**ICRC-S & SPRC Research to Practice Webinar Q&A with the Panelists
Advances in Suicide Prevention:
Research, Practice, and Policy Implications for LGBT Populations**

On July 10, 2014, the ICRC-S and SPRC hosted a "Research to Practice" webinar entitled, "Advances in Suicide Prevention: Research, Practice, and Policy Implications for LGBT Populations." The panelists generously agreed to respond to selected questions from people who attended the webinar and people who submitted questions on the SPRC Training Institute website. We hope that you find this information helpful in your suicide prevention efforts.

Research to Practice Panelists

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Questions related to research

What are the differences in suicide risk, ideation, and/or behavior for this population compared to the general population? How should assessment and treatment for suicide differ accordingly?

Surveys of both youth and adults show that LGB people are 2-7 times more likely to report experiencing suicidal ideation and making a lifetime suicide attempt. This should alert clinicians to the need for special attention to possible suicide risk in their work with LGBT clients. Most LGBT people are not at high risk, however, so care should be taken to assess - not assume. (AH)

How do you propose to identify sexual orientation, gender identity, etc. for furthering research, when these things cannot be rigidly identified, and can only be self-identified by the individual?

Although sexual orientation and gender identity are complex phenomena, much work has been done to develop valid and reliable measures for research as well as suicide prevention activities. For specific information about these measures, I recommend that you read the two Williams Institute resources I listed on my slide #14. (AH)

Doesn't this information have to come from self-reports? And how are you working to expand measures for accuracy in relation to an individual's full, intersectional identity to more fully identify risk and protective factors?

Information about sexual orientation and gender identity rely essentially on the individual's own sense of himself or herself, but anonymous self-reports are often not the best way to measure suicidal behavior. Many people are unsure of what constitutes a suicide attempt, and may describe seriously thinking about suicide or planning to make an attempt as an actual attempt. On the other hand, for many different reasons, people may deny making a suicide attempt when they've actually made one. Face-to-face, clinical interviews are generally much more likely than surveys to allow for follow-up questions and conversation that helps the interviewers gain an accurate picture of the respondent's intent to die and other aspects of the described behavior. Likewise, clinical interviews generally provide a clearer assessment of suicide risk and protective factors. (AH)

I am very curious and interested in hearing how/where sexual orientation beyond M/F will be noted. And, do you see a broader categorization option emerging on other records in addition to the death certificate?

M/F are two categories of gender, not sexual orientation. Other categories of gender include

transgender (or more specifically male-to-female or female-to-male transgender) and gender non-conforming. Sexual orientation categories generally include lesbian or gay, straight (that is, not lesbian or gay), and bisexual. Sexual orientation and gender identity are increasingly included in health and mental health surveys as well as in health-related records. There is also discussion about the inclusion of clear questions about sexual orientation and gender identity in the U.S. Census, since population estimates are a requirement for determining many different kinds of "rates," including suicide rates. (AH)

What does the research say about transgender individuals and suicide prevention?

Several surveys of transgender adults have shown alarmingly high percentages - up to 43% - reporting a lifetime suicide attempt. Attempts appear to be related, in particular, to the pervasive stigma and discrimination experienced by transgender individuals. However, targeted suicide prevention efforts for this highly diverse population are, as yet, rare. (AH)

Has research been conducted on cyber-bullying and cyber-suicide, particularly with regard to LGBT individuals?

To date, no major studies on bullying have identified participants' sexual orientation or gender identity, although this clearly needs to be done. (AH)

Many caution against language such as "cyber-suicide" - because suicide is typically much more complicated than one single "cause" (such as cyber-bullying) - and because words like "cyber-suicide" or "bully-cide" risk imply that suicide is a logical response to cyber/bullying. (SR)

Are there any studies on the suicide risk in parents of LGBT people?

I'm not aware of any such studies. (AH)

Same. We know anecdotally that some parents of LGBT children experience concern about maltreatment of their children, but there has been no clear link with parents' own mental health. (SR)

Does geographical location play a role in LGBT suicides?

Since sexual orientation and gender identity are not systematically identified at time of death, we have no data on rates at which LGBT people die by suicide - or by any other manner or cause. We also don't know how LGBT suicide rates may vary by age, gender, geographical location, or any other demographic variable. (AH)

Questions related to practice:

One recommendation is to educate the LGBT community about suicide risks. What are your best recommendations for how to do so without increasing risk (by making suicide seem normative)?

We should always make clear that although suicide attempts are more frequently reported by LGBT people compared to those who are heterosexual, the majority of all LGBT populations are not suicidal, and many, many LGBT people of all ages show marked resilience in the face of an often challenging social environment. We also need to avoid identifying experiences that are commonly experienced by LGBT people - bullying, impact of discriminatory laws, social stigma, etc. - as "causes" of suicide, and emphasize that suicide almost always results from a complex interaction of stressful experiences and mental health vulnerabilities. (AH)

Agreed - the strategy is to focus on social and cultural marginalization / stigmatization, rather than on the fact of being LGBT itself. The research and theory point to stigmatization (discrimination, bullying, rejection…) as the key mechanisms that are precursors to suicide risk. (SR)

Are there specific programs that can be implemented on a local level (e.g. NAMI Connect) that would address the needs of sexual and gender minorities?

