Helping Out: Suicide & Self Harm Amongst Lesbian, Gay, Bisexual & Transgendered Adolescents

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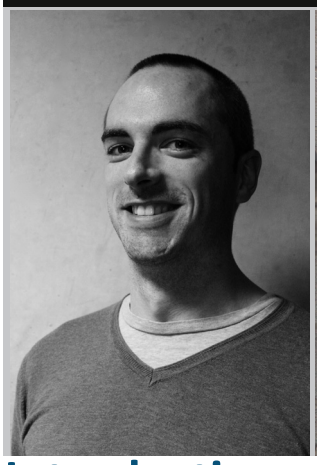

Introduction

Lesbian, gay, bisexual and transgendered (LGBT) adolescents worldwide are disproportionately more likely than their heterosexual peers to inflict self-injury, to attempt suicide, and to die by suicide[1,2,3,4]. The particular stressors that LGBT people experience, such as victimisation and homophobia, lead to them being a high risk group for suicidal and self-injurious behaviours[5,6,7]. This literature review aims to explore why the LGBT community are at high risk, and to ascertain what healthcare professionals can do to help in dealing with this reality. I also endeavour to provide a critique of literature which researches this issue.

Three strong themes emerged from the literature, which were: the reality of the statistical gap, the concepts of homophobia and heterosexism, and the contribution of healthcare professionals.

Clarification

Hereafter the acronym "LGBT" will be used at all times, and I will specify gender/transgender or sexuality when applicable.

Is there really a difference in numbers?

Research ranging from 1991 to 2009 proves that the discrepancy in the statistics is real. The earlier research suggests that suicide risk factors unique to LGBT youth may exist: Remafedi (1991) proposed that pervasive social stigma attached to homosexuality acted as a stressor for LGBT youth[1]. This research comprised qualitative structured interviewing of 137 males aged 14-21. 30% of participants (41/137) reported at least one suicide attempt, and almost half of these (18) more than one attempt. 75% of all attempts were preceded by self-identification as gay or bisexual. The researchers noted that gender non-conformity was a precipitating factor in the subjects who attempted suicide more than once. Further research by Remafedi *et al* in 1998 showed the same result[2], and like in 1991, the issue of gender non-conformity was highlighted.

Further studies in America by Blake *et al* (2001) and Remafedi (2002) report a similar trend in the statistics[8,9]. Quantitative research in 2000 by Cochran & Mays recruited 3,648 participants. Evidence emerged of the increased risk of suicidality amongst men who had a history of homosexual experiences[3].

A UK-based controlled cross-sectional study by King *et al* in 2003 found similar results[4]. The researchers used snowball sampling to reach people who do not attend LGBT establishments or groups. The survey included 1,161 men and 1,018 women. The results showed that more than 25% of the gay men and almost 33% of the lesbians involved had deliberately harmed themselves in the past, compared to 14% of the heterosexual subjects.

Research in both New Zealand and Canada yielded the same result; in each case, LGBT boys and girls were more at risk of suicidal feelings and attempts than heterosexual boys and girls, as well as self-harm[10,11].

In Ireland, the National Strategy for Action on Suicide Prevention, "Reach Out" (2005-2014) includes the LGBT community as a high risk group for suicide and self-harm[12].

The search for literature yielded only one item which specifically researched the transgender community. Grossman & D'Augelli (2007) conducted qualititative interviews with 31 male-to-female (MTF) transgendered individuals and 24 female-to-male (FTM) individuals[13]. Almost half of all the participants reported having seriously thought about taking their own lives, and half of those directly related their suicidal ideation to their be-

ing transgender. One participant reported 20 attempts at suicide.

Homophobia and heterosexism: What are they?

Within a literature review carried out by van Wormer & McKinney (2003) to attempt to identify what American schools can do to help LGBT students, homophobia is defined as "an irrational fear of homosexuality and homosexuals" and heterosexism as "neglect of, and prejudice against, non-heterosexuals"[5]. Research by the Gay, Lesbian and Straight Education Network (GLSEN) in 1999 was cited as finding that 90% of students across the USA had heard anti-gay epithets at school (many from teachers), and that 69% of LGBT teens reported verbal and physical harassment at school. The authors cited research in the UK by Charles (2000) which found that of 190 LGBT youths who experienced bullying in school, 40% attempted suicide or harmed themselves, and that over 16% suffered post traumatic stress later in life. The authors contended that the prevalence of homophobia is by far the most detrimental influence on LGBT youth.

A qualititative Irish study of homophobic bullying in secondary schools was carried out by Norman & Galvin (2006), comprising 125 interviews of students, parents, teachers and principals[6]. The researchers asserted that homophobia and heterosexism are part and parcel of the modern Irish secondary school experience. The students in particular held the view that to be heterosexual was "normal". The research showed that teachers seemed to take it for granted that homophobic bullying happened in their schools, and many chose to ignore it. Students and teachers alike spoke of homophobic taunts being used in everyday conversation. The parents reported that they would feel sadness upon learning that their child was LGBT, explaining that they felt that life is harder for LGBT people, especially in school.

