LGBTQ Suicide: Classic and Contemporary Theories Explored

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INTRODUCTION

Suicide – not an easy topic. Yet it seems to be all around us. We hear stories in the news, from our friends and family, we experience the loss of loved ones or acquaintances through this act, or we have thoughts of our own. We are directly or indirectly affected by it. And for some, we are the ones that cause the affect.

I was 17 when I attempted suicide and 20 when I came out as bisexual to my friends. I have reflected often on what caused me to reach that point. What made life so bad that I felt like suicide was the only way out? Was it just me? Was it family and friends? Was it school? Was it society? Was it my sexuality?

Although for me, my suicide attempt was not about my sexuality, about which I was mostly unaware, for many it is. For young people coming of age sexually, discovering aspects of themselves that are difficult to reconcile with negative messages from the culture, their families, and communities, the nature of their lives may seem hopeless. Who they are is denied, shunned, ridiculed, reviled, disowned, threatened or endangered such that they feel suicide is the only escape. I can say now, there was another way out for me, but I wanted to know why so many consider this option and even take actions to end their lives.

I didn’t start out planning to do this research. It took months for me to come up with my thesis idea. I knew I wanted to do something about sexuality as a newly “out” bisexual. I wanted to know how sexuality plays into everyday life socially and sociologically. I went through many topic ideas. I explored queer criminology (Buist and Lenning 2015) wondering about the experience of LGBTQ (lesbian, gay, bisexual, transgender, and queer) folks in the criminal justice system. I wanted to interview incarcerated people or correctional officers, but time and IRB constraints convinced me to switch to another topic within queer criminology. After another
month or so of reading and working on a possible thesis to explore, I turned my attention toward a topic that was more personally engaging. Suicide and sexuality are two very important aspects of my life. I decided that I wanted to explore if and how they may relate or interact. Again, my first preference would be to interview people with direct experience to explore more deeply their first-hand perspectives (Chambliss and Schutt 2019). However, securing IRB approval, recruiting participants, conducting interviews, and analyzing qualitative data was out of the question for the remaining time available to complete this project. Therefore, I looked for an existing data set that would allow me to investigate the prevalence of suicide and how sexuality plays a role in the apparent disparity between the suicide rates of LGBTQ and heterosexually identified youth.

Connecting suicide rates with sexual identity is difficult as that may be unknown after death. Indeed, being closeted has been associated with a greater likelihood of attempting suicide than those who are out and experience minimal or no family rejection (Amitai and Apter 2012). I expanded my inquiry to suicidality, defined as “the risk of suicide, usually indicated by suicidal ideation or intent, especially as evident in the presence of a well-elaborated suicidal plan” (American Psychological Association 2022). In this way I could see data from youth who were able to self-identify and had engaged in the behavioral pattern I wanted to explore.

While this topic is deeply personal for me and other individuals, it also is experienced as a tragedy for many families, friends, and loved ones. As a whole, 54% of Americans have been impacted by suicide (American Foundation for Suicide Prevention 2022). Suicide is also a leading cause of death in the United States with 45,979 deaths in 2020, amounting to one death every 11 minutes (Centers for Disease Control 2022). Similarly, in 2020, around “12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2
million attempted suicide” (CDC 2022). Relatedly, in 2020 suicide was the second leading cause of death among individuals between the ages of 10 and 34 (CDC 2022). Not only does suicide affect the individual who is experiencing such thoughts, but it affects other members of society as well. It can affect the health and well-being of friends, family, and the community. When someone dies by suicide, their surviving family and friends may “experience shock, anger, guilt, symptoms of depression or anxiety, and may even experience thoughts of suicide themselves” (CDC 2022). In addition to being a socially and psychologically risky act, it creates a financial toll on society. According to the CDC, “suicides and suicide attempts cost the nation over $70 billion per year in lifetime medical and work-loss costs alone” (2022). As sociologists, we can also see this phenomenon as both a social problem and public issue. A public issue is one that challenges our widely held social values. It is an issue which impacts categories of people and arises from patterns in our institutions. According to C.W. Mills, the source of public issues is within our institution by definition and therefore, public issues must be addressed at the institutional level (Walden 2022). Relatedly, a public issue is a condition that arises from a social context that frames people and their actions (Mills 1959). Although sociologists view suicide as a public issue, and one that is rooted in society, psychologists often de-emphasize the impact of society and focus on individual factors that lead to suicide. Gusfield explores how in the creation of “social problems,” certain groups (often professional groups) will assert their expertise on the matter and their ability to address or solve this problem. There is evidence in research and treatment programs that psychology has claimed “ownership” of this problem (Gusfield 2006), and thus has shaped our understandings and approaches to this phenomenon. However, sociology offers its own contributions to our understanding of this and possible means of addressing it as well.
So, although psychology is often considered the owner of this social problem, this phenomenon has been a topic of sociological theorizing from the discipline’s earliest days. One of the founding fathers of sociology thought this was important enough to devote an entire monograph to the topic. Emile Durkheim was interested in suicide and how this seemingly individual act was embedded in larger “social facts” such as obligations, attitudes, values, and morals originating from social relationships and human association (Gingrich 1999). Others since Durkheim have studied and theorized about suicide, and I wondered if Durkheim’s original ideas would hold up along with contemporary theories for explanatory power, and consequently for offering insights for addressing this social problem.

I wondered if this classic theory held up over time or if there were other sociological theories that might improve and expand upon Durkheim’s work. After reading in this field, I chose minority stress theory as the contemporary candidate and sought out a data source for making comparisons between the two theories. This thesis is the result of this exploratory study and analysis.

A REVIEW OF THE LITERATURE

Definition of Terminology

Suicide is defined as “death caused by self-directed injurious behavior with an intent to die as a result of the behavior” (Klonsky, May, and Saffer 2016). Although the definition has evolved over time and across disciplines and “official” uses, the general consensus remains the same. Suicide attempts are defined as “a nonfatal, self-directed, potentially injurious behavior with the intent to die as a result of the behavior even if the behavior does not result in injury” (Klonsky et al. 2016). Suicidal ideation is defined as, “thinking about, considering, or planning suicide” (Klonsky et al. 2016). Suicide in itself is a social problem. Social problems are a
category of thought. It is a way in which we see certain conditions as needing change, possibly through public action (Gusfield 1989). Essentially, a social problem refers to conditions within society that have damaging or disruptive effects that affects the way in which people can reach their full potential (Glicken 2010). Also, it is important to acknowledge that social problems are constructed through social processes of awareness building and negotiation. Therefore, nothing is inherently a social problem (Walden 2022). The five most common social problems in sociology refer to poverty, unemployment, unequal opportunity, racism and malnutrition. (Glicken 2010). Suicide, most would argue, is something that needs to be changed. It is a condition that can be entirely addressed through collective action at an institutional level such as education aimed at prevention or a medical institution providing interventions or “treatment.”

Prevalence and Distribution of Suicide and Suicidality in the US

As mentioned earlier, this social condition can be further described by the rates of suicide in the US. According to the CDC, suicide is the 10th leading cause of death in the United States, taking the lives of nearly 46,000 Americans in 2020. This adds up to one suicide death every 11 minutes. As for suicidality, 12.2 million Americans have considered suicide, 3.2 million made a plan for suicide, and 1.2 million Americans have attempted suicide (CDC 2022).

Suicidality also varies across the life course, impacting all ages. Suicide is the 2nd leading cause of death for individuals ages 10-34, while it is the 4th leading cause of death for individuals ages 35-44 (AFSP 2022). While it remains a leading cause of death for approximately the life course, these rates highlight the vulnerability of youth, including teens. Suicide and suicidality are not only correlated with age, but also marginalization and minority group status. Non-Hispanic American Indian/Alaska Native and non-Hispanic White populations have higher rates of suicide than other groups. Similarly, “young people who identify as lesbian, gay, or bisexual
have higher rates of suicidal thoughts and behavior compared to their peers who identify as heterosexual (CDC 2022). This statistic not only represents the effects of marginalization on suicide trends but reiterates the trend of suicidality among vulnerable youth. LGBTQ youth experience multiple marginalizations through age and sexual/gender minority status. As a result of this, they may experience stressors that are exceptional when compared to the general population. According to the CDC, individuals whose identity as marginalized by their society “may disproportionately experience factors linked to suicide, such as substance misuse, job or financial problems, relationship problems, physical or mental health problems, and/or easy access to lethal means” (2022). Therefore, it is important to explore how marginalization in any form affects suicidality so that more effective measures can be devised to address this issue.

