to standard gender roles than are families that have been in the United States for several generations (Ryan, 2004). Other researchers maintain that the question of whether particular ethnic minority cultures in the United States are less accepting of LGB people remains open (Herek & Gonzalez-Rivera, 2006). Some researchers theorize that LGB youth who are members of ethnic groups with particularly strong prohibitions against homosexuality may be subject to levels of stress that can lead to increased risk of depression, anxiety, or suicidal ideation (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Kulkin et al., 2000; Lebson, 2002; Morrison & L’Heureux, 2001; Morrow, 2004; Pinhey & Millman, 2004; Rotheram-Borus, Rosario, Van Rossem, & Reid, 1995).

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<sup>1</sup> The term *gender nonconformity* is not used as a pejorative by any of the researchers whose work is cited in this section or by the authors of this report.

## **Suicidal Behavior in Family and Friends**

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Exposure to suicide or suicide attempts by family members or friends is a risk factor for suicidal behavior. Research also indicates that LGB youth who reported suicidal ideation and attempts were more likely to report that a member of their family or close friend has attempted or died by suicide (D'Augelli, Hershberger, & Pilkington, 2001; Russell & Joyner, 2001). More LGB youths know of peers who have attempted or died by suicide: more than half of LGB youth in one study knew of a suicide attempt by a close friend, while for adolescents generally another study estimates 20 percent knew of a friend's suicide attempt (D'Augelli, Hershberger, & Pilkington, 2001).

## **Suicidal Behavior and Transgender Youth**

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There is a paucity of research on suicide, suicide attempts, and suicidal ideation among transgender youth. A recent study focused on transgender youth age 15 to 21. Of transgender youth participating in the study, 45 percent had thought seriously of killing themselves, and half of these said their thoughts were related to their transgender status. When comparing transgender youth who reported having attempted suicide with those who had not, researchers found that the youth who had attempted suicide had experienced more physical and verbal abuse from their parents (Grossman and D'Augelli, 2007).

One study that was not restricted to young people found that 83 percent of transgender people had thought about suicide and 54 percent had attempted it (Dean et al., 2000). In another study that surveyed transgender people of all ages, about one third (30.1 percent) of respondents reported at least one suicide attempt (Kenagy, 2005). A study of transgender people over the age of 18 found that 32 percent had attempted suicide. This study found that the risk factors associated with attempted suicide among transgender people were younger age (under 25), depression or a history of substance abuse, forced sex, and gender-based victimization and discrimination (Clements-Nolle, Marx, & Katz, 2006). Although these studies were not restricted to youth, all of them found high attempt rates for transgender people.

While little research exists on transgender people and suicidal behavior, it is reasonable to hypothesize that transgender youth—in common with LGB youth—have elevated risk and lower protective factors for suicidal behavior. Transgender youth often exhibit gender nonconformity and are presumed by others to be LGB even if they do not identify as such. Transgender youth also experience high rates of rejection and physical and verbal abuse at the hands of their parents (Grossman, D'Augelli, Howell, & Hubbard, 2005). Grossman and D'Augelli (2007) have summarized the experiences of transgender youth as indicated in recent

research – victimization by their peers, negative parental reactions, substance abuse, and family violence – as similar to those of their LGB counterparts, who have higher rates of suicidal behavior.

## **The Current State of Suicide Prevention for LGBT Youth**

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The staff members of the Suicide Prevention Resource Center (SPRC) have identified LGBT youth programs that explicitly incorporate components of suicide prevention as well as suicide prevention programs that specifically focus on LGBT youth by (a) searching the World Wide Web; (b) posting queries to LGBT advocate and provider e-mail lists and to suicide prevention e-mail lists; (c) asking SPRC’s collaborators and contractors about suicide prevention services for LGBT youth; and (d) reviewing the medical, psychological, and social science literature.

SPRC identified only one program with a primary focus on preventing suicide by LGBT youth. The Trevor Project operates the nation’s only 24-hour toll-free suicide prevention helpline for LGBT and questioning youth (1-866-4-U-TREVOR).

## **Programs Serving LGBT Youth**

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SPRC staff found that most programs serving LGBT youth do not offer services explicitly related to suicide prevention but give priority to other issues, such as school safety, health promotion, violence and harassment prevention, civil rights, peer education, emergency support, and HIV and AIDS prevention and support services. Many of these organizations offer services that contribute to suicide prevention by strengthening protective factors, even if suicide prevention is not among their explicit organizational goals. Training in life skills, enhancing peer relationships, connecting LGBT young people with supportive adults, and helping parents and teachers provide support to LGBT youth are all activities that contribute to preventing suicide.

Several youth suicide prevention state coalitions include state chapters of Parents, Families, and Friends of Lesbians and Gays (PFLAG) or other organizations serving LGBT people. Many of these organizations explicitly acknowledge the importance of suicide prevention and actively pursue this work along with other issues. Cooperation among these organizations has reciprocal benefits: LGBT organizations can ensure that statewide coalitions include LGBT youth in developing public awareness, training, data, and interventions, and statewide coalitions can provide resources and suicide prevention expertise to LGBT organizations. Some organizations with a broad focus on public health provide specific suicide prevention resources for LGBT youth – for example, the King County (Washington) Public Health Department features a suicide prevention page focusing on LGBT youth on its Web site.

## Youth Suicide Prevention Programs

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SPRC also considered the scope of youth suicide prevention programs and whether they explicitly included LGBT youth. A summary of suicide prevention programs for all youth found that most are implemented in three settings – schools, communities, and health care systems – and follow one of two broad goals: case-finding with referral and treatment or reduction of risk factors (Gould, Greenberg, Velting, & Shaffer, 2003).

Case-finding programs include school-based suicide awareness curricula, gatekeeper training, screening, and crisis centers and hotlines. School-based awareness programs are generally designed to heighten student awareness of adolescent suicide, increase recognition of signs of and risk factors for suicide, change attitudes about getting help, and publicize resources. Gatekeeper training teaches people who come into contact with youth – teachers, peers, school staff, and others – to identify warning signs and to refer youth at risk for suicide to treatment or other services. Screening, which can include questions about mood, suicidal thoughts, and substance abuse, identifies high-risk youth for further assessment and treatment. Risk-factor reduction includes lethal-means restriction, media training, youth life skills training, and postvention (that is, interventions that follow suicidal behavior) (Berman, Jobes, & Silverman, 2006).

Rather than only reducing risk factors, many suicide prevention programs emphasize building protective factors, as recommended by *The Surgeon General's Call to Action to Prevent Suicide*. Programs to enhance protective factors or resilience are as important as programs for risk reduction (U.S. Public Health Service, 1999). A study of American Indian and Alaska Native youth suicide attempts found that increasing protective factors was more effective for reducing attempt probability than decreasing risk factors. Protective factors included ability to discuss problems with family or friends, connectedness to family, and emotional health (Borowsky, Resnick, Ireland, & Blum, 1999).

The Garrett Lee Smith Memorial Act funds state and tribal youth suicide prevention and early intervention programs across the country. Substantial work has been underway since 2005 to develop programs that address at-risk youth and to evaluate the effectiveness of interventions. Several grantees have decided to focus on LGBT youth as an at-risk population, mostly by training parents of LGBT youth and staff from schools and agencies that serve youth. The higher risk of suicidal behavior by LGBT youth, as well as risk and protective factors for LGBT youth, are discussed in training sessions. The Maine Youth Suicide Prevention Program and the Tennessee Department of Mental Health are grantees that work directly with LGBT youth when developing training, awareness, and resource materials. Other grantees offer clinicians the Suicide Prevention Resource Center

training “Assessing and Managing Suicide Risk” which identifies LGBT youth as a group at higher risk for suicidal behavior.

Most states have suicide prevention coalitions with plans that follow the goals of the *National Strategy for Suicide Prevention*. Some plans specifically refer to LGBT people as a risk group to address. Many statewide coalitions oversee the implementation of the state plan and hold yearly conferences for providers, survivors, and agencies involved in suicide prevention. Conferences frequently include workshops on such topics as the higher risk for suicidal behavior among LGBT youth and recent research on risk and protective factors for LGBT youth. In addition, the largest national conference on suicide prevention, hosted yearly by the American Association of Suicidology, has featured sessions in recent years on topics related to suicidal behavior and LGBT people. National organizations including the Suicide Prevention Action Network USA and the American Foundation for Suicide Prevention, and the federal agency Substance Abuse and Mental Health Services Administration, have also featured the topic in national meetings and conferences.