UK-based qualitative research carried out by McDermott *et al* (2008) investigated the opinions of LGBT youth who engage in self-destructive behaviours[7]. The researchers found that LGBT participants (aged 16-25) perceived a strong link between distress due to homophobia and self-destructive behaviour. The researchers suggested that homophobia punishes the individual at a deep level and demands that the LGBT person negotiates life being seen as abnormal because of their sexual practices or gender non-conformity. They also propose that because LGBT people employ individual tactics to cope with stress arising from homophobia, the expectation and utilisation of external support may decrease.

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Homophobia pervades all aspects of society, and the hospital setting is no exception. In research by Mayock *et al* (2009), almost 25% of subjects reported that non-disclosure of their sexuality was due to fear of homophobic reactions from healthcare staff caring for them[14]. Furthermore, the presumption of heterosexuality by healthcare staff was highlighted as an issue, as well as the failure or refusal to acknowledge the partners of LGBT patients in the Irish healthcare setting.

An investigation into "internalised homophobia" as an explanation for mental health discrepancies between LGBT and heterosexual people was undertaken by Williamson (2000)[15]. In this paper Williamson defined "internalised homophobia" as negative or distressing thoughts experienced by the LGBT individual which are inspired by heterosexism and personal history of victimisation. Williamson proposed that internalised homophobia is a precipitating factor in LGBT suicide and self-harm, and that it may have an effect on coping strategies employed by the individual, therefore negatively affecting health.

Willging *et al* (2006) conducted qualitative research in Canada comprising ethnographic interviews with 20 rural healthcare providers[16]. The results included evidence of LGBT clients being denied services, discouraged from discussing sexuality and gender issues, and isolated within residential settings.

What can healthcare professionals do?

Much attention has been paid to culturally sensitive or competent care; ordinarily this refers to sensitivity to the patient's race or religious beliefs. Scourfield (2008) proposed that culturally competent care be extended to include the LGBT community, and that LGBT youth be prioritised in suicide prevention policies[17]. McAndrew & Warne (2004) provided a discourse on research literature which deals with LGBT youth suicidality, and suggested that UK mental health professionals should turn away from mental health policy which ignores the continual proof of the connection between LGBT experience and suicide risk[18].

Richardson (2009) outlined a nursing model for paediatric nurses working with LGBT patients, citing Troiden (1989), who proposed four stages of homosexual identity formation, and outlines interventions which can be applied at the nurse's discretion in an age-appropriate manner[19]. These interventions can be summarised as confidentiality, non-judgemental open-mindedness, avoidance of assumption of heterosexuality, and not dismissing or trivialising the patient's feelings or attractions. Richardson maintained that it is not necessary for healthcare professionals to understand why an adolescent is attracted to the same sex, but that it may help to understand the experience of forming a homosexual identity, in order to provide culturally sensitive care. These ideas are mirrored by the NICE Guidelines on depression in children and young people (2005), and the Guidelines on self-harm (2005), wherein a supportive and collaborative relationship is recommended between the patient and the healthcare professional, with special attention given to confidentiality, patient's consent, parental involvement and child protection[20,21].

The concept of "visibility management" emerged from qualitative research by Lasser & Tharinger (2003), and it is described as the complex, multi-layered process by which LGBT youth decide when to disclose their orientation, to whom, how and where[22]. It is further defined as a never-ending discourse within the LGBT individual, and as being central to LGBT identity development. Lasser & Tharinger suggested that an awareness of this phenomenon is useful to the healthcare professional, claiming the client can be aided in exploring identity, dealing with victimisation, and creating coping strategies. The researchers stressed the importance of the healthcare professional acting as an ally to the LGBT client.

Brown (2002) offers an overview of literature dealing with suicidality and self-harm in LGBT youth, arriving at a model for affirming, sensitive practice[23]. She began by advising the practitioner themselves to analyse their own feelings towards the LGBT community, and cites Davies (1997) to recommend the inclusion of personal attitudes, feelings, fears and prejudices in this self-examination. Further recommendations in this work included familiarising oneself with the language used by LGBT youth, and the provision of clearly labelled information to clients and their families.

Mayock *et al*'s research (above) found that approximately 75% of the research subjects felt that healthcare professionals need to be more aware and more culturally competent when dealing with LGBT clients[14].

Conclusion

Research has proven, time and time again, that LGBT youth are more at risk of suicide and self-harm than heterosexual youth. The problematic issue of homophobia and heteronormativity is endemic in society, and forces the LGBT young person to strategically manage their day-to-day life from an early age in a stressful, demanding manner. The healthcare professional can increase his or her awareness of the difficulties encountered by the LGBT individual, as well as arming him- or herself with tools to effectively provide the best care possible to this diverse community. Preserving a sense of the challenge of constructing a healthy homosexual identity, as well as acknowledging the needs of the family unit of the LGBT service user, means the healthcare professional can strive to act as an advocate and an ally for LGBT clients.

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