When discussing suicide, it is important to acknowledge the complexities within the phenomenon. For one, suicidality is a process that progresses throughout the life course (Ream 2020). Youth are particularly impacted by suicide attempts and ideation. In fact, suicide is the second leading cause of death for youth in the United States (Horwitz et al. 2021). More specifically, suicide is the second leading cause of death for 15 to 29 year-olds (McDermott, Hughes, and Rawlings 2018).

**Sexual/Gender Identity and Vulnerability to Suicidality**

Gathering data on suicide and suicidality among LGBTQ identified people is complex and difficult. As sexuality is viewed as a spectrum, it may be difficult to determine who “counts” in this group. A person who engages in lethal actions cannot self-identify and may or may not have been “out” to family. Understanding this behavior within this diverse community also runs the risk of “homogenization,” where people with different identities and experiences within this broad umbrella term are lumped together erasing important unique features that could have
explanatory power. However, from statistical evidence, there does appear to be a higher risk for youth who identify with some aspect of this umbrella term. LGBTQ youth are more likely to have suicidal ideation and attempt suicide when compared to their heterosexual counterparts (Aranmolate et al. 2017). In regard to suicide attempts specifically, “LGBTQ youth are four to six times more likely to attempt suicide, which results in injury, poisoning, or overdose that requires treatment from a doctor or nurse than heterosexual youth” (Aranmolate et al. 2017). The experiences of LGBTQ individuals across the life course are inherently different from their heterosexual peers. Individuals within the LGBTQ community are often faced with increased risk factors such as family and peer rejection. Similarly, protective factors within this community are harder to achieve such as employment security and relationship stability (Ream 2020).

Overall, the additional stigma and victimization that LGBTQ individuals face can lead to inflated rates of suicide attempts and suicidal ideation (Lytle et al. 2018). LGBTQ youth may also be less likely to seek help due to fear of rejection and prejudice (Lytle et al. 2018). Sexual minority youth are two to four times more likely to have a history of suicidal ideation and attempts compared to straight youth (Horwitz et al. 2021). In addition to the elevated levels of suicide attempts and suicidal ideation, members of the LGBTQ community experience a more extreme trajectory of suicidal thoughts and behaviors. This includes an earlier age of onset for these feelings, a greater number of attempts and a stronger desire to die during an attempt (Horwitz et al. 2021). According to the CDC, almost a quarter of high school students identifying as LGBTQ reported attempting suicide in the last 12 months which is almost four times higher than their heterosexual peers. However, suicide attempts seem to decrease with age for sexual minorities. Five and a half percent of individuals from ages 18-25 attempted suicide whereas 2.2% of individuals ages 26-49 attempted suicide in the past 12 months (CDC 2022).
Unique Experiences Under the Umbrella: Bisexuality and Suicidality

Although an analysis of LGBTQ individuals as a whole is necessary, it is also important to acknowledge variation within the broader community. Individuals identifying as bisexual are of particular interest due to their exceptional suicide rates and suicidal ideation when compared to their homosexual or heterosexual peers. Bisexual individuals are shown to have higher rates of depression, anxiety, suicidal ideation and suicide attempts compared to homosexual and heterosexual youth (Pompili et al. 2014). More broadly, bisexual individuals tend to experience more psychological distress than other groups. This may be in part due to the fact that bisexual individuals often feel as if they don’t belong to a particular group. This within-sexual minority difference may be a result of structural and interpersonal issues these individuals face. In particular, bisexual individuals experience monosexism, bisexual erasure or invisibility and a lack of bisexual-affirming support (Salway et al. 2019). Similarly, bisexuals may experience other forms of sexual identity-based stigma. However, psychological indicators aren’t the only stressors that these individuals face. Bisexual individuals also show significant health disparities across multiple domains when compared to their peers (Taliaferro et al. 2018). In regard to psychological disparities, according to Salway et al. (2019), “minority stress models predict that various forms of biphobia and monosexism will accumulate across the life span of bisexual individuals, ultimately creating emotional and cognitive dysfunction that may manifest as depression, anxiety, and in some cases, suicide ideation or attempt.” Similarly, under the minority stress theory, stigma, prejudice and discrimination all work to create a hostile and stressful social environment, both of which can lead to increased rates of mental health problems (Taliaferro et al. 2018). Without a sense of belonging, bisexuels experience increased levels of stress which can result in increased rates of depression, suicidal behavior, social anxiety,
substance use and body image disturbance (Pompili et al. 2014). It seems as if the experience of erasure and invisibility may be a major mechanism contributing to higher rates of suicidal ideation and attempts in the bisexual community (Salway et al. 2019). However, it is important to recognize that bisexual identity is not the sole contributing factor to increased risks within this community. Risk behaviors and less involvement in protective factors may be another contributing factor to the higher rates of depression and suicidal behavior within this community (Taliaferro et al. 2018).

All of these contributing factors truly come down to the notion that bisexuals have a particularly unique and difficult path that may result in increased suicide attempts and ideation. For example, while “outness” for gay and lesbian individuals is shown to be beneficial for health outcomes, bisexual “outness” is associated with worse health outcomes (Ream 2020).

Bisexual youth are also shown to have higher rates of suicidal ideation and suicide attempts compared to straight and other sexual minority youth (Horwitz et al. 2021). Some believe that bisexuals may experience unique societal pressures such as biphobia or monosexism. Bisexuals may also have less opportunities to engage in sexual minority organizations or be a member of a LGBTQ community. Also, bisexuals are often less open about their sexuality and have greater conflict in regard to their sexual orientation. All of these factors combined can lead to higher levels of identity confusion, less self-disclosure, and less community connection relative to their peers (Horwitz et al. 2021). Additionally, it is likely due to these unique stressors that individuals identifying as bisexual experience lifetime suicidal ideation and have a history of a suicide attempt when compared to their straight and other sexual minority peers (Horwitz et al. 2021).
Youth vs. Young Adult Suicidality

Although much of this exploratory analysis focuses on youth suicide, it is important to recognize the differences between youth and young adult suicide. It is apparent now that there is a disparity between LGBTQ and non-LGBTQ suicide attempts and ideation. Specifically, LGBTQ youth are more likely to die by suicide than non-LGBTQ youth. Not only do young people who identify as LGBTQ have elevated risks of suicide attempts, they also have elevated risks of self-harm (McDermott et al. 2018). This increased risk of suicide is thought to be about four to seven times larger than their heterosexual peers (McDermott et al. 2018). However, according to Ream (2020), this suicide disparity may be greater in adolescents because LGBTQ-specific risk factors and circumstances are more prevalent among adolescents than young adults. For example, it has been shown that bullying, family and peer rejection, and nonsuicidal injury are more common in younger LGBTQ cases, highlighting the disparity among LGBTQ and non-LGBTQ youth. Similarly, LGBTQ adolescents’ suicide is more likely to have involved LGBTQ-specific risk factors while LGBTQ young adults are more likely to die by suicide overall (Ream 2020). Outside of the LGBTQ population, young adults are more likely to die by suicide than adolescents. This is largely due to increased possibilities as a result of increased age. For example, young adults have greater access to firearms, dangerous substances, and personal problems that are more likely to result in life-altering consequences (Ream 2020).