Suicide prevention programs can increase their capacity to serve the specific needs of LGBT youth by taking the following steps:

- Providing information about LGBT youths’ risk of suicidal behavior to the staff of case-finding programs, including gatekeepers, crisis line staff, and screening program staff
- Including information about LGBT youths’ risk of suicidal behavior in school-based and public awareness material
- Identifying LGBT-inclusive services and providers to use for referrals of youth from screening programs, crisis lines, or gatekeepers
- Including LGBT youth in program development and evaluation
- Developing peer-based support programs
- Including in life skills training and programs to reduce risk behaviors the topic of coping with stress and discrimination
- Supporting parents or guardians and other family members of LGBT youth
- Emphasizing protective factors relevant to LGBT youth

Russell (2003) reports that there are no published studies of the efficacy of suicide prevention programs for sexual minority youth. Since LGBT youth are at higher

risk for suicidal behavior, it is imperative that programs that address this population be developed, implemented, and evaluated.

## **A Cultural Competence Approach to Preventing Suicide Among LGBT Youth**

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One way in which service providers – whether they work for an agency that serves all youth or LGBT youth only – can better serve LGBT youth is by using a cultural competence model. Cultural competence encompasses a set of behaviors, attitudes, and policies that enables a system, agency, or professional to work effectively in cross-cultural situations (Messinger, 2006). Many providers already use cultural competence to ensure that their services are effective for ethnic and racial minorities. Given that LGBT youth are a minority dealing with negative social forces, a cultural competence approach for LGBT people can help address service disparities.

Awareness of and sensitivity to LGBT people can be promoted through training. A key role for instructors is to create a nonjudgmental and supportive learning space with safety guidelines developed by the group being trained. This approach allows for open exploration and discussion. Training begins with comprehending the existence of LGBT people, learning and becoming comfortable with LGBT terminology, and developing an initial awareness of one's own biases and assumptions. Values clarification and empathy development is an important part of sensitivity training. Instructors explore the group's values about LGBT people, policies, and civil rights. Participants are asked to imagine the stresses that sexual and gender minority people face. Competency training allows participants to rehearse skills and often uses case studies and exercises in which participant groups develop LGBT-inclusive policies and programs (Turner, Wilson, & Shirah, 2006)

The National Center for Cultural Competence has created a checklist (Dunne, Goode, & Sockalingam, 2003) of the core functions necessary for programs to effectively serve culturally and linguistically diverse groups of children and youth with special needs. The checklist, adapted here by staff of the national Suicide Prevention Resource Center for programs seeking to effectively serve LGBT youth, is in Appendix B. Lack of support and barriers to care appear to be risk factors for LGBT youth; more inclusive and aware providers, fostered by cultural competence, can serve as a protective factor.

## **Suicide Prevention Programs: Other Considerations**

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Family connectedness – including the ability of youth to talk with parents, youth feeling cared about and understood, and the family having fun together – has been

shown to reduce the risk of suicidal ideation and suicide attempts for some LGB groups by half (Eisenberg & Resnick, 2006). Thus, programs that build family support are important, especially for LGBT young people. Supporting the development of PFLAG groups, LGBT youth support groups, family agencies that provide culturally sensitive services to families with LGBT youth, and gay-straight alliances may help to reduce the isolation of LGBT youth and create the social supports that operate as a protective factor against suicidal behavior.

A review of studies on adolescent health, risk behavior, and sexual orientation revealed that the initiation of some risk behaviors for suicide before age 13 was correlated with LGB identity (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998). One study reported that many LGB youth make their first attempt before disclosing their identity (D'Augelli et al., 2001). A study of LGB adults found that the average age for first disclosure was 29, with a range of ages for first disclosure from age 10 to 68 (D'Augelli & Grossman, 2001). These findings suggest that suicide prevention for LGB youth should begin at the age range in which they are considering disclosing their identity to their parents. Because LGB people often become aware of their orientation at very young ages, it is important to direct some suicide prevention interventions at younger adolescents and their parents.

Gatekeeper training teaches people to recognize youth at risk for suicide and to refer them for help. Peer gatekeeping programs may be an effective intervention with LGB youth: youth often first confide their problems to peers (Berman et al., 2006) and for many LGB youth, a gay or lesbian friend may be the most important person in their lives (Garofalo et al., 1998).

## **Strategic Venues for LGBT Youth Suicide Prevention**

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Efforts to reduce suicidal behavior in LGBT youth need to identify promising venues through which to reach them as well as optimal features for each venue. Practitioners seeking to develop prevention efforts within schools, health care services, and mental health and social service agencies should give highest priority to staffing and the overall program environment. As important as knowledgeable and sensitive staff members are, they cannot work in isolation but need an environment – physical setting, policies and procedures, colleagues and board – that supports safety and inclusiveness.

### **Schools**

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Adolescents spend a substantial amount of time in school. School provides much of the context for the social, intellectual, emotional, and sexual development of young people.



Many students feel unsafe at school. The 2005 National School Climate Survey of middle and high school students concluded that “anti-LGBT language, as well as bullying and harassment on the basis of sexual orientation or gender identity/expression remain common in America’s schools” (p. xii). Nearly two-thirds of the respondents felt unsafe at school because of their sexual orientation. Slightly more than 64 percent of students responding said they had been verbally harassed, and 17.6 percent said they had been physically assaulted because of their sexual orientation (Kosciw & Diaz, 2006). Because the National School Climate Survey is not a scientific survey, results may not be representative of the entire LGBT youth population; however, this does not lessen the fact that hundreds of LGBT students reported being harassed in school.

A study of ninth- and twelfth-grade students indicated that approximately one in seven LB females and one in five GB males report feeling a high degree of safety in school (Eisenberg & Resnick, 2006). In a study of high school students, LGB youth were almost five times as likely as non-LGB youth to have missed school because of fears about their safety and more than four times as likely to have been threatened with a weapon on school property (Garofalo et al., 1998). LGB youth report school avoidance at higher rates than other students in the Massachusetts 2005 Youth Risk Behavior Survey. Thirteen percent of LGB students reported having skipped school in the previous month because of feeling unsafe at or en route to school, compared to only 3 percent of non-LGB students (Massachusetts Department of Education, 2006a).

Victimization – violence, bullying, and verbal harassment – is a risk factor for suicide attempts and suicidal ideation (Bagley & Tremblay, 2000; Bontempo & D’Augelli, 2002; Huebner, Rebchook, & Kegeles, 2004; Rivers, 2001; Russell & Joyner, 2001) as well as for mental health issues that increase the risk of suicide, including substance abuse and low self-esteem among LGB youth (Bontempo & D’Augelli, 2002; Huebner et al., 2004). Studies suggest that LGB students are victimized by other students at higher rates than are their heterosexual peers (Bagley & Tremblay, 2000; Bontempo & D’Augelli, 2002; D’Augelli, 2002; DuRant et al., 1998; Garofalo et al., 1999).

Aside from explicit victimization, many adolescents who identify as LGBT experience social isolation, ostracism, and stressed interpersonal relationships at school. Many school staff members are not prepared and sometimes unmotivated to intervene on behalf of LGBT youth (Elze, 2006). In a 1991 study, only one fifth of guidance counselors had received training on serving gay and lesbian students, and two-thirds had negative feelings toward non-heterosexual people (Prezbindowski & Prezbindowski, 2001).

Research emphasizes that school safety seems to be a critical protective factor against suicidal ideation and attempts for LGBT youth. Schools can play an

important role in preventing suicidal behavior among LGBT youth by taking the following steps:

- Ensuring that the school is a safe and supportive environment for LGBT youth by instituting and enforcing policies that prohibit harassment and discrimination
- Including specific content about the needs of LGBT youth in trainings for staff, teachers, and parents on youth development, mental health issues, gatekeeper skills, and violence prevention
- Including material on LGBT youth in curricula and resources in the library related to sexuality
- Integrating specific activities on and for LGBT youth in evidence-based programs that help all youth to develop life skills and critical-thinking skills, and to resist violence, substance abuse, and other risk behaviors

**Box 1. Model School Program: Out for Equity**

Out for Equity is a program within the St. Paul (Minnesota) Public Schools that is committed to:

- Reducing high-risk behavior among lesbian, gay, bisexual, and transgender students
- Reducing harassment and violence against lesbian, gay, bisexual, and transgender students, staff, and families
- Fostering school environments that value diversity

Staff dedicated to speaking out against harassment and supporting LGBT students are called Safe Staff and commit to activities including the following:

- Be accurately informed and continue learning about LGBT issues
- Examine personal attitudes and beliefs
- Challenge speech and actions that harass or are violent against LGBT people
- Be comfortable talking with LGBT people and about LGBT issues
- Respect confidentiality
- Be aware of services for LGBT people
- Help set a school climate of safety and support for all students

Furthermore, Out for Equity has developed a list of ways for staff to end homophobia in schools:

- Do not assume heterosexuality.
- Guarantee equality. Include sexual orientation and gender identity in non-discrimination and harassment policies as well as diversity statements.
- Create a safe environment that does not tolerate physical violence or harassing language.
- Diversify library and media holdings – often the first place students go to for

- accurate sexuality and gender information.
- Provide training for faculty and staff to develop understanding of LGBT youth and children from LGBT families.
  - Provide appropriate health care and education. Counselors and health staff need to make their sensitivity to LGBT issues clear.
  - Be a role model. Demonstrate respectful language, intervene in harassment instances, and bring diverse images into the classroom.
  - Provide support for students. Gay-straight alliances are one way to help build peer support and acceptance as well as promote equality and school change.
  - Reassess the curriculum to integrate LGBT issues.
  - Broaden entertainment and extracurricular activities to include content that reflects diversity.