Much can be done to foster the connections that LGBT people experience within their families, peer groups, and community institutions. It is essential, however, that the processes and outcomes of such programs be carefully evaluated, so that we know what they are achieving. Too commonly in suicide prevention, we assume that interventions are having the intended effects, only to later discover that they are not reaching the audiences most in need, or are impacting the target audience in unintended ways. (AH)

What is known about school-based prevention? For instance, can school-based health centers or Gay-Straight Alliances (student groups) be effective?

There is recent evidence that students who attend schools with safe spaces for LGBT students or GSAs are significantly less likely to experience suicidal ideation. See:
Hatzenbuehler, M.L., Birkett, M., Van Wagenen, A., & Meyer, I.L. (2014). Protective school climates and reduced risk for suicide ideation in sexual minority youths. *American Journal of Public Health, 104*(2), 279-286. *(AH)*

There is strong and growing evidence of multiple factors that can promote a safe and welcoming school climate for LGBT and all students - including Gay-Straight Alliances, as well as a number of policy and program strategies. Not all strategies have been directly linked to suicide risk per se, but there is clear evidence that these strategies are linked to many other indicators of student well-being. See:
Russell, S. T., Kosciw, J., Horn, S., & Saewyc, E. (2010). Safe schools policy for LGBTQ students. *Society for Research in Child Development Social Policy Report, 24* (4), 1-25. *(AH)*

What are the best ways to educate schools about suicide risk for LGBT without promoting the stigma that every LGBT student is at risk?

See response to similar question above. (AH)

I live in a very conservative state and am currently working with very rural schools. How do we introduce this topic to the faith-based groups in these communities (mostly Mormon) to support LGBT students?

In my experience, people who hold conservative beliefs regarding LGBT often feel that education or social change is a threat to their personal beliefs. My suggestion is that conversations / strategies clearly acknowledge that all personal views are just that - personal - and should be understood and respected as such. And the issue for schools is to create supportive environments where all students can thrive. So the challenge is not to change people's beliefs, but to identify strategies in schools that can create positive climates for everyone. That is a way to let people know that you aren't there to change THEM, but to change / improve the school climate for everyone (including, for example, a student who might be mistreated for religious beliefs). Clearly showing the ways that bullying and other forms of discrimination undermine student well-being (see article below) is then another way to establish a context that is focused on changing and improving the school climate, rather than changing individual values or beliefs. See:
Russell, S. T., Sinclair, K. O., Poteat, P. V., Koenig, B. W. (2012). Adolescent health and harassment based on discriminatory bias. *American Journal of Public Health, 102*(3), 493-495. *(SR)*

What resources are out there specifically for ethnic minority LGBT youth? For traumatized LGBT adolescents?

The Ali Forney Center in New York City (and similar centers in other large cities) offer excellent services for homeless and abused LGBT youth. (AH)

Please define the LGBTQ "culture." Is it defined differently from how we define "culture" when addressing mental health issues? If we have a parent education night about "culture" and mental health issues is it appropriate we also include LGBT families and mental health issues under the "umbrella of culture"?

"LGBTQ culture" is not a single entity; there are many differences among the distinct populations included in this acronym. Inclusion of LGBT populations in any discussion of cultural diversity and mental health is entirely appropriate. (AH)

What additional factors for suicide risk should child and youth mental health practitioners consider when working with LGBT youth who are in the discovery phase of sexual orientation or identity?

First, don't assume risk - but know that the discovery and disclosure (coming out) periods are times when depression and self-harm are heightened among LGBTQ youth. One contemporary challenge is that many young teens feel "ready" to come out, but don't have the emotional maturity / experience to understand and anticipate the reaction of others (in a way that an adult might). So although it is not appropriate to ask whether a youth is "sure" that they are LGBTQ (implying that maybe if they are older they will find out that they are "really" heterosexual) - it is appropriate to help them think through disclosure to others. What will your friends / teachers / family think? How will they react? Do you have one person that you know will be a safe ally? Who can you tell first, and how can you build a network of support - in case some of the reaction may not be supportive? (SR)

I read a critique of the "It Gets Better" project, saying that it has an effect of "blaming the victim." What is your take on that?

The key aim of this project - instilling hope in LGBT youth by showing that many LGBT adults have launched happy and successful lives despite difficult experiences in their younger years - is well-intended, and it is likely that some LGBT youth have found the IGB video postings to be inspirational and a source of comfort. Others, however, have heard the message as saying, "Suck it up; what you're experiencing now doesn't really matter." And some LGBT activists fear that the project's messaging deflects attention away from addressing things like bullying, family rejection, peer exclusion and other forms of discrimination that are objectively painful and emotionally damaging to many LGBT youth. (AH)

Agreed - there have been a number of critiques. "It Gets Betters" seems to be particularly compelling for people who are already adults (and in particular, those who became socially advantaged adults - those for whom things actually did get better!). The challenge for many

youth and advocates is that they, of course, do now want to wait for it to get better - but want things to be better now! So - the challenge and critique is that the very strong popularity of that message might overshadow the need for communities to work on creating positive change for contemporary youth. (SR)

Where can we view the Family Acceptance Project videos?

The videos can be accessed [here](). (SPRC)