Risk Factors

Risk factors refer to problems that individuals might face that can lead to an increased vulnerability to suicidality (Aranmolate et al. 2017). There are a multitude of risk factors that can contribute to suicide ideation and attempts related to sexual identity and other life experiences. However, LGBTQ individuals do face unique risk factors that may contribute to what appears to
be higher rates than the general population of suicide we are seeing today. Risk factors that LGBTQ youth share with the general population but may experience with greater frequency or intensity due to heterosexism in US society include: a history of a mental illness, history of alcohol or substance abuse, impulsive and aggressive tendencies, having a family history of suicide or violence, recent loss, and access to lethal methods. In particular, LGBTQ youth may experience certain mental health challenges that only work to exacerbate the already present risk factors. Some mental health challenges of LGBTQ youth can include: lack of acceptance from peers, discrimination, family rejection, and school failure (Aranmolate et al. 2017). Similarly, in a nationally representative sample of bisexual youth, isolation, disconnection, bullying, alcohol and drug use, relationship violence, and multiple sexual partners were all shown to be correlated with higher rates of suicidality within this population (Taliaferro et al. 2018). However, the most significant correlation is having a previous suicide attempt (Aranmolate et al. 2017). LGBTQ individuals who reported higher levels of family rejection are eight times more likely to have a suicide attempt compared to their peers that experience low levels of family rejection (Lytle et al. 2018). When LGBTQ youth are faced with these challenges they “often lack the life skills and experience to cope with feelings of fear and anxiety related to their acceptance in the society” (Aranmolate et al. 2017). Similarly, when this fear is real and LGBTQ individuals are faced with negative attitudes and forms of discrimination, consequences can include things such as isolation, family rejection, and a lack of access to support groups. When faced with these challenges, stress levels, depression, and substance use may increase which has been shown to be a contributing factor to suicide risk in LGBTQ youth (Aranmolate et al. 2017). For reference, “LGBTQ youth whose family highly rejected their sexual orientation are 8.4 times more likely to have attempted suicide compared to their LGBTQ peers that experience no or low levels of
family rejection” (Aranmolate et al. 2017). As discussed, when risk factors are paired with other mental health challenges unique to the experiences of LGBTQ youth, it makes this group especially vulnerable to suicide ideation and attempts.

Peer relationships, although sometimes beneficial, can also have negative consequences for LGBTQ youth. Poor peer relationships, isolation, and normalizing self-harm are linked to suicidal behaviors. Additionally, the death of a friend by suicide can result in increased rates of depression, suicidal thoughts, and suicide attempts (Lytle et al. 2018). Bisexual individuals, in particular, have more risk factors including bullying, victimization, and depression compared to straight and other sexual minority youth (Horwitz et al. 2021).

Bullying is another risk factor for suicide. Experiencing bullying during childhood increases the odds of a suicide attempt (Amitai and Apter 2012). This applies for both LGBTQ identified individuals and heterosexual identified individuals. However, it is sexual minorities that are more likely to experience bullying (Mueller et al. 2015). Bullying is associated with suicidal ideation for all race, ethnic, and gender categories. Not only does bullying isolate individuals, but it applies a social stigma to LGBTQ youth. It is this social stigma that may be responsible for the increased risk of suicidality in LGBTQ populations (Mueller et al. 2015).

**Barriers to Seeking Support**

In addition to stressors and risks, there can be significant barriers that prevent youth from seeking help for mental or social stressors. This is especially prevalent for members of the LGBTQ community. Some barriers include: the stigma of being labeled mentally ill, the fear of negative consequences such as being viewed as attention-seeking, poor mental health literacy, an inability to communicate and express emotions effectively, and finally, the cultural expectation of self-reliance and the view that needing help is a sign of failure (McDermott et al. 2018). Of
these, LGBTQ individuals were found to struggle the most with the stigma of mental health, fear of being viewed as attention-seeking, emotional competence, and self-reliance. However, LGBTQ individuals also experience additional barriers. LGBTQ individuals found it hard to access support because they may not be “out” or may be concerned with reactions from medical professionals or community members if they discuss their sexuality. They fear both mental health stigma and the stigma that comes from identifying as a member of the LGBTQ community. Additionally, LGBTQ youth feared that their emotional distress would not be taken seriously by adults (McDermott et al. 2018).

As a whole, McDermott et al., suggested that reluctance to seek help was due to three interconnecting factors: “negotiating sexuality, gender, mental health and age norms; being unable to talk about emotions; and coping with self-reliance” (2018). It is through these interconnecting factors that research has shown LGBTQ individuals have elevated rates of suicidality and the norms and normative processes connected to sexual orientation and gender identity are additional barriers that individuals experience that may contribute to this phenomenon.

Protective Factors

In specific relation to this thesis, protective factors can be viewed as factors that support and protect LGBTQ youth from suicidality (Aranmolate et al. 2017). As with risk factors, protective factors are unequally distributed among groups within society. Empirical studies have identified several factors that are associated with decreased rates of suicide including effective clinical care, family and community support, cultural and religious beliefs that discourage suicide, and support of tendencies for self-preservation (Aranmolate et al. 2017). Even physical activities can serve as a protective factor. Aerobic activity, sport participation and adequate sleep
have all been shown to be a protective factor in the bisexual population (Taliaferro et al. 2018). When looking at the bisexual community in particular, family acceptance has shown to be a major protective factor (Pompili et al. 2014). According to one study, family acceptance led to more social support, higher levels of self-esteem, better outcomes, and decreased rates of suicide attempts and suicidal ideation (Lytle et al. 2018). However, it is also shown that individuals identifying as bisexual are shown to have fewer protective factors such as parent-family connectedness and positive affect.

It has also been shown that LGBTQ individuals seeking help from other LGBTQ youth can be more beneficial than family support (Lytle et al. 2018). Although there may be benefits from reaching out to peers, seeking support from more formal sources such as parents, teachers and professionals can be more beneficial for young people than simply reaching out to peers (Lytle et al. 2018). However, LGBTQ youth that have support from both family and friends experience lower levels of distress (Lytle et al. 2018).

**Suicide as a Sociological Question**

Durkheim was the first to systematically explore suicide as a social phenomenon. He defines suicide as “death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result” (Kushner and Sterk 2005). Durkheim argued that social phenomena must be explained by social facts. He defines social facts as “things external to, and coercive of, the actor” (Gingrich 1999). More specifically, he asserts that social facts are created by the collective, rather than the individual. According to him, social facts are “real” in that they actively constrain individuals, with those constraints located outside the actor. When we in the U.S. hear the word constraint, we typically have negative associations. However, social facts help regulate, coordinate, and give order to social life and human actions.
Social facts can include laws, policies and social sanctions or they may be enforced by such. In particular, Durkheim asserted that there are two types of social facts: material and non-material. Material social facts refer to social structures and institutions. In a sense, material social facts are the features of broader society. Non-material social facts can include things such as norms, values, belief systems or morality (Gingrich 1999). Additionally, Durkheim distinguished between normal and pathological social facts. Normal social facts contribute to the maintenance of society and social life. Pathological social facts refer to social problems within society (Gingrich 1999). Suicide is just one example of a pathological social fact. However, there may be other pathological social facts which contribute to suicide, such as discrimination, economic hardship, racism, or heterosexism in cultural meanings and patterns.

Again, Durkheim argued that social facts contribute to suicide. When using this perspective to theorize the causes of suicide, Durkheim argued that the level of pathological social facts and anomie on the macro-level are what lead to differences among particular groups in suicide rates. As a reminder, when social life is characterized by rapid change, lack of group cohesion, and/or confusion, anomie appears. Essentially, Durkheim predicted that the more anomie and pathological social facts, the higher the rate of suicide (Graeff and Mehlkop 2007).

Durkheim conceptualized the causes of suicide to be beyond individual thought processes, located in non-material social facts defined as social currents. Social currents are “characteristics of society but may not have the permanence and stability that some parts of collective consciousness or collective representation have” (Gingrich 1999). Social currents include public sentiments such as general cultural pessimism or optimism. In a sense, he was trying to explain something anti-social (suicide) through a social lens (aspects of culture, groups or society).
Because the effects of social currents can be observed in rates of behavior, those numbers can be analyzed statistically.

*Durkheim’s Theory of Suicide*

Before diving into Durkheim’s Theory of Suicide it is important to understand some of his critical terminology and underlying theoretical objective. Durkheim’s basic premise argues that the structure of social relationships that individuals have shape their ability to be happy and healthy (Mueller and Abrutyn 2016). Rather than providing a psychological lens to suicide, Durkheim purports that despite suicide being a deeply personal act, death by suicide is rooted in societal structures (Mueller and Abrutyn 2016). As a refresher, Durkheim defines suicide as “death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result” (Kushner and Sterk 2005).