Finally, educators can play an important role in making their schools inclusive and safe for sexual and gender minorities by adapting forms, classroom materials, and textbooks; redesigning counseling services, school activities, and student resources; and adopting anti-harassment policies and procedures (Horowitz and Loehning, 2005).

## **Mental Health and Social Services**

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It can be especially damaging for young LGBT people to receive less-than-supportive services from mental health care providers. Some mental health care providers still consider an LGB orientation pathological (Morrison & L'Heureux, 2001), despite the fact that the American Psychiatric Association removed homosexuality from its list of psychiatric disorders in 1973 (Ryan & Futterman, 2001). Other providers may simply lack experience and training in supporting LGBT people. All mental health providers need to ensure that their practice responds to the needs of LGBT young people.

Morrow (2006) has developed guidelines for social work practice with LGBT youth that could be applied to other types of providers. These include the following:

- Assess the degree of LGBT identity development and the degree to which youth have developed a positive or negative self-identity.
- Assess the level of disclosure of sexual orientation to others (including parents, friends, and schoolmates), and help young people explore the advisability and consequences of disclosure.

- Assess safety, since LGBT youth can be at risk of violence from family and classmates as well as of suicidal ideation, substance abuse, self-harm, and depression.
- Provide accurate educational information on sexual orientation and gender identity, given that such material is often excluded (or presented inaccurately) in health classes.
- Establish an LGBT-supportive work area, for example, by hiring and training staff supportive of LGBT youth and by displaying LGBT-supportive literature.
- Advocate for enhanced social services, a more supportive school environment, and civil rights and social change.

Working with transgender children, youth, and their parents raises additional challenges for which child welfare workers and other professionals need guidance. Research based on focus groups of transgender people indicates that some felt they were treated poorly by psychotherapists and attributed this poor treatment to the provider's lack of experience with transgender people or the provider's belief that transgenderism is an illness. Some members of the focus groups reported that participating in peer support groups was helpful (Xavier & Bradford, 2005). Mallon and DeCrescenzo (2006) recommend that practitioners work with transgender clients to develop strategies for expressing gender variance and dealing with discrimination and prejudice. They also emphasize that practitioners should closely monitor the safety of the youth, as sexual violence toward transgender youth is prevalent.

Meyer (2007) emphasizes the need to address the social stressors faced by sexual minority individuals at both the structural and individual levels, in prevention and intervention. It is important for providers to work to eliminate sources of stress in the social environment by working to reduce antigay violence, eliminate discrimination, and create a supportive social environment. There are many national organizations to support this work. Individual-level interventions must acknowledge the importance of individual agency and resilience. Prevention programs can build LGB youth sense of self, while clinical interventions can focus on issues of internalized homophobia, antigay violence, and rejection and discrimination. He concludes:

“Ignoring the social environment would erroneously place the burden on the individual, suggesting that minority stress is only a personal problem for which individuals must be treated” (p. 259).

## Health Care Services

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Many youth seek help for emotional issues such as depression or substance abuse from their primary health care providers. Health care providers are in a position to respond to suicidal behavior in youth even if young people do not readily volunteer information about these problems.

Unfortunately, LGBT people report hostile treatment and substandard care as well as denials of care by health care providers (Elze, 2006). LGBTQ youth in one study reported bad clinical interactions and said that they value what all youth value in health care – competence, cleanliness, respect, and honesty. (“Q” designates youth who are “questioning”.) LGBTQ youth repeatedly emphasized the importance of confidentiality. They also valued specific knowledge of LGBTQ issues and sensitivity (Ginsburg et al., 2002).

Frankowski and the Committee on Adolescence of the American Academy of Pediatrics have developed guidelines for pediatricians working with LGB youth that are also appropriate for other types of health care providers. These recommendations include raising issues of sexual orientation and behavior with *all* adolescent patients, since many LGB youth will not bring up their sexual orientation voluntarily. The guidelines recommend that the provider give factual, current, and nonjudgmental information while maintaining confidentiality. Professionals who feel unable to provide care to LGB youth are advised to refer these patients to other providers (Frankowski & American Academy of Pediatrics Committee on Adolescence, 2004).

The GLBT Health Access Project in Massachusetts has developed comprehensive standards of practice for quality health care services for LGBT clients. The standards address administrative practice and service delivery in personnel, client rights, intake and assessment, service planning and delivery, confidentiality, and community outreach and health promotion. The standards, funded by the Massachusetts Department of Public Health, include indicators to assess progress and help providers meet the standards (Gay, Lesbian, Bisexual, and Transgender Health Access Project, 2006).

## **Box 2. Model Health Care Program: Fenway Community Health**

Fenway Community Health in Boston, Massachusetts provides medical and mental health care to LGBT individuals, raises awareness about LGBT health issues, and hosts a national LGBT helpline. Fenway offers primary and specialty health care, mental health and addiction services, alternative therapies, health promotion and community activities, violence prevention and recovery, and family and parenting services. Fenway has the broad goal of improving the health of the larger local and national community through education and training, policy and advocacy, and research and evaluation. Since its beginning decades ago, Fenway has been a leader advocating for sexual minority health care needs.

Fenway staff members are trained to address depression and suicide and work with the GLBT Health Access Project, which offers training and technical assistance to health care providers. Fenway's Peer Listening Line and GLBT Helpline are anonymous and confidential phone lines that offer LGBT adults and youth information, referrals, and support.

The Fenway Institute at Fenway Community Health is an interdisciplinary center whose research aims to better understand the needs of the LGBT community and to create programs and policies based on that knowledge. In 2007, the National Institutes of Health awarded Fenway Institute a federal population center grant, and the Institute became the first federally funded research center to focus specifically on sexual minority population research. Research will focus on the diversity of LGBT individuals, families, and households; demographic features of LGBT health, illness, disability and mortality; and behavioral issues in HIV transmission.

Working with the American College of Physicians, the Fenway Institute published the nation's first medical textbook focused on LGBT people, *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*. *The Guide* is a comprehensive textbook that aims to eliminate disparities in health care for sexual and gender minorities. It includes content about health promotion for LGBT patients, basic issues for transgender and intersex patient health, and unique clinical issues for LGBT populations.

Fenway is a leading example of LGBT health centers across the country that offer models of inclusive and effective ways to provide LGBT people with services that reduce the risk of suicidal behavior.

## **Working with LGBT Youth at Higher Risk**

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Although LGBT youth in general are at higher risk for suicidal behavior, certain subpopulations of LGBT youth are at especially high risk. For purposes of planning suicide prevention services, LGBT youth who are not living at home—homeless and runaway youth as well as youth in foster care and juvenile justice

settings—face similar challenges. The issues of family conflict and rejection, cycles of abuse and neglect, and juvenile criminal offenses are often closely related, and many young people may experience all of them.

## **Homeless and Runaway Youth**

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Although family conflict is the primary reason that youth leave or are expelled from their homes, LGB youth are at higher risk of being told to leave—or feeling that they need to leave—their homes than young heterosexual people. Once out of the home, LGB youth are more likely to end up on the streets than their heterosexual peers, often because of the hostile environment they face in foster or group homes and shelters for runaway and homeless youth (Ray, 2006). Studies have found that gay and lesbian youth make up 11 to 35 percent of homeless and runaway youth (Cochran, Stewart, Ginzler, & Cauce, 2002). The percentage may be larger in big cities perceived as welcoming to LGBT people: a study in Seattle found that 40 percent of homeless youth identified as LGB (Ray, 2006).

Life on the street represents risks for *all* homeless youth. Homeless and runaway youth have elevated rates of mental illness, violence, sexual exploitation, and substance abuse (Van Leeuwen et al., 2006). They also have a high rate of suicide attempts: one study found that 76 percent of homeless youth reported attempting suicide at least once, and 86 percent of that group reported more than one attempt (Van Leeuwen et al.).