Anomie, which is a key component of any of his theories refers to, “normlessness, resulting from the absence of regulation” (Bearman 1991). Essentially, anomie occurs as a result of changes to social integration and regulation (Graeff and Mehlkop 2007). Anomie is often related to lower levels of integration and regulation. Integration relates to, “the extent of social relations binding a person or a group to others such that they are exposed to the moral demands of the group” (Bearman 1991). Regulation refers to, “normative or moral demands placed on the individual that come with membership in a group” (Bearman 1991). He argues that regulation and integration determine the prevalence of suicide within a population (Mueller and Abrutyn 2016). In essence, it is integration and regulation that are “distinct social forces that are sufficient to cause suicide” (Mueller and Abrutyn 2016). Integration and regulation not only stimulate anomie in certain situations, but they are the key components of Durkheim’s four types of suicide: anomic, fatalistic, egoistic and altruistic.
Anomic suicide occurs when there is a lack of social rules or clarity about expectations and norms (Graeff and Mehlkop 2007). This occurs during times of rapid social or personal change, dissemination of new discoveries or technologies, or crises such as natural disasters, wars, or epidemics (Walden 2022). Essentially, the predictability and smooth running of society is disrupted in these scenarios. With this disruption there is little guidance for an individual to navigate norms and values to manage expectations or predict what others will do and what they should do, or even to make sense of new realities (Moore 2016).

While a functional level of regulation is necessary to avoid anomie and simply accomplish the necessary tasks in society, too much regulation can become a pathological social fact. Fatalistic suicide occurs when an individual experiences over regulation (Graeff and Mehlkop 2007). Under this notion, regulation is so excessive that individuals experience little or no control over their lives (Moore 2016). When this lack of ability to change situations is coupled with oppressive conditions despair may set in. Suicide may appear to be the only act fully under one’s control.

Egoistic suicide occurs when an individual is not well integrated into their group. When the individual isn’t well integrated, “they feel as if they are not part of the community, but the community also feels that the individual is not part of their lifestyle” (Moore 2016). Without the support or even watchful eye of the community, the individual is isolated and doesn’t receive social moral guidance on how to operate in their social environment, and society as a whole (Moore 2016). They feel alone in the world. Everything is up to them and them alone. Who’s to tell them what is right or wrong or help them find their way?

Altruistic suicide occurs when the individual is so integrated into society to the point where the pressure to succeed for the greater good becomes overwhelming (Moore 2016). The
individual is not what matters. The whole, their goals and interests, outweigh an individual’s need for survival. We see such examples in war or survival situations where one will lay down their life for others or for a group cause. While egoistic suicide claims that the individual’s individualistic rule system becomes more important than collectivist rules, altruistic suicide occurs when the collectivist rule becomes superior (Graeff and Mehlkop 2007).

In plain terms, anomic suicide occurs when there are high levels of integration and low levels of regulation. Egoistic suicide occurs when there are low levels of both integration and regulation. Altruistic suicide occurs when there are high levels of both integration and regulation. Finally, fatalistic suicide occurs when there are low levels of integration and high levels of regulation.

As a whole, Durkheim’s theory of suicide argues that suicide is a social phenomenon that is based on social facts (Graeff and Mehlkop 2007). However, there are two core tenants to his theory. First, the structure of social relationships shapes the structure of suicide. Second, integration and regulation are the center structural dimensions of social relationships (Abrutyn and Mueller 2014). He argued that individuals subject to too little or too much integration would engage in either egoistic or altruistic suicide. On the other hand, if individuals are subject to too much regulation they would engage in anomic or fatalistic suicide. If the groups they belong to engage in any of these factors, individuals become less protected against the impulse toward pathological behavior (Abrutyn and Mueller 2014).

There are ways in which the different types of suicide can be grouped and analyzed. Anomie and egoism are a result of a collapse of traditional restraints. If this occurs, an individual is more likely to engage in either anomic or egoistic suicide (Kushner and Sterk 2005)
In regard to rates of suicide, the rate of anomic suicide measures alienation, defined as the degree to which someone is isolated from a group or society (Kushner and Sterk 2005). The rate of egoistic suicide measures the decline of self-restraint. Finally, the rate of altruistic suicide measures socially sanctioned self-sacrifice (Kushner and Sterk 2005).

Simply put, “Durkheim’s theory implies that suicide rates – as a social phenomenon—are part of the special principles that societies use to organize their social activities. If social adaptation fails in the course of development, the anomic states occur, indicating maladjustments of integration and regulation and counting as a reason for increasing or decreasing rates of suicide” (Graeff and Mehlkop 2007). In order to avoid suicide, people need moral regulation or guidance from society and sufficient integration to manage their own needs and aspirations (Meyer 2003). Without this regulation and integration, anomie, lack of social control and alienation can lead to suicide because basic social needs cannot be met (Meyer 2003).

Theories From the Sociology of Deviance

Sociology, while not completely ceding the social problem of suicide to psychologists, tends to approach the topic from a “deviance” perspective. Although not therapeutically based, this approach may still offer promise for understanding suicide to a greater degree as well as improving policy that targets suicide prevention (Mueller et al. 2021).

Differential Association

Differential association theory refers to the idea that “people vary in their exposure to behavioral and normative patterns through their associations with others” (Pratt et al. 2010). In essence, this theory explains that people learn to engage in suicide from their environment. It is through the association with others who express norms, values and attitudes conductive to the behavior that increases support for the behavior (Thomas 2021). In particular, differential
associations vary in frequency, duration, priority and intensity. Frequency refers to the idea that the more frequent the behavior, the more influence the behavior will have on the individual. Duration refers to the idea that the longer the behavior takes place, the greater influence the behavior will have. Priority speaks to the idea that the interactions made early in life are more likely to have a greater influence on the individual. Finally, intensity refers to the idea that the more importance or prestige that is attributed to the individuals engaging in the behavior, the greater the influence the behavior has (Thomas 2021). This can be through the interactions of others that individuals learn the values, attitudes, methods, and motives for suicide (Walden 2022). It is sometimes associated with social learning theories as this has been discussed as a mechanism of social learning. These ideas also have a particularly salient influence when considered with cultural scripts. As will be discussed in more detail in the next section, scripts are constantly changing and are never fixed. This becomes problematic when an individual is exposed to a suicide of someone they identify as a type of role model. In turn, this can facilitate the growth of a cultural script that identifies the role model’s behavior as something that is good (Abrutyn, Mueller, and Osborne 2020).

Empirical research has shown support for differential association theory (Matsueda 1988). However, this was not easy. One serious criticism of differential association theory is its difficulty to test the theory empirically. Despite the difficulties, with a more direct strategy of operationalization, empirical studies have shown support for this theory (Matsueda 1988). However, there are still questions and limitations that must be acknowledged about this theory. Although there have been significant revisions to the theory and additional theoretical frameworks, the theory does not provide support for answering the question of how social structures facilitate communication and learning (Matsueda 2000).
Cultural Scripts

A cultural script is an “available, taken-for-granted social fact” (Abrutyn et al. 2020). Relatedly, when analyzing the rates of youth suicide, a fairly controversial idea begins to emerge. What if suicide ideation and attempts are increasing because we have subconsciously created scripts that reinforce the idea that suicide is acceptable? Literature has shown that it is indeed a phenomenon that exposure to suicide increases a youth’s vulnerability to suicide ideation and attempts (Abrutyn et al. 2020). One contributing factor to such a phenomenon is linked to the concept of shared symbolic meanings. According to Abrutyn et al. (2020), shared symbolic meanings refer to, “how humans come to mobilize behavior, and interpret and justify their and others’ behaviors, and therefore become capable of adopting novel attitudes or behaviors.” As a result of such shared symbolic meanings, suicide clusters, and in turn, suicide diffusion begins to emerge. Suicide clusters refer to “suicides or episodes of suicidal behavior localized in both time and geographical space” (Niedzwiedz et al. 2014). These clusters are a contributing factor to suicide diffusion, although diffusion can also occur without clusters present. Suicide diffusion occurs when suicide, whether attempts or ideation, begin to spread through social relationships or social groups. This may also happen through media exposure. This exposure to suicidal behaviors and actions is known as suicide contagion, which will be discussed later (Abrutyn et al. 2020).

Ethnographic research, in particular, plays an important role in determining how suicide clusters and diffusion can create cultural scripts. Most ethnographic research shows that different social environments provide different meanings for who dies by suicide. This also includes cultural meanings on why, when, how and where the suicide took place. Essentially, “there are meanings about suicide embedded within cultures that are often broadly known and taken for
It is important to note that although these macro-level meanings are known, they can always be changed. These broader meanings can be challenged by micro-level forces such as social groups or individuals. Whether stagnant or challenged, these cultural meanings contribute to cultural scripts.

When these meanings are learned and internalized, they turn into cultural scripts. Cultural scripts are “the mechanisms by which real, imagined, and mythic narrative models of behavior overlap with real performance” (Abrutyn et al. 2020). Essentially, cultural scripts contain meaning that can influence social behavior. Certain cultural scripts may contribute to suicide. If one is exposed to suicide as a possibility, it may alter personal meanings in such a way that points to the idea that suicide is an easily accessible and applicable option, which in turn shifts the script to one that supports suicide. Although it is hard to consider a cultural script supporting suicide, the mere presence of suicide may introduce it into collective or group consciousness as a possibility. The possibility and meaning of suicide presents itself in a way that through clusters, communities can begin to make sense of suicide which therefore expands the script of whom suicide is an option for (Abrutyn et al. 2020). As discussed, cultural scripts are continually shaped by human experience, symbolic communication, and action. A suicide script emerges or transforms when a suicide contradicts a previously existing and shared meaning of suicide. When this contradiction is learned by individuals, a suicide script is generated collectively. It is through this collective thought that suicide can be rendered logical, and therefore, a suicide script is born (Abrutyn et al. 2020).

This evolving theory is gaining evidence indicating exposure to suicide does truly exacerbate youth’s vulnerability to suicidality (Abrutyn et al. 2020). There are large bodies of evidence including longitudinal and causal-modeling strategies to indicate this phenomenon
Abrutyn et al. 2020; Baller and Richardson 2009; Abrutyn and Mueller 2014; Randall, Nickel, and Colman 2015; Fletcher 2017). However, there are some limitations to this theory. One major limitation of this theory is that the current research focuses on which types of network structures can create a diffusion effect and who in the network is the best at diffusing ideas and behaviors. However, the specifics of suicide itself have less empirical evidence. Therefore, the current literature is insufficient for explaining something as complex as suicide and if suicide can permeate through social ties like other information, ideas, and scripts and how that happens (Abrutyn et al. 2020).

**Contagion Theory**

A rather controversial, yet profoundly important contemporary theory is contagion theory. As discussed above, contagion theory refers to the idea that exposure to suicide increases the risk of suicidal behavior (Miklin et al. 2019). Current research has shown that exposure to suicide is a risk factor for suicidality (Miklin et al. 2019). This risk is dependent on the individual’s reaction to the suicide. For some, being exposed to suicide frames suicide as an option. This exposure may make suicide more thinkable, but also more doable. For others, exposure to suicide is a representation of not only hurting oneself but hurting others. Although abstract, exposure to suicide is not risky in and of itself. Instead, it is inherently distressing for the individuals that were exposed. The meaning that individuals attribute to the suicide determines their level of vulnerability to suicidality after being exposed. However, it is important to acknowledge that exposure to suicide does increase the risk of suicidality in the individual who was exposed. Exposure to suicide is a complex phenomenon that may facilitate suicidality for some but decrease suicidality for others. In essence, it all depends on how the individual interprets the experience.
As a whole, suicide exposure begins to become part of an individual’s cultural experience. This implies that one’s normative capacity for suicide is dependent on their exposure and whether or not they view suicide as an option (Miklin et al. 2019). As contagion theory is a relatively new subfield of sociology, there is a significant lack of rigorous assessment of the underlying concept and theory (Cheng et al. 2014).

**Minority Stress Theory**

Although the minority stress theory is fairly new, it is important to recognize some key terminology before looking at each aspect of the theory. Minority stress theory, unsurprisingly, has its foundation in the stressors that minority individuals face. Minority stress is an elaboration of social stress theory. Minority stress is defined as the “excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position” (Meyer 2003). One stressor that minority individuals can be exposed to is internalized homophobia. Internalized homophobia refers to, “hearing negative messages from others about one’s social position can be directly damaging, but it may also shape an individual’s own beliefs about that social identity. Internalization of socially generated meanings can result in self-devaluation for some sexual minority individuals (Holman 2018). Another form of stress is when individuals experience expectations of fear and rejection. Holman claims, “even in the absence of direct or overt discrimination from a known perpetrator, LGBTQ individuals can experience stigma-related stress as a result of chronic expectation or anticipation of rejection or harassment” (2018). Concealment is an interesting stressor as it can also serve as a coping mechanism (Meyer 2003). Concealment occurs when an individual chooses to hide their minority identity for safety or social concerns (Holman 2018). Each of these stressors can be thought of as minority stressors, and in particular, LGBTQ-specific stressors. These stressors can be divided into two
categories, a distal and proximal stressor. A distal stressor is the “objective conceptualization of marginalization, that is stigmatization or victimization that is perpetrated by another actor toward the LGBTQ individual” (Holman 2018). A proximal stressor is the “subjective form of stigma in that the process occurs within the individual rather than from something that is done to them” (Holman 2018). Distal and proximal stressors range from external, objective stressful events and conditions that can be both chronic or acute, to expectations of such events and the recognition this expectation requires, and finally, the internalization of negative social attitudes. All of these work together to create increased minority stress.

It is important to recognize stress and how it can be different for minority individuals. According to Holman, “stress processes specific to a sexual minority orientation can affect the psychological health and well-being of LGBTQ individuals” (2018). In particular, the stress that those with a stigmatized identity experience may be exaggerated compared to the general stressors that other individuals face (Holman 2018). The prominence of one’s sexual identity may exacerbate their levels of stress. Similarly, the level of valiance, or the evaluative features that are tied to identity and self-evaluation can be increased in minority individuals, causing more stress and pressure (Meyer 2003). Essentially, minority stress related to someone’s sexual identity is unique to that individual and their unique identity. This reflects society’s negative responses and reactions to them (Baams, Grossman, and Russell 2015).

The theory as a whole is used to explain the stigma, prejudice, and discrimination that all work to create a hostile and stressful environment. An environment like this one can cause mental health problems, and in serious cases, suicide attempts or suicidal ideation. In particular, the model includes stress processes such as, “the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes”
In other words, and in regard to the different mechanisms contributing to stress, the experience of prejudice events, expectation or rejection and discrimination, concealment of one’s sexual identity and internalized homophobia are all mechanisms that can contribute to minority stress (Baams et al. 2015).

“In developing the concept of minority stress, researchers' underlying assumptions have been that minority stress is (a) unique—that is, minority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people are required an adaptation effort above that required of similar others who are not stigmatized; (b) chronic—that is, minority stress is related to relatively stable underlying social and cultural structures; and (c) socially based—that is, it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors or biological, genetic, or other nonsocial characteristics of the person or the group” (Meyer 2003).

Despite the stressors that minority individuals face, self-ameliorating factors can be very beneficial for minority individuals as they can help cope with stress. Although a minority status is associated with stress, it is also associated with important resources such as group solidarity and cohesiveness. These protective factors can work to prevent the adverse mental health effects that can occur to minority individuals. By establishing structures, values and a community that counteracts society’s negative attitudes towards them, LGBTQ individuals can counteract minority stress. Not only does this allow minority individuals to respond to stress through coping but it’s also them responding with resilience (Meyer 2003).

There are a multitude of theories that can help to explain suicidality among the LGBTQ population. However, the minority stress theory is particularly illuminating when considering the
factors that contribute to LGBTQ suicide. According to Ream, “minority stress theory holds that LGBTQ+ persons have higher rates of suicidality and other physical and psychological problems because of homophobia, biphobia, and transphobia in society, which encourage victimization of LGBTQ+ persons and limit their opportunities” (2020). Although these experiences are external to the individual, many members of the LGBTQ community begin to internalize these attitudes which results in greater stress. Particularly, stress that stems from being your true self.