For LGB youth, these risks are amplified. One study found that 62 percent of LGB homeless youth reported having attempted suicide, compared to 29 percent of non-LGB homeless youth (Van Leeuwen et al., 2006). A study of homeless youth in eight Midwestern cities found higher rates of suicidal ideation and previous suicide attempts for LGB youth (73 percent and 57.1 percent respectively) than for heterosexual youth (53.2 percent and 33.7 percent respectively) (Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). A study comparing homeless LGBU youth (“U” designates youth who stated they were “unsure” about their sexual orientation) and heterosexual youth found that LGBU youth had a higher rate of recent depression (and of recent suicide attempts for females) and a higher rate of lifetime history of suicide attempts (Noell & Ochs, 2001). Studies have also found that LGBT homeless youth have higher rates of depression, posttraumatic stress disorder, and psychopathology than do other homeless youth (Cochran et al., 2002; Whitbeck et al., 2004). A recent study reports that LGBTQ homeless youth compared to other homeless youth have almost twice the rate of sexual victimization and higher rates of HIV infection (Van Leeuwen et al., 2006). As many as one in five transgender people need or are at risk of needing homeless assistance, yet transgender youth face difficulties—in most shelters youth are housed by birth sex rather than by gender identity (Ray, 2006).

Families in conflict relating to a youth's sexual orientation may benefit from family therapy and other forms of support to reduce family stress and the likelihood that LGBT adolescents will leave the home (Cochran et al., 2002). Programs serving homeless and runaway youth may be more effective if they work to ensure that relevant staff members are informed about the particular risks of LGBT youth—risks that include more frequent victimization, higher rates of highly addictive drug use, and more sexual partners (Cochran et al.).

The National Gay and Lesbian Task Force report on LGBT homelessness (Ray, 2006) makes the following recommendations for practitioners:

- Agencies receiving funds to serve homeless youth should be required to demonstrate LGBT cultural competence and to adopt nondiscrimination policies for LGBT youth.
- Providers who seek professional licenses should be required to take LGBT awareness training and to demonstrate cultural competence.
- LGBT cultural competence training should be mandatory for all state agency staff who work in child welfare or juvenile justice.

These recommendations could reduce the stressors to LGBT youth and make services more accessible, thus preventing homelessness and reducing suicide risk.

## **Youth in Foster Care**

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Trauma, disruption, and isolation typify the lives of many foster children, a substantial proportion of who were abused by their families or come from families that were unable to provide care for them. Youth living in out-of-home settings have higher rates of emotional disorders and substance abuse and often lack the protective factors of youth with a more permanent family life. Adolescents in foster care have higher rates of past-year suicidal ideation (26.8 percent versus 11.4 percent) and higher rates of suicide attempts (15.3 percent versus 4.2 percent) than those who have not been in foster care (Pilowsky & Wu, 2006).

LGBT youth in foster care face significant challenges. Although abuse and neglect of LGBT youth in the foster care system have been documented, a recent survey found that no state child welfare agency had policies prohibiting discrimination based on sexual orientation or requiring training for staff or foster parents on the needs of LGBT youth (Elze, 2006). LGBT youth in foster care receive fewer services than their non-LGBT counterparts and are often labeled as difficult. They experience fears about their safety, rejection at intake, harassment, and violence. They have longer stays out of their homes, more frequent placement changes, and difficulties accessing appropriate physical and mental health services (Hunter,



Cohall, Mallon, Moyer, & Riddel, 2006). Foster care providers might assess how well they follow the guidelines for serving LGBT youth outlined below in Box 3.

## **Youth in Juvenile Justice**

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The juvenile justice system – which includes probation, diversion programs, courts, residential detention facilities, and group and foster care homes – addresses the rehabilitation of youth and the prevention of criminal acts by youth. Young people enter the juvenile justice system due to either crimes or status offenses (that is, offenses that apply only to youth, such as skipping school or running away from home). The juvenile justice system almost by definition deals with at-risk youth, many of whom are at elevated risk of suicide because of mental or substance abuse disorders, legal issues, and family conflict.

The pressures that cause LGBT youth to run away or be thrown out of their homes can also lead to their becoming involved with juvenile justice. Although some of these young people enter the system for reasons unrelated to their sexual orientation or gender identity, others enter the system because of behaviors directly related to conflicts with family or peers over their sexual orientation or gender identity. Many runaway youth living on the street – including LGBT youth – commit crimes related to their homelessness, including crimes committed while trying to support themselves on the street, such as robbery, prostitution, shoplifting, and selling drugs.

A study of LGBT youth in New York suggests they were overrepresented in the juvenile justice system, where they experienced widespread discrimination, abuse, and mistreatment. The authors of this study say that “even at its best, the system is widely ignorant of the existence and needs of LGBT youth” (p. 6). Although the report often notes suicide as a risk for these young people, none of the recommendations refer specifically to suicide prevention (Feinstein, Greenblatt, Hass, Kohn, & Rana, 2001). Staff members at juvenile justice residential services might assess how well they follow the guidelines for serving LGBT youth outlined below in Box 3.

**Box 3. The Model Standards Project for LGBT Youth in Child Welfare and Juvenile Justice Systems and CWLA *Best Practice Guidelines: Serving LGBT Youth in Out-Of-Home Care***

Legal Services for Children, which provides free legal and social services to youth in the San Francisco Bay Area, and the National Center for Lesbian Rights, a national legal resource center for LGBT people, undertook the Model Standards Project (MSP) in 2002. The goal of the MSP is to improve practices to benefit LGBT youth in foster care and juvenile justice out-of-home care.

The Model Standards Project calls for:

1. A safe and inclusive environment that prohibits slurs based on race, culture, religion, gender, gender identity, sexual orientation, or any other difference
2. Displaying posters and other visuals that demonstrate an LGBT-friendly environment
3. Using respectful inclusive language and intervening when youth show disrespect for LGBT differences
4. Training about LGBT youth for all staff, caregivers, and service providers as well as ongoing supervision and evaluation after this training
5. Policies prohibiting harassment and discrimination that apply to all levels of an institution as well as private contractors
6. Ensuring that potential caregivers practice nondiscriminatory, inclusive care and provide a safe home
7. Ensuring safety in residential agencies through close staff supervision, an emphasis on relationship between staff and residents, and high-quality programming (Wilber, Reyes, & Marksamer, 2006).

The recommendations of the MSP were used to develop *CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care*, published by the Child Welfare League of America (Wilber, Ryan, & Marksamer, 2006). See Appendix A for more information about the Best Practice Guidelines.

## Recommendations

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The authors assert the following recommendations to strengthen or increase protective factors and to reduce risk factors among LGBT youth. Agencies that serve youth – schools, health practices, suicide prevention programs, and youth services – as well as funders, can help to reduce suicidal behavior among these youth. The authors recommend that these agencies and individuals:

- Implement training for all staff members to effectively serve LGBT youth by including recognition and response to warning signs for suicide and the risk and protective factors for suicidal behavior in LGBT youth
- Include information about higher rates of suicidal behavior in LGBT youth in health promotion materials
- Assess and ensure that youth services and providers are inclusive, responsive to, and affirming of the needs of LGBT youth, and refer youth to these services and providers
- Develop peer-based support programs
- Include the topic of coping with stress and discrimination and integrate specific activities for LGBT youth in life skills training and programs to prevent risk behaviors
- Support staff advocacy for LGBT youth
- Incorporate program activities to support youth and their family members throughout the development of sexual orientation and gender identity, including awareness, identity, and disclosure. These programs must address young children and adolescents.
- Promote organizations that support LGBT youth, such as Gay-Straight Alliances and Parents, Families, and Friends of Lesbians & Gays (PFLAG)
- Institute protocols and policies for appropriate response if a client or student is identified as at risk of self-harm, has made a suicide attempt, or has died by suicide
- Make accurate information about LGBT issues and resources easily available

- Use an LGBT cultural competence model that enables individuals and agencies to work effectively with LGBT youth cultures
- Include LGBT youth in program development and evaluation
- Institute, enforce, and keep up to date non-discrimination and non-harassment policies for all youth
- Implement confidentiality policies that are clear, comprehensive, and explicit
- Assume that clients or students could be any sexual orientation or gender identity and respond accordingly
- Address explicitly the needs of LGBT youth in school-based programs and policies to prevent violence and bullying

Researchers and program developers, as well as funders, also play a role in reducing suicidal behavior in LGBT youth. The authors recommend that they:

- Use evaluation results, surveillance data, and research conclusions to develop evidence-based programs to build protective factors and to prevent suicide among LGBT youth
- Undertake large-scale epidemiological studies that include complex measures of sexual orientation and gender identity and include research on discrimination and mental illness
- Include LGBT youth in research development and evaluation
- In developing programs, emphasize protective factors for LGBT youth
- Develop research projects and funding for research on risk and protective factors for suicidal behavior for youth generally and for LGBT youth specifically and work with program staff to encourage getting research results into program design

These recommendations will help not only to reduce the disparate rate of suicidal behavior of LGBT youth but to promote the health, safety, and inclusion of LGBT youth as visible and empowered members of our communities.

## Conclusion

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The greater risk of suicidal behavior among LGBT youth may be seen as largely a function of our social environment, including discrimination and stigma. Social stressors are associated with mental illness, isolation, victimization, and stressful interpersonal relationships with family, peers, and community. The effect of this stress is compounded by the fact that many youth-serving professionals and institutions are not effectively meeting the needs of LGBT youth.