This theory claims that the health disparities experienced by sexual minorities are a result of greater life stressors such as prejudice, rejection, concealment and internalized homophobia as a result of their stigmatized identity (Horwitz et al. 2021). According to Horwitz et al., “the differences between bisexual and mostly straight youth on minority-stress-related variable, such as bully-victimization and parent-family connectedness (which were significantly associated with suicidal ideation and attempts for all sexual minority youth), may explain why bisexual youth have greater prevalence of suicidal ideation and attempts” (2021).

**Interpersonal-Psychological Theory**

Within the broader concept of minority stress theory, lies interpersonal-psychological theory. When applying this theory to suicide, this theory focuses specifically on the feelings and attitudes of perceived burdensomeness of LGBTQ individuals, identities and experiences (Ream 2020). This feeling of burdensomeness can come from a variety of factors. For one, these individuals may face a sense of needing protection from others or needing help in school or workplace situations. Also, rejection from family or romantic interests can result in decreased levels of belongingness. Finally, if the individual has experienced physical or sexual victimization, they are more likely to have the psychological capacity to engage in self-harm that may have lethal effects (Ream 2020). In addition to perceived burdensomeness, thwarted
belongingness leads to increased suicidality. However, it is perceived burdensomeness that helps to determine how much of a burden one views themselves as and how much more of a burden their suicide would be (Miklin et al. 2019). For example, as a protective effect, witnessing the grief of others in the wake of a suicide may motivate individuals to avoid that sort of behavior as a way of minimizing burdensomeness.

METHODS

Deductive Reasoning

My reading in this field led me to wonder if Durkheim’s historical ideas around religion as a source of social integration and regulation still held in a more generalized form for larger communities such as schools or even cultural groups or smaller primary groups such as families and peers. I also wondered if there were better theories to explain the contemporary situation in which LGBTQ youth are at higher risk for suicidal behaviors (CDC 2022). To address this, I searched for a data base that would provide simple, but comprehensive statistics on this group and this type of behavior. What I found was either databases that did not separate for sexual or non-binary gender identities, for example, the CDC and AFSP, or “reports” that included the information I wanted to explore, but offered no access to the original data, for example, The Trevor Project. Since it did not appear I would be able to test hypotheses for statistical significance, I hoped to deduce theoretically intriguing predictive statements from existing theories that could be compared in an exploratory way against reported statistics. This is similar to deductive reasoning in that my research is deduced from a specific expectation of a general premise and then tested (Chambliss and Schutt 2019). However, it is not purely such, as there is no systematic testing of a null hypothesis. Given my time and resources, this study serves as a pilot foray into the strength of these theories and their potential for generating policy and
programs that alleviate suffering. The nature of the methods for this thesis entails deductive reasoning from existing theories. For the purposes of analysis, I chose to analyze preexisting data through the scope of Durkheim’s theory of suicide and minority stress theory. By using these theories, I will be able to formulate predictions and possible explanations for the statistics that I chose. Additionally, by using this deductive approach I am able to test the strengths and usefulness of each theory.

**Predictive Statements**

In order to make my exploratory comparisons of theories, I came up with four statements derived from the respective theories to compare with the data in The Trevor Project. Two predictive statements stem from Durkheim’s theory of suicide and the remaining two stem from minority stress theory. The two predictive statements for Durkheim’s theory test his notions on integration and regulation. In particular, I chose to look at egoistic and fatalistic suicide and how they might be illustrated or not by the findings from The Trevor Project. For my predictive statements for minority stress theory, I chose to focus on comparisons between LGBTQ youth and the overall population as well as an examination of multiple identities in order to explore the role of intersectionality in suicidality (Vargas, Huey, and Miranda 2020).

It is important to acknowledge that any findings may be theoretically intriguing, but not statistically significant.

**Selection of a Data Set: The Trevor Project**

I chose to use The Trevor Project as the source of pre-existing data. The Trevor Project is “the world’s largest suicide prevention and crisis intervention for LGBTQ (lesbian, gay, bisexual, transgender, queer, and questioning) young people” (The Trevor Project 2021). Every year this organization conducts a national survey measuring LGBTQ youth mental health. For
my data set, I chose to use their most recent third annual survey. This survey was conducted in 2021 and was able to receive responses from nearly 35,000 LGBTQ youth from the ages of 13-24 in the United States. This survey is very comprehensive and includes the topics of: the impacts of COVID-19 on mental health, mental health care disparities, discrimination, food insecurity, conversion therapy, and suicide, in addition to a variety of other measures.

**Strengths of this Data Set**

There are a variety of reasons as to why I chose to use The Trevor Project as my primary source of pre-existing data. First, as I continued my research, I recognized it is extremely difficult to find a cohesive and representative dataset depicting LGBTQ suicide rates and suicidal ideation. The Trevor Project was the first dataset I found that had a large, representative sample size as well as a variety of information that would be beneficial for my exploratory analysis. The national survey contains plenty of measures that are useful to analyze correlations and trends represented. Although no dataset will have all of the information necessary for an analysis, this data set provided me with preliminary data that I could use to explore through a theoretical and sociological lens. Additionally, this data set proved to serve our limitations of time and resource restrictions.

*The Trevor Project Report vs. Raw Data*

As discussed, finding a data set full of raw data pertaining directly to my subject of analysis was very difficult. So, rather than using raw data that indirectly or incompletely provided insight into my topic, I chose to use The Trevor Project’s 2021 report as it contained more specifically what I was interested in. Since this provided no raw data, I was no longer interested in statistical analysis. Instead, I was interested in looking at the correlations and trends in their reported results. Specifically, and most importantly, The Trevor Project had statistics that
allowed for exploration of the strength of various theories’ ability to predict suicidality among LGBTQ identified youth. This allowed for an exploratory evaluation of Durkheim’s theory of suicide and minority stress theory relative to the statistics represented in the report.

**Qualitative Approaches**

My initial impulse was to gather interview data that would capture the richness of subjective experience and meaning in order to add depth to our understanding of this phenomena. Qualitative analysis is defined as, “the nonnumerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationship” (Babbie 2016). Incorporating qualitative analysis proved to be beneficial for this thesis as it allowed me to draw connections between data and theory. In an ideal situation, I would have loved to conduct research using a qualitative approach through interviews or ethnographic research, however, once again, time and advisor availability hindered my ability to conduct such research.

**Quantitative Approaches**

Alternatively, in an ideal world, if I were to conduct research with the intent of looking for generalizable trends and patterns, I would have conducted quantitative research. Quantitative research refers to “statistical techniques used to describe and analyze variation in qualitative measures” (Chambliss and Schutt 2019). However, the lack of appropriate existing data sets and lack of time to collect better data limited this option.

**Justification of a Creative “Little Bit of Everything” Approach**

When analyzing data such as rates and statistics, I decided that it would be more beneficial to qualify each statistic through a mixed-method approach. A mixed-methods approach refers to “analytic techniques applied to both the quantitative and the qualitative data as
well as mixing the two forms of data concurrently and sequentially in a single project or a multiphase project” (Creswell and Plano Clark 2018). It is important to acknowledge that my research is neither purely qualitative nor purely quantitative. Instead, I conducted exploratory comparisons of trends based upon theoretically derived predictions. Due to time constraints, I did not work from raw data in order to conduct statistical analyses. Without the ability to collect data that would shed light on my specific questions and population of interest, and barring an existing data set that would do that job, I settled for a more preliminary and comparative method as the best fit. While I use the numbers gathered by The Trevor Project, I do not run the statistical comparisons on those numbers that would indicate significance at that level. Instead, I treat this as content for insights and comparisons rather than tests of significance.

In summary, while a qualitative approach involving interviews could have helped me see the true richness of social experience, lack of time and resources prevented me from engaging in such research. Similarly, quantitative methods could have provided me the statistical tools to make generalizations or test for the significance of my findings, but again time and resources constricted my research. Therefore, the loosely mixed-method approach I chose was best suited for my research and is beneficial in creating a “greater depth of understanding, reveal or correct errors in other methods, and fill in the steps in complex social processes” (Chambliss and Schutt 2019).