The good news is that we know enough about many of these risk and protective factors to do something to change them. To accomplish this, we urgently need to build the capacity of agencies that specifically serve LGBT youth and youth in general, all the while keeping our eye on the goal of reducing the disparity in suicidal behavior between LGBT youth and their peers. There is a tremendous opportunity for school staff, mental health providers, social service agency staff, and health care providers, as well as suicide prevention program staff, to take steps at the individual and institutional level to increase safety and inclusion, and further to advocate for LGBT youth so that all can recognize their potential.

The steps we take to reduce suicidal behavior among LGBT youth can have the additional benefit of reducing the social stigma and discrimination against LGBT people in our families, schools, and communities. Our ultimate goal is not to merely help lesbian, gay, bisexual, and transgender youth survive but to support them to thrive as healthy, productive, and vibrant youth welcomed and empowered in their communities.

## References

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- American Psychiatric Association. (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors*. Washington, DC: Author.
- Bagley, C., & Tremblay, P. (2000). Elevated rates of suicidal behavior in gay, lesbian and bisexual youth. *Crisis, 21*(3), 111-117.
- Balsam, K., Huang, B., Fieland, K. C., Simoni, J. M., & Walters, K. L. (2004). Culture, trauma and wellness: A comparison of heterosexual and LGB, and Two-Spirit Native Americans. *Cultural Diversity and Ethnic Minority Psychology, 10*(3), 287-301.
- Beautrais, A. L. (2001). Suicides and serious suicide attempts: Two populations or one? *Psychological Medicine, 31*(5), 837-845.
- Beautrais, A. L. (2003). Life course factors associated with suicidal behaviors in young people. *American Behavioral Scientist, 46*(9), 1137-1156.
- Beautrais, A. L. (2004). Further suicidal behavior among medically serious suicide attempters. *Suicide and Life-Threatening Behavior, 34*(1), 1-11.
- Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.
- Biddle, L., Donovan, J., Hawton, K., Kapur, N., & Gunnell, D. (2008). Suicide and the internet. *BMJ, 336*, 800-802.
- Bontempo, D. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364-374.
- Borges, G., Angst, J., Nock, M. K., Ruscio, A. M., Walters, E. E., & Kessler, R. C. (2006). A risk index for 12-month suicide attempts in the National Comorbidity Survey Replication (NCS-R). *Psychological Medicine, 36*(12), 1747-1757.
- Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatrics & Adolescent Medicine, 153*(6), 573-580.
- Botnick, M., Heath, K. V., Cornelisse, P. G., Strathdee, S. A., Martindale, S. L. & Hogg, R. S. (2002). Correlates of suicide attempts in an open cohort of young men who have sex with men. *Canadian Journal of Public Health, 93*(1), 59-62.
- Brent, D. A., & Bridge, J. (2003). Firearms availability and suicide: Evidence, interventions, and future directions. *American Behavioral Scientist, 46*(9), 1192-1210.
- Brent, D. A., Perper, J. A., Allman, C. J., Moritz, G. M., Wartella, M. E., & Zelenak, J. P. (1991). The presence and accessibility of firearms in the homes of adolescent suicides: A case-control study. *Journal of the American Medical Association, 266*(21), 2989-2995.
- Brown, G., Maycock, B., Burns, S. (2005). Your picture is your bait: Use and meaning of cyberspace among gay men. *Journal of Sexual Research, 42*(1), 63-73.

- Centers for Disease Control and Prevention. (2007). Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved February 20, 2008 from <http://www.cdc.gov/ncipc/wisqars/>
- Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality, 51*(3), 53-69.
- Cochand, P., & Bovet, P. (1998). HIV infection and suicide risk: An epidemiological inquiry among male homosexuals in Switzerland. *Social Psychiatry and Psychiatric Epidemiology, 33*(5), 230-234.
- Cochran, B., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*(5), 773-777.
- Cochran, S. D., & Mays, V. M. (2000a). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. *American Journal of Public Health, 90*(4), 573-578.
- Cochran, S. D., & Mays, V. M. (2000b). Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the US population. *Journal of Epidemiology, 151*(5), 516-523.
- Conwell, Y., Duberstein, P. R., Connor, K., Eberly, S., Cox, C., & Caine, E. D. (2002). Access to firearms and risk for suicide in middle-aged and older adults. *American Journal of Geriatric Psychiatry, 10*(4), 407-416.
- Cooperman, N. A., & Simoni, J. M. (2005). Suicidal ideation and attempted suicide among women living with HIV/AIDS. *Journal of Behavioral Medicine, 28*(2), 149-156.
- D'Augelli, A. R. (2002). Mental health problems among lesbian, gay and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*(3), 433-456.
- D'Augelli, A. R., & Grossman, A. H. (2001). Disclosure of sexual orientation, victimization, and mental health among lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence, 16*(10), 1008-1027.
- D'Augelli, A. R., & Hershberger, S. (1995). A multiyear analysis of changes in AIDS concerns and homophobia on a university campus. *Journal of American College Health, 44*(1), 3-10.
- D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology, 21*(4), 421-448.
- D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (1998). Lesbian, gay, and bisexual youth and their families: Disclosure of sexual orientation and its consequences. *American Journal of Orthopsychiatry, 68*(3), 361-371.
- D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (2001). Suicidality patterns and sexual orientation-related factors among lesbian, gay, and bisexual youths. *Suicide and Life-Threatening Behavior, 31*(3), 250-264.

- Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., et al. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association*, 4(3), 102-151.
- Dunne, C., Goode, T. & Sockalingam, S. (2003). *Planning for cultural and linguistic competence in state Title V programs serving children and youth with special health care needs and their families*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.
- DuRant, R. H., Krowchuk, D. P., & Sinal, S. H. (1998). Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *The Journal of Pediatrics*, 133(1), 113-118.
- Eaton, D., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Harris, W.A., et al. (2006). Youth risk behavior surveillance – United States, 2005. *MMWR Surveillance Summaries*, 55 (SS-5).
- Egan, J. (2000, December 10). Lonely gay teen seeking same. *New York Times Magazine*.
- Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health*, 39(5), 662-668.
- Elze, D. E. (2006). Oppression, prejudice, and discrimination. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual, and transgender people* (pp. 43-80). New York: Columbia University Press.
- Feinstein, R., Greenblatt, A., Hass, L., Kohn, S., & Rana, J. (2001). *Justice for all? A report on lesbian, gay, bisexual and transgendered youth in the New York juvenile justice system*. New York: Urban Justice Center.
- Fenaughty, J., & Harre, N. (2003). Life on the seesaw: A qualitative study of suicide resiliency factors for young gay men. *Journal of Homosexuality*, 45(1), 1-22.
- Fergusson, D., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, 56(10), 876-880.
- Fitzpatrick, K. K., Euton, S. J., Jones, J. N., & Schmidt, N. B. (2005). Gender role, sexual orientation and suicide risk. *Journal of Affective Disorders*, 87(1), 35-42.
- Frankowski, B. L., & American Academy of Pediatrics Committee on Adolescence. (2004). Sexual orientation and adolescents. *Pediatrics*, 113(6), 1827-1832.
- Garofalo, R., Wolf, R. C., Kessel, S., Palfrey, J., & DuRant, R. H. (1998). The association between health risk behaviors and sexual orientation. *Pediatrics*, 101(5), 895-902.
- Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatric & Adolescent Medicine*, 53(5), 487-493.
- Gay, Lesbian, Bisexual and Transgender Health Access Project. (2006). *Community standards of practice for the provision of quality health care services to lesbian, gay, bisexual, and transgender clients*. Boston, MA: Justice Resource Institute Inc. Retrieved June 18, 2007, from <http://www.glbthealth.org/CommunityStandardsofPractice.htm>