Elimination of Other Methods

There were quite a few methods I considered before deciding on my method of inquiry. This section will briefly discuss my reasoning as I designed my study.
Meta-Analysis

One other method I was considering for my research is a meta-analysis. A meta-analysis is a “quantitative, formal, epidemiological study design used to systematically assess previous research studies to derive conclusions about that body of research” (Ab 2010). Strengths include the ability to review large and complex bodies of literature which may sometimes be contradictory. However, limitations include the failure to identify the majority of existing studies that apply to the research at hand. Due to this limitation, and my own limitations, I decided against conducting a meta-analysis.

Content Analysis

At first, I was considering completing a content analysis of pre-existing data. Content analysis is “a research method for systematically and quantitatively analyzing characteristics of messages” (Chambliss and Schutt 2019). Essentially, a content analysis is a “survey” of messages. However, due to the restraints discussed earlier, I chose to complete an exploratory study of pre-existing data in order to compare data to theory. However, I thought it was important to speak about content analysis and how some of my analysis stems from this research method. Similar to content analysis, my analysis included looking at pre-existing data in order to recognize comparisons and differences between groups. I chose to use an archive of LGBTQ suicide rates and statistics. Rather than coding the data like a content analysis, I decided to use the data to look for correlations and trends. Although a content analysis would have been beneficial, the situation in which I was in allowed me to use the foundation of a content analysis to develop an exploratory research approach.
Interviews

Finally, and I would argue most importantly, was my decision to not conduct interviews. Interviews were the ideal sociological method that I hoped to engage in during the formulation of this thesis. An interview is, “a technique for evaluating questions in which researchers ask people test questions, and then probe with follow-up questions to learn how they understood the question and what the answer means” (Chambliss and Schutt 2019). Interviews not only provide researchers with qualitative data, but rich, descriptive interpersonal data which would have served me greatly for my research. However, due to time constraints, resources, and IRB approval, conducting interviews was not something that was feasible for me.

DISCUSSION

In this section, I will discuss what the data from The Trevor Project indicates about the relative strength of each theory with regards to the predictive statements. While no claims are made regarding the statistical significance of these findings, they serve as indicators of next steps for more rigorous study that could inform programs and policy.

Predictive Statement #1

As discussed in the literature review earlier, Durkheim’s theory has two core principles: “the structure of suicide rates is a positive function of the structure of a group or class of people’s social relationships and those that social relationships vary according to their level of integration and (moral) regulation” (Mueller et al. 2021). It is through these core principles that I formulated my first two predictive statements. In developing these statements, it was necessary to operationalize the concepts they utilize in terms available in the existing data. Operationalization involves “the process of specifying the operations that will indicate the value of cases on a
variable” (Chambliss and Schutt 2019). Essentially this means defining a concept or idea as something that can be directly observed and measured.

Based upon Durkheim’s theory of suicide, low levels of social integration should lead to higher rates of suicide attempts and suicidal ideation (Gingrich 1999). Low levels of integration occurs when individuals are socially isolated or they feel as if they do not belong to a group or community (Mueller and Abrutyn 2016). Specifically, low levels of integration would refer to lower levels of social relationships and fewer density ties (Mueller et al. 2021). According to Durkheim, this type of suicide resulting from lower levels of integration can be categorized as egoistic suicide. In the scope of this exploratory analysis, I operationalized the concept of social integration as low “affirming spaces,” defined as, a space with increased acceptance and affirmation (The Trevor Project 2021). This leads to the following predictive statement 1: less access to affirming spaces should result in higher rates of suicidal ideation and attempts, that Durkheim would categorize as egoistic suicide.

I would argue that the data from The Trevor Project is ambiguous regarding whether the availability of affirming spaces affects suicide rates. While LGBTQ youth who had access to affirming spaces did report lower rates of attempting suicide, the difference is not dramatic. Of LGBTQ youth who attempted suicide in the past year 14% had affirming online communities while 16% did not have access to affirming online communities. Similarly, 12% of those who attempted suicide said they had an affirming school while 18% who attempted suicide said their school was not affirming. Finally, 11% of individuals who reported attempting suicide had an affirming home while 16% found their home not affirming (The Trevor Project 2021).

Previous research has shown that individuals without affirming spaces, which is associated with a low sense of belonging, have a higher risk of suicidal thoughts and attempts
(Hatcher and Stubbersfield 2013). Others hypothesize that internalized feelings of homo/bi/transphobia and fear of rejection outweigh the support of any affirming spaces (Holman 2018). Although individuals may have an affirming space and a strong support system, these internalized feelings may never be curbed. If an individual has internalized cultural messages denigrating their identity, affirming spaces may not be enough to counter those messages and feelings. Given the low percentage difference and suggesting from other research about alternative variables that may be more influential, future research should include the reported levels of self-acceptance with the presence of affirming spaces to see if one of these is stronger or if there is an additive effect. My conclusion regarding the strength of this predictive statement is that it has some, but very low predictive value. Therefore, designing policy around this such as insuring “safe spaces” or forming support groups for LGBTQ youth may not reduce suicide rates very much.

*Predictive Statement #2*

Durkheim’s work also notes that excessive or pathological rates of social regulation lead to higher rates of suicidal ideation and attempts. This would mean that there is a higher degree of a collective moral order and social controls that regulate individual’s attitudes and behaviors such that an individual may feel overly constrained, controlled, or have a sense of “no way out” (Mueller et al. 2021). To Durkheim, this type of suicide is categorized as fatalistic suicide. Fatalistic suicide occurs when individuals are subject to “intense psychic and physical coercion such that there was no hope for a future without suffering” (Mueller et al. 2021). Similarly, Durkheim argued that structural inequalities and violent oppression may make groups of oppressed individuals more vulnerable to fatalistic suicides (Mueller et al. 2021). For this thesis, I operationalized social regulation as the experience of “discrimination” and social “conversion
therapy” (The Trevor Project 2021). Social conversion therapy is defined as “the use of various methods (such as aversive stimulation or religious counseling) in an attempt to change a person’s sexual orientation to heterosexual or to change a person’s gender identity to correspond to the sex the person has or was identified as having at birth” (Merriam-Webster 2022). These represent attempts to control and change the behavior and identity of LGBTQ youth and these are asked about in The Trevor Project’s data. This leads to predictive statement 2: The presence of reported experiences with discrimination and/or conversion therapy should result in higher rates of suicide attempts.

Twenty one percent of individuals who reported being discriminated against on the basis of sexual identity in the last year attempted suicide, while only 9% of those who had not been discriminated against attempted suicide. Similarly, 24% of those who had been discriminated against on the basis of gender identity in the past year attempted suicide while 12% of those who were not discriminated against attempted suicide. Finally, 23% of LGBTQ youth of color who have been discriminated against on the basis of race, ethnicity or nationality attempted suicide while 14% of those who were not discriminated against attempted suicide.

LGBTQ youth who have been subject to conversion therapy exhibit similar results. Of LGBTQ youth who attempted suicide in the past year, 27% were subjected to conversion therapy while 12% were not subjected to conversion therapy. In the mind of Durkheim, this extremely high level of regulation would lead to fatalistic suicide, which is supported by The Trevor Project’s Data.

The differences between the groups that did or did not experience excessive social regulation are much larger than for the previous statement. Therefore, I would argue that this data illustrate support for this aspect of Durkheim’s theory of suicide, and in particular, the effect
high regulation has on suicide rates. Although Durkheim only includes fatalistic suicide in the footnotes of his theory, it is the concept best supported by the data from The Trevor Project. However, it may not be the regulation itself having the strongest impact. The higher rates of suicide attempts may be a result of extreme regulation amplifying the already present negative internalized feelings that LGBTQ individuals face. Alternatively, high levels of regulation might increase feelings of fear of rejection. This fear may result in higher rates of suicide attempts and suicidal ideation. Although other explanations can be made, the scope of my exploratory analysis does not allow for such explanations and further research should refine their scope in order to determine whether it is regulation that is resulting in higher levels of suicide attempts and ideation. However, this observation could also be interpreted as indicating support for another more contemporary theory which will be discussed next.