- Gibb, S. J., Beautrais, A. L., & Fergusson, D. M. (2005). Mortality and further suicidal behaviour after an index suicide attempt: A 10-year study. *Australian and New Zealand Journal of Psychiatry*, 39(1), 95-100.
- Gibson, G., & Saunders, D. E. (1994). Gay patients: Context for care. *Canadian Family Physician*, 40, 721-725.
- Gibson, P. (1989). Gay male and lesbian youth suicide. In M. R. Feinleib, (Ed.), *Report of the Secretary's Task Force on Youth Suicide* (Chapter 8). Washington, DC: Department of Health and Human Services.
- Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health*, 91(6), 933-939.
- Ginsburg, K. R., Winn, R. J., Rudy, B. J., Crawford, J., Zhao, H., & Schwartz, D. F. (2002). How to reach sexual minority youth in the health care setting: The teens offer guidance. *Journal of Adolescent Health*, 31(5), 407-416.
- Goggin, K., Sewell, M., Ferrando, S., Evans, S., Fishman, B., & Rabkin, J. (2000). Plans to hasten death among gay men with HIV/AIDS: Relationship to psychological adjustment. *AIDS Care*, 12(2), 125-136.
- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). *Reducing suicide: A national imperative*. Washington, DC: National Academies Press.
- Gould, M. S. (2001). Suicide and the media. *Annals of the New York Academy of Sciences*, 932, 200-221 (discussion 221-24).
- Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(4), 386-405.
- Gould, M. S., Jamieson, P., & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist*, 46 (9):1269-1284.
- Gould, M. S., Petrie, K., Kleinman, M. H., & Wallenstein, S. (1994). Clustering of attempted suicide: New Zealand national data. *International Journal of Epidemiology*, 23(6), 1185-1189.
- Gould, M. S., Wallenstein, S., & Davidson, L. (1989). Suicide clusters: A critical review. *Suicide and Life-Threatening Behavior*, 19(1),17-29.
- Gould, M.S., Wallenstein, S., & Kleinman, M. (1990). Time-space clustering of teenage suicide. *American Journal of Epidemiology*, 131(1),71-78.
- Gould, M. S., Wallenstein, S., Kleinman, M. H., O'Carroll, P., & Mercy, J. (1990). Suicide clusters: An examination of age-specific effects. *American Journal of Public Health*, 80(2), 211-212.
- Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2005). Parents' reactions to transgender youths' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services*, 18(1), 3-16.
- Grossman, A.H. & D'Augelli, A. R. (2007) Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior*, 37(5), 527-537.

- Hedge, B., & Sherr, L. (1995). Psychological needs and HIV/AIDS. *Clinical Psychology & Psychotherapy*, 2(4), 203-209.
- Herek, G., Chopp, R., & Strohl, D. (2007). Sexual stigma: Putting sexual minority health issues in context. In I. Meyer and M. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 171-208). New York: Springer.
- Herek, G. M., & Gonzalez-Rivera, M. (2006). Attitudes toward homosexuality among U.S. residents of Mexican descent. *Journal of Sex Research*, 43(2), 122-135.
- Hillier, L., Kurdas, C., & Horsley, P. (2001). *"It's just easier": The Internet as a safety-net for same sex attracted young people*. Melbourne: Australian Research Centre in Sex, Health, and Society, Latrobe University.
- Horowitz, A., & Loehning, G. (Eds.). (2005). *Safe schools manual*. Saint Paul, Minnesota: Out for Equity of the Saint Paul Public Schools.
- Huebner, D. M., Rebchook, G. M., & Kegeles, S. M. (2004). Experiences of harassment, discrimination, and physical violence among young gay and bisexual men. *American Journal of Public Health*, 94(7), 1200-1203.
- Hunter, J., Cohall, A. T., Mallon, G. P., Moyer, M. B., & Riddel, J. P. (2006). Health care delivery and public health related to LGBT youth and young adults. In M. D. Shankle (Ed.), *The handbook of lesbian, gay, bisexual, and transgender public health: A practitioner's guide to service* (pp. 221-245). New York: The Haworth Press.
- Igartua, K. J., Gill, K., & Montoro, R. (2003). Internalized homophobia: A factor in depression, anxiety, and suicide in the gay and lesbian population. *Canadian Journal of Community Mental Health*, 22(2), 15-30.
- Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, 30(1), 19-26.
- Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56(7), 617-626.
- Kidd, S., Henrich, C. C., Brookmeyer, K. A., Davidson, L., King, R. A., & Shahar, G. (2006). The social context of adolescent suicide attempts: Interactive effects of parent, peer, and school social relations. *Suicide and Life-Threatening Behavior*, 36(4), 386-395.
- Kitts, R. L. (2005). Gay adolescents and suicide: Understanding the association. *Adolescence*, 40(159), 621-628.
- Koblin, J. (2006, February 14). MySpace: The new gay space for teens and 20-somethings. Columbia News Service. <http://jscms.jrn.columbia.edu/cns/2006-02-14/koblin-myspace>.
- Komiti, A., Judd, F., Grech, P., Mijch, A., Hoy, J., Lloyd, J. H., et al. (2001). Suicidal behaviour in people with HIV/AIDS: A review. *Australian and New Zealand Journal of Psychiatry*, 35(6), 747-757.
- Kosciw, J.G. & Diaz, E.M. (2006). The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools. New York: Gay, Lesbian & Straight Education Network. Retrieved October 23, 2007, from [http://www.glsen.org/binary-data/GLSEN\\_ATTACHMENTS/file/585-1.pdf](http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/585-1.pdf).

- Kulkin, H., Chauvin, E., & Percle, G. (2000). Suicide among gay and lesbian adolescents and young adults: A review of the literature. *Journal of Homosexuality, 40*(1), 1-29.
- Lebson, M. (2002). Suicide among homosexual youth. *Journal of Homosexuality, 42*(4), 107-117.
- Lenhart, A. & Madden, M. (2007, January 3). Social networking sites and teens: an overview. Retrieved July 10, 2008, from [http://www.pewinternet.org/PPF/r/198/report\\_display.asp](http://www.pewinternet.org/PPF/r/198/report_display.asp)
- Lippa, R. A. (2000). Gender-related traits in gay men, lesbian women, and heterosexual men and women: The virtual identity of homosexual-heterosexual diagnosticity and gender diagnosticity. *Journal of Personality, 68*(5), 899-926.
- Maczewski, M. (2002). Exploring identities through the Internet: Youth experiences online. *Child and Youth Care Forum, 31*(2):111-29.
- Massachusetts Department of Education. (2006a). Violence-related behaviors and experiences. In Massachusetts Department of Education, 2005 Massachusetts Youth Risk Behavior Survey results. Malden, MA: Author. Retrieved November 1, 2007, from <http://www.doe.mass.edu/cnp/hprograms/yrbs/05/ch5.doc>
- Massachusetts Department of Education. (2006b). Suicidality and self-inflicted injury. In Massachusetts Department of Education, 2005 Massachusetts Youth Risk Behavior Survey results. Malden, MA: Author. Retrieved November 1, 2007, from <http://www.doe.mass.edu/cnp/hprograms/yrbs/05/ch6.doc>
- Mallon, G. P., & DeCrescenzo, T. (2006). Transgender children and youth: A child welfare practice perspective. *Child Welfare, 85*(2), 215-241.
- Mays, V., & Cochran, S. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91*(11), 1869-1876.
- McBee-Strayer, S., & Rogers, J. R. (2002). Lesbian, gay, and bisexual suicidal behavior: Testing a constructivist model. *Suicide and Life-Threatening Behavior, 32*(3), 272-283.
- McFarlane, M., Bull, S.S., & Rietmeijer, C.A. (2002). Young adults on the Internet: Risk behaviors for sexually transmitted diseases and HIV. *Journal of Adolescent Health, 31*(1):11-16.
- Medeiros, D. M., Seehaus, M., Elliott, J., & Melaney, A. (2004). Providing mental health services for LGBT teens in a community adolescent health clinic. *Journal of Gay & Lesbian Psychotherapy, 8*(3/4), 83-95.
- Messinger, L. (2006). Toward affirmative practice. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual, and transgender people* (pp. 460-470). New York: Columbia University Press.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38-56.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5): 674-697.

- Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In I. Meyer and M. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 242-267). New York: Springer.
- Miller, M., Azrael, D., Hepburn, L., Hemenway, D., & Lippmann, S. J. (2006). The association between changes in household firearm ownership and rates of suicide in the United States, 1981-2002. *Injury Prevention, 12*(3), 178-182.
- Morrison, L. L., & L'Heureux, J. (2001). Suicide and gay/lesbian/bisexual youth: implications for clinicians. *Journal of Adolescent Health, 24*(1), 39-49.
- Morrow, D. F. (2004). Social work practice with gay, lesbian, bisexual, and transgender adolescents. *Families in Society, 85*(1), 91-99.
- Morrow, D. F. (2006). Gay, lesbian, bisexual, and transgender adolescents. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual, and transgender people* (pp. 177-195). New York: Columbia University Press
- Noell, J. W., & Ochs, L. M. (2001). Relationship of sexual orientation to substance use, suicidal ideation, suicide attempts, and other factors in a population of homeless adolescents. *Journal of Adolescent Health, 29*(1), 31-36.
- Peden, M., McGee, K., & Krug, E. (Eds.). (2002). *Injury: A leading cause of the global burden of disease, 2000*. Geneva: World Health Organization.
- Pilowsky, D. J., & Wu, L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health, 38*(4), 351-358.
- Pinhey, T. K., & Millman, S. R. (2004). Asian/Pacific Islander adolescent sexual orientation and suicide risk in Guam. *American Journal of Public Health, 94*(7), 1204-1206.
- Prezbindowski, K. S., & Prezbindowski, A. K. (2001). Educating young adolescent girls about lesbian, bisexual, and gay issues. In P. O'Reilly, E. M. Penn, & K. deMarrais (Eds.), *Educating young adolescent girls* (pp. 47-80). Mahwah, NJ: Lawrence Erlbaum.
- Proctor, C. D., & Groze, V. K. (1994). Risk factors for suicide among gay, lesbian, and bisexual youths. *Social Work, 39*(5), 504-513.
- Ray, N. (2006). *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness*. New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless.
- Remafedi, G. (2002). Suicidality in a venue-based sample of young men who have sex with men. *Journal of Adolescent Health, 31*(4), 305-310.
- Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics, 87*(6), 869-875.
- Remafedi, G., French, S., Story, M., Resnick, M. D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health, 88*(1), 57-60.

- Rivers, I. (2001). The bullying of sexual minorities at school: Its nature and long-term correlates. *Educational and Child Psychology, 18*(1), 32-46.
- Robertson, K., Parsons, T. D., Van Der Horst, C., & Hall, C. (2006). Thoughts of death and suicidal ideation in nonpsychiatric human immunodeficiency virus seropositive individuals. *Death Studies, 30*(5), 455-469.
- Rotheram-Borus, M. J., Rosario, M., Van Rossem, R., & Reid, H. (1995). Prevalence, course, and predictors of multiple problem behaviors among gay and bisexual male adolescents. *Developmental Psychology, 31*(1), 75-85.
- Roy, A. (2003). Characteristics of HIV patients who attempt suicide. *Acta Psychiatrica Scandinavica, 107*(1), 41-44.
- Russell, S., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91*(8), 1276-1281.
- Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist, 46*(9), 1241-1257.
- Ryan, C. (2004). Families of lesbian, gay and bisexual adolescents. *Current Problems in Pediatric and Adolescent Health Care, 34*(10), 369-375.
- Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Ryan, C., & Futterman, D. (2001). Social and developmental challenges for lesbian, gay and bisexual youth. *SIECUS Report, 29*(4), 5-18.
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology, 67*(6), 859-866.
- Savin-Williams, R.C. (1990). *Gay and lesbian youth: Expressions of identity*. New York: Hemisphere.
- Savin-Williams, R. C. (2001). A critique of research on sexual-minority youths. *Journal of Adolescence, 24*(1), 5-13.
- Savin-Williams, R. C., & Ream, G. L. (2003). Suicide attempts among sexual-minority male youth. *Journal of Clinical Child and Adolescent Psychology, 32*(4), 509-522.
- Shelton, A. J., Atkinson, J., Risser, J. M. H., McCurdy, S. A., Useche, B., & Padgett, P. M. (2006). The prevalence of suicidal behaviours in a group of HIV-positive men. *AIDS Care, 18*(6), 574-576.
- Shenassa, E. D., Catlin, S. N., & Buka, S. L. (2003). Lethality of firearms relative to other suicide methods: A population based study. *Journal of Epidemiology and Community Health, 57*(2), 120-124.
- Silenzio, V., Peña, J., Duberstein, P., Cerel, J., & Knox, K. (2007). Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American Journal of Public Health, 97* (11), 2017-2019.

- Turner, K. L., Wilson, W. L., & Shirah, M. K. (2006). Lesbian, gay, bisexual, and transgender cultural competency for public health practitioners. In M.D. Shankle (Ed.), *The handbook of lesbian, gay, bisexual, and transgender public health: A practitioner's guide to service* (pp. 59-83). Binghamton, NY: Harrington Park Press/The Haworth Press.
- United Nations. (1996). *Prevention of suicide: Guidelines for the formulation and implementation of national strategies*. New York: Author.
- U.S. Department of Health and Human Services. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD: Author.
- U.S. Public Health Service (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: Author.
- Van Heeringen, C., & Vincke, J. (2000). Suicidal acts and ideation in homosexual and bisexual young people: A study of prevalence and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, 35(11), 494-499.
- Van Leeuwen, J. M., Boyle, S., Salomonsen-Sautel, S., Baker, D. N., Garcia, J. T., Hoffman, A., et al. (2006). Lesbian, gay, and bisexual homeless youth: An eight-city public health perspective. *Child Welfare Journal*, 85(2), 151-170.
- Whitbeck, L. B., Chen, X., Hoyt, D. R., Tyler, K. A., & Johnson, K. D. (2004). Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *Journal of Sex Research*, 41(4), 329-342.
- Wilber, S., Reyes, C., & Marksamer, J. (2006). The Model Standards Project: Creating inclusive systems for LGBT youth in out-of-home care. *Child Welfare Journal*, 85(2), 133-149.
- Wilber, S., Ryan, C., & Marksamer, J. (2006). *CWLA Best practice guidelines: Serving LGBT youth in out-of-home care*. Arlington, VA: CWLA Press.
- Williams, P., Narciso, L., Browne, G., Roberts, J., Weir, R., & Gafni, A. (2005). The prevalence, correlates, and costs of depression in people living with HIV/AIDS in Ontario: Implications for service directions. *AIDS Education and Prevention*, 17(2), 119-130.
- Xavier, J., & Bradford, J. (2005). *Transgender health access in Virginia: Focus group report*. Richmond, VA: Virginia HIV Community Planning Committee and Virginia Department of Health.
- Ybarra, M., & Mitchell, K. (2008). How risky are social networking sites? A comparison of places online where youth sexual solicitation and harassment occurs. *Pediatrics*, 121, e350-e357.

## **Appendix A: Resources on LGBT Issues**

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Appendix A contains items in the following categories: Schools, Health Care Providers and Consumers, Telephone and E-mail Help, Data and Research, and Other Resources. For resources on cultural competence, please refer to Appendix B.

### **Schools**

#### **Beyond the Binary A Toolkit for Gender Identity Activism in Schools (2004)**

[www.gsanetwork.org/BeyondtheBinary/toolkit.html](http://www.gsanetwork.org/BeyondtheBinary/toolkit.html)

*Beyond the Binary* was produced by the Gay-Straight Alliance Network, Transgender Law Center, and the National Center for Lesbian Rights. It has practical information to assist teachers and students in creating a safe space within the school for transgender and gender nonconforming students.

#### **The Gay, Lesbian, and Straight Education Network (GLSEN)**

[www.glsen.org](http://www.glsen.org)

This organization provides free and inexpensive tools to help establish school Gay-Straight Alliances, including Jump-Start Activity Guides, Safe Schools policies, stickers, do-it-yourself training kits, and results from the National School Climate Survey of LGBT students.

#### **Out for Equity**

<http://outforequity.spps.org/index.html>

This organization, which is part of Saint Paul [Minnesota] Public Schools, offers resources about creating a safe school environment, including a *Safe Schools Manual*.

### **Health Care Providers and Consumers**

#### **Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)**

[www.algbtic.org/resources/listing.htm](http://www.algbtic.org/resources/listing.htm)

A division of the American Counseling Association, this organization provides a variety of resources about the counseling of LGBT individuals, including a list of therapists.

### **Gay and Lesbian Medical Association (GLMA)**

[www.glma.org](http://www.glma.org)

This association offers extensive references and resources for providers and patients as well as for advocates.

### **GLBT Health Access Project**

[www.glbthealth.org/index.html](http://www.glbthealth.org/index.html)

This project, funded by the Massachusetts Department of Public Health, works with GLBT populations and the health care providers who serve them. The project offers a variety of resources, including community standards of practice for quality health care services, with indicators for both administrative practices and service delivery.

### **Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender Health (2001)**

[www.glma.org/\\_data/n\\_0001/resources/live/HealthyCompanionDoc3.pdf](http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf)

This document, co-written by the Gay and Lesbian Medical Association and the National Coalition for LGBT Health, contains quantitative and qualitative research and information specific to LGBT health and discusses the overall health status of LGBT people.

### **Transgender Health Access in Virginia: Focus Group Report (2005)**

[www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCP/ documents /TG Focus Group Report final 1.3.pdf](http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCP/ documents /TG Focus Group Report final 1.3.pdf)

This detailed report presents findings on both mental and physical health issues facing transgender individuals.

### **NAMI Multicultural Action Center's Gay, Lesbian, Bisexual, and Transgender (GLBT) Mental Health Resources**

[www.nami.org/Content/NavigationMenu/Find\\_Support/Multicultural\\_Support/Resources/GLBT\\_Resources.htm](http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/GLBT_Resources.htm)

This Web page contains research, fact sheets, training materials, and other resources on GLBT mental health.

### **The National Coalition for Lesbian, Gay, Bisexual, and Transgender Health**

[www.LGBTHealth.net](http://www.LGBTHealth.net)



This coalition is committed to improving the health and well-being of lesbian, gay, bisexual, and transgender individuals and communities through public education, coalition building, and advocacy. The Web site has health updates and information about events.