Predictive Statement #3

Minority stress theory claims that minority individuals experience higher levels of stress which can result in higher rates of suicide attempts and suicidal ideation. For this theory, minority refers to “a small group of people within a community or country, differing from the main population in race, religion, language, or political persuasion” (Cyrus 2017). Similarly, stress relates to “a state of mental or emotional strain or tension resulting from adverse or demanding circumstances” (Cyrus 2017). It is from this stress that stigma, prejudice and discrimination can work to create hostile and stressful social environments that can be conductive to suicide (Cyrus 2017). As discussed above, minority stress is unique, chronic, and socially based. Therefore, the stressors experienced by minority groups are different from those experienced by the general population which in turn, relates to the idea of increased suicide rates among LGBTQ youth as a result of these unique stressors (Meyer 2003). From the outset of my
research, I came up with predictive statement 3: LGBTQ youth experience stressors such as discrimination that have an additive effect that leads to higher rates of suicide than the general population. Although minority stress theory includes stressors such as victimization and prejudice, for the purposes of this thesis, I have operationalized “discrimination” as one of the central stressors LGBTQ individuals face. Discrimination can be seen as a distal stressor, one that is outside of the individual and conductive to increased minority stress.

According to the American Foundation for Suicide Prevention, 8.9% of youth in grades 9-12 reported at least one suicide attempt in the past year. In comparison, The Trevor Project reports that 42% of LGBTQ individuals reported seriously contemplating attempting suicide. This alarming comparison illustrates minority stress theory and how it seems as if LGBTQ individuals do experience more stressors that can be conducive to an increased rate of suicide attempts and suicidal ideation. LGBTQ individuals may face stressors that the general population does not such as internalized homophobia, fear of rejection, and discrimination. I would argue that all of these stressors likely lead to increased rates of suicide attempts in LGBTQ youth compared to the general population. However, it is important to recognize potential flaws in this reasoning. In order to truly grasp the influence of strain on individuals, there must be data on if increased strains play a role in suicide attempts and suicidal ideation. In the future, data should refine possible explanations for attempts.

**Predictive Statement #4**

One major limitation of minority stress theory is that it does not consider intersectionality to the degree in which it should. Intersectionality is a vital concept for understanding inequalities. The concept, originally developed by Kimberlé Crenshaw in 1989, “addresses differences in social locations as they create inequalities in power and resources in historical and
cultural contexts” (Azmitia and Thomas 2015). Resources and privileges are affected by gender, race, class, ethnicity, sexuality, physical ableness and other dimensions as they interact and increase, decrease, or alter the experience of privilege or oppression. Although no direct causal mechanisms are given, why some of these dimensions support resources and privileges, the inequality is clearly visible and measurable all the same across time. It is through intersectionality, and an intersectional lens, that we are able to analyze social conditions, like suicide, that perpetuate and reflect differences in power and privilege (Azmitia and Thomas 2015).

Viewing LGBTQ suicide without an intersectional lens oversimplifies the issue and risks missing conditions that could have strong explanatory power that could lead to better solutions. Any perspective that ignores intersectionality risks “the elision of intersecting structures of inequality that contribute to the pain and suffering of queer people worldwide…” (Grzanka and Mann 2014). Without applying an intersectional lens, we undermine efforts to address intersecting forms of oppression and support heterosexism. In order to truly grasp the identities of queer individuals, we must understand all of their intersecting identities and how the social meanings and structures around these perpetuate intersecting systems of oppression (Grzanka and Mann 2014). By applying this lens in this thesis, I hope to gain better insight into how identifying as LGBTQ is just one contributing factor for suicidality.

By applying an intersectional lens to minority stress theory, I was able to analyze data through a perspective that considers multiple identities and experiences. In order to operationalize this phenomenon, I used The Trevor Project’s data to compare suicidality among white LGBTQ-identified individuals, and minority LGBTQ individuals on the basis of race/ethnicity. Accordingly, I proposed predictive statement 4: LGBTQ youth that also hold
other minority identities would have a higher likelihood of suicidal ideation and attempts due to the additive factor and stresses of multiple marginalization. Multiple marginalization is very similar to intersectionality in that it refers to the idea that if an individual has multiple minority identities, their identity is affected not only by one, but all of their minority identities. This has implications for all groups within society. Not only does multiple marginalization marginalize those apart of minority groups, but it interacts with the broader social climate, determining the level to which the minority status is accepted or rejected (Steele 2005).

According to The Trevor Project’s data on the consideration of suicide and suicide attempts, white youth, expectedly, reported lower levels of suicide consideration and attempts compared to racial/ethnic minorities. Of the white youth surveyed, 39% considered suicide while 12% attempted suicide. The only other minority identity that has similar rates are those of Asian/Pacific Islander youth with 38% considering suicide while 12% attempted suicide. Other racial/ethnic groups are more at risk for these types of behaviors. Forty-seven percent of Black youth considered suicide while 21% attempted suicide. Forty-three percent of Latinx youth reported considering suicide while 18% attempted suicide. Of those with more than one race/ethnicity, 48% reported considering suicide while 21% attempted suicide. The largest percentages of all groups belong to Native/Indigenous youth. Fifty-two percent of Native/Indigenous youth considered suicide while 31% attempted suicide. As mentioned, although I cannot draw any causal claims these percentages indicate that holding more than one intersecting identity does contribute to the variation or suicidality in LGBTQ youth.

As depicted in The Trevor Project’s data, holding multiple minority identities does seem to indicate a higher likelihood of suicide attempts or suicidal ideation. This is likely in part due to
the concept of intersectionality and how it is necessary to look at how each minority identity intersects and how that has an influence on suicide attempts and ideation.

CONCLUSIONS

In conclusion, it is now abundantly clear that LGBTQ youth experience higher rates of suicidality than the general population (CDC 2022). Not only is this alarming statistic prevalent, but levels of regulation, minority stress, and to a lesser degree, integration, all initially appear to be contributing factors in this phenomenon. At the conclusion of my research, I would argue that minority stress theory, with an intersectional lens, has the strongest evidence for supporting my predictive statement. I would also argue that minority stress theory as a whole was stronger than Durkheim’s theory of suicide with the one caveat being they were operationalized quite similarly. Therefore, perhaps, these two theories represent the various ways of looking at the common structure of oppression within society. It also seems as though my predictive statement regarding integration has the weakest evidence. However, intuitively, I would argue that this is a surprising result. The question is now, why might the effect of “affirming spaces” be so small in the prevention of suicidality among LGBTQ youth? Perhaps, affirming spaces are helpful but only to a certain degree. Maybe affirming spaces need another mechanism to support individuals in need. This perplexing phenomenon can be seen in marginalized ethnic groups that have a supportive family and community but are still subject to alarmingly high suicide rates (Cose 1993). Therefore, what are the next steps? I would argue that discrimination is one of the strongest factors that may lead to increased suicidality, and therefore, the larger inequalities within society must be addressed in order to support marginalized groups.

This research has offered me insights into the societal structures that perpetuate increased suicidality among LGBTQ youth as well as deeper understanding of the sociological
theories that might be applied to such a phenomenon for a more complete understanding that could inform policies and approaches to preventing suicidality among LGBTQ youth as well as the general youth population. I see several possibilities. First, we as a society must provide resources and affirming spaces for LGBTQ youth in order to mitigate the discriminatory experiences that LGBTQ youth face. Additionally, steps need to be taken to address forms of discrimination and over regulation of the LGBTQ population. Through the theoretical backing provided in this thesis, policies can be formulated in order to protect LGBTQ youth in the future. Unless we are able to look at the larger structural inequalities present in society, inequalities will persist. Although psychology has tried to take the reins on suicidality, a psychological approach may be bound to be limited in their effectiveness as long as this inequality persists. So, perhaps, with an intersecting approach of psychological and sociological inquiries, we as a society can address these deeply rooted inequalities that perpetuate discrimination and marginalization in society, and in turn, perpetuate increased suicidality among LGBTQ youth.

Although this thesis provides insights into LGBTQ suicidality, there are limitations to my study. In the future, qualitative research through interviews is necessary in order to get a deeper understanding of individual LGBTQ experiences. Additionally, a raw data set is needed in order to conduct statistical analyses to get a better grasp of how these rates compare to the general population. Although time and resources didn’t allow me to conduct this type of research, my research can serve as the steppingstone for future research in protecting the lives of LGBTQ youth.
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