**Provider’s Introduction to Substance Abuse Treatment for LGBT Individuals (2001)**

[www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf](http://www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf)

This publication from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA) presents information to assist providers in improving substance abuse treatment for LGBT clients by raising awareness about issues unique to LGBT clients.

**Recommended Framework for Training Mental Health Clinicians in Transgender Care (2006)**

[www.vch.ca/transhealth/resources/library/tcpdocs/training-mentalhealth.pdf](http://www.vch.ca/transhealth/resources/library/tcpdocs/training-mentalhealth.pdf)

This document, a collaboration between Transcend Transgender Support and Education Society and Vancouver Coastal Health’s Transgender Health Program, presents recommendations for community mental health professionals about working with transgender individuals.

**World Professional Association for Transgender Health (WPATH)**

[www.wpath.org](http://www.wpath.org)

Formerly known as the Harry Benjamin International Gender Dysphoria Association, WPATH is a professional organization devoted to the understanding and treatment of gender identity disorders. Its Web site contains information about WPATH activities and a number of resource links.

**Telephone and E-mail Help**

**Fenway Community Health’s Gay, Lesbian, Bisexual, and Transgender Helpline and The Peer Listening Line**

[www.fenwayhealth.org](http://www.fenwayhealth.org)

These anonymous and confidential phone lines offer gay, lesbian, bisexual, and transgender adults and youths from all over the United States a safe place to call for

information, referrals, and support. Trained volunteers address topics such as locating local GLBT groups and services as well as issues including coming out, HIV/ AIDS, safer sex, and relationships.

**Fenway Gay, Lesbian, Bisexual and Transgender Helpline**

617-267-9001

Toll-free - 888-340-4528

**Fenway Peer Listening Line**

617-267-2535

Toll-free - 800-399-PEER

**GLBT National Help Center**

[www.glnh.org](http://www.glnh.org)

This center offers free telephone and e-mail peer counseling, information, and local resources for GLBTQ callers throughout the United States.

GLBT National Hotline:

Toll-free 1-888-THE-GLNH (1-888-843-4564)

HOURS:

Monday through Friday from 1 pm to 9 pm, *Pacific Time*

Saturday from 9 am to 2 pm, *Pacific Time*

Email: [glnh@GLBTNationalHelpCenter.org](mailto:glnh@GLBTNationalHelpCenter.org)

GLBT National Youth Talkline

Toll-free 1-800-246-PRIDE (1-800-246-7743)

HOURS:

Monday through Friday from 5 pm to 9 pm, *Pacific Time*

Email: [youth@GLBTNationalHelpCenter.org](mailto:youth@GLBTNationalHelpCenter.org)

**The Trevor Project**

[www.thetrevorproject.org](http://www.thetrevorproject.org)

Trevor operates the nation's only 24-hour toll-free suicide prevention helpline for gay, lesbian, bisexual, transgender, and questioning youth (1-866-4-U-TREVOR).

## **Data and Research**

### **Family Acceptance Project**

<http://familyproject.sfsu.edu/overview>

This project, directed by Caitlin Ryan at San Francisco State University, is the first major study of the families of lesbian, gay, bisexual, and transgender youth. Findings will be available to policymakers, families, and providers to inform policy and practice and to change the way that systems of care address the needs of LGBT adolescents.

### **GayData.org**

[www.gaydata.org/](http://www.gaydata.org/)

This Web site, maintained by Randall L. Sell at Drexel University, provides extensive research summaries and links for data, and promotes the collection of sexual orientation data and further analysis of data sources that have already collected such data.

### **LGBT Youth: An Epidemic of Homelessness (2007)**

[www.thetaskforce.org/reports\\_and\\_research/homeless\\_youth](http://www.thetaskforce.org/reports_and_research/homeless_youth)

This report from the National Gay and Lesbian Task Force discusses the reasons so many LGBT youth are homeless and the risks they face in shelters and on the street.

### **Living in the Margins: A National Survey of LGBT Asian and Pacific Islander Americans (2007)**

[http://thetaskforce.org/reports\\_and\\_research/api\\_study](http://thetaskforce.org/reports_and_research/api_study)

This report from the National Gay and Lesbian Task Force discusses the discrimination that Asian and Pacific Islander American LGBT persons face.

## **Other Resources**

### **Creating Safe Space for GLBTQ Youth: A Toolkit (2006)**

[www.advocatesforyouth.org/publications/safespace/safespace.pdf](http://www.advocatesforyouth.org/publications/safespace/safespace.pdf)

A resource for youth-serving professionals, *Creating Safe Space* provides tips and strategies for assessment, inclusive programming, lesson plans, and addressing harassment.

**Child Welfare League of America's Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care (2006)**

[www.cwla.org/pubs/pubdetails.asp?PUBID=10951](http://www.cwla.org/pubs/pubdetails.asp?PUBID=10951)

This book, by Shannan Wilber, Caitlin Ryan and Jody Marksamer describes best practices for providing services to LGBT youth in foster care or juvenile justice residential care and can be ordered from the CWLA web site.

**The Gay, Lesbian, Bisexual, and Transgender Youth Support Project**

[www.hcsm.org/glys/glys.htm](http://www.hcsm.org/glys/glys.htm)

This program, part of Health Care of Southeastern Massachusetts Inc., provides tools, training, and ongoing support for educators and health and human service providers. The Web site contains assessment tools, legal and policy statements, and other information.

**The National Center for Transgender Equality (NCTE)**

[www.nctequality.org](http://www.nctequality.org)

This social justice organization is dedicated to advancing the equality of transgender people through advocacy, collaboration, and empowerment. Its Web site contains news and resources.

**National Gay and Lesbian Task Force**

[www.thetaskforce.org](http://www.thetaskforce.org)

The mission of the National Gay and Lesbian Task Force is to build the grassroots power of the lesbian, gay, bisexual, and transgender (LGBT) community. The Task Force trains activists, develops the organizational capacity of the movement, and equips state and local organizations with the skills needed to organize broad-based campaigns to defeat anti-LGBT referenda and advance pro-LGBT legislation.

**Parents, Families, and Friends of Lesbians & Gays (PFLAG)**

[www.pflag.org/](http://www.pflag.org/)

This group promotes the health and well-being of gay, lesbian, bisexual, and transgender persons and their families and friends. PFLAG's Web site contains sections on support, education, and advocacy.

## Transgender Law Center

[www.transgenderlawcenter.org](http://www.transgenderlawcenter.org)

This organization works to make California a state in which people can freely express gender identities. The organization's web site has comprehensive collections of resources on transgender law and current work in education, health care, employment, and business.

## Appendix B: Resources on Cultural Competence

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### NCCC Cultural Competence Resources

The National Center for Cultural Competence (NCCC) provides a 2004 resource titled *Planning for Cultural and Linguistic Competence in State Title V Programs*, which addresses cultural and linguistic competence in programs serving children and youth with special health care needs and their families. The resource, which includes a checklist and guidelines, can be found at

[http://www11.georgetown.edu/research/gucchd/nccc/documents/NCCC%20Title%20V%20Checklist%20\(CSHCN\).pdf](http://www11.georgetown.edu/research/gucchd/nccc/documents/NCCC%20Title%20V%20Checklist%20(CSHCN).pdf) The NCCC checklist was adapted for LGBT youth by staff at the national Suicide Prevention Resource Center.

To serve the needs of LGBT youth effectively, an organization should:

- Perform needs and asset assessments with LGBT groups
- Develop and administer policies in partnership with consumers, including LGBT youth
- Design services and supports to meet the needs of LGBT youth (for example, consumer-driven and community-based services, culturally based advocacy, and participatory action research)
- Use appropriate strategies to address barriers to the design and delivery of services and supports (for example, staff attitude and manner, service location, lack of insurance, and fear and distrust of the service system)

In the area of human resources and staff development, an organization should:

- Employ a diverse, culturally competent workforce, including LGBT staff
- Provide pre-service and in-service training and professional development activities for governing boards and all staff to ensure understanding and acceptance of program values, principles, and practices governing cultural competence
- Provide orientation training, mentoring, and other supports for all volunteers to ensure understanding and acceptance of program values, principles, and practices governing cultural competence
- Incorporate areas of awareness, knowledge, and skills in cultural competence into position descriptions and performance evaluations for all staff

Furthermore, a culturally competent organization has policies and sufficient fiscal resources to support and sustain the above activities. The requirements and objectives for cultural competence should be incorporated into contracts as well.

## **Other Cultural Competence Resources**

Family & Children's Service has been providing counseling, family and school support, violence reduction, and community development programs in the Twin Cities [Minnesota] for more than 125 years. The FCS checklist for organizations seeking to be more culturally competent for LGBT youth can be found at <http://tinyurl.com/yoljxu>.

Seattle and King County [Washington] Public Health has a Web site that provides tips for providers on how to give culturally competent care to GLBT patients at <http://www.metrokc.gov/health/glbtproviders.htm#tips>.