## Sexual Minority Youth and Suicide Risk


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*Numerous studies spanning the past quarter century have used varied designs and methods in multiple settings and have consistently demonstrated that sexual minority youth are among those most likely to report suicidality (suicidal thoughts, plans, and attempts). This article reviews the methodological challenges that have defined and limited research in this area, including issues of sampling, the measurement of sexual minority status, and the measurement of suicide risk. Attention is then given to risk and protective factors for suicide among sexual minority youth. Normative risk and protective factors, those common to all youth, and risk and protective factors unique to sexual minority youth are reviewed. In closing, attention is given to the state of suicide prevention and intervention efforts that target sexual minority youth, along with recommendations for further research.*

***Keywords:*** *suicide; sexual orientation; sexual minority; gay and lesbian; youth; adolescent*

**A key risk indicator** for suicide among adolescents is sexual minority status, that is, whether one engages in same-sex sexual behavior, has enduring emotional or sexual attractions to the same sex (usually termed sexual orientation), or claims a same-sex sexual identity as gay, lesbian, or bisexual. Until recently, this conclusion was controversial (e.g., Remafedi, 1999; Shaffer, 1993); some continue to argue against the accumulated evidence of suicide risk among sexual minority youth (Savin-Williams, 2001). However, numerous studies spanning the past quarter century have used varied designs and methods in multiple settings and have consistently demonstrated that sexual minority youth are among those most likely to report suicidality (suicidal thoughts, plans, and attempts).

Beginning in the early 1970s, reports indicated that young gay men were at high risk for suicide (Roesler & Deisher, 1972; Saghir & Robins, 1973). In 1989, the Department of Health and Human Services published its *Report of the Secretary's Task Force on Youth Suicide*. The report included two controversial chapters that linked sexual minority status to suicide, one on "Gay Male and Lesbian Youth Suicide" (Gibson, 1989) and a second on "Sexual Identity Issues" (Harry, 1989). The Gibson (1989) chapter is the origin of the much-quoted statistics that

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"gay youth are 2 to 3 times more likely to attempt suicide than other young people" and that they "may comprise up to 30 percent of completed youth suicides annually" (p. 110). The chapters were controversial because they were not based on original research and because they drew from studies that had been criticized because the samples were composed of self-identified gay and lesbian young people that were opportunistic, nonrepresentative, and that offered no comparison or control groups. Nevertheless, in the years surrounding the publication of this report, multiple studies continued to provide evidence that self-identified gay or lesbian youth were at disproportionate risk for suicide. Between the mid-1980s and mid-1990s, multiple investigations of gay and lesbian youth drawn from community samples corroborated earlier studies (D'Augelli & Hershberger, 1993; Hammelman, 1993; Harry, 1989; Hershberger, Pilkington, & D'Augelli, 1997; Hunter, 1990; Martin & Hetrick, 1988; Nicholas & Howard, 1998; Proctor & Groze, 1994; Remafedi, Farrow, & Deisher, 1991; Rotheram-Borus, Hunter, & Rosario, 1994; Schneider, Farberow, & Kruks, 1989); each retained the methodological limitations of sample design, selection, and comparison that characterized past studies.

A new generation of studies on sexual minority status and the risk for suicide began in the late 1990s with the publication of the first research based on large-scale, representative, and thus generalizable samples of adolescents (DuRant, Kowchuck, & Sinal, 1998; Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautrais, 1999; Garofalo et al., 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, French, Story, Resnick, & Blum, 1998; Russell & Joyner, 2001). These studies provide new evidence for a strong link between sexual minority status and suicidality. Most have relied on measures other than same-sex sexual identity and thus have both broadened the field of inquiry and raised new questions about the nature of adolescent same-sex sexuality and its link to mental health and suicide.

This article reviews past studies (most conducted in the United States unless otherwise indicated), with careful attention to those that challenge the existing evidence linking suicide risk to adolescent sexual minority status. Through this review, the article provides a context for identifying fruitful avenues for the next generation of research in this area. The article begins with a review of the methodological challenges that have defined and limited research in this area, with attention to recent studies that have addressed many of these challenges. The subset of past studies that investigate risk and protective factors for suicide among sexual minority youth is then highlighted. Although many past studies have documented high rates of suicidality among sexual minority youth, studies that examine risk and protective factors are beginning to provide a knowledge base to explain why sexual minority youth are at such risk. In closing, attention is given to the state of suicide prevention and intervention efforts that target sexual minority youth, along with recommendations for further research.

## METHODOLOGICAL CHALLENGES

Three interrelated challenges have characterized the methodological limitations in this field of study: identifying sample populations, measuring adolescent sexual minority status, and measuring suicide risk. These three issues are considered below.

### SAMPLING

Until recently, most of the published studies were based on small opportunistic samples of self-identified lesbian, gay, or bisexual (LGB) youth with no analytic comparison groups. For years, these samples were presumed to be biased; the extent to which the youth who made their way into these studies were uniquely at risk could not be estimated. Furthermore, although many of the reported samples included only school-age youth, others included college-age students and young adults. As a result, conclusions about suicidality often were based on very small numbers of LGB youth spanning a wide age range.

Given the low prevalence of same-sex orientation, behavior, or identity in the general population, very large samples are required for population-based studies to yield the numbers of sexual minority youth suitable for analysis. Over the past decade, large-scale, representative, and population-based surveys focused on school-age teens have begun to include attention to sexual minority status. Youth Risk Behavior Surveys (YRBS) in Massachusetts (1993) and Vermont (1995) have included attention to same-sex sexual behavior and the 1995 Massachusetts YRBS included an item measuring sexual identity. (In addition, questions on sexual minority status have been added to YRBSs in recent years and have been included on the YRBS surveys for several cities. To date, these data have not been published in scientific, peer-reviewed outlets.) Minnesota included a question on homosexuality on the statewide 1987 Adolescent Health Survey. Even in these large studies, the actual numbers of gay, lesbian, or bisexual youth are so small that within sexual minority group differences cannot be estimated (see Faulkner & Cranston, 1998; Garofalo et al., 1998, 1999; Remafedi, 1998). Because more adolescents in these studies self-identify as bisexual than lesbian or gay, the link between sexual minority status and suicidality documented in these studies is based on samples of predominantly bisexual-identified youth, a group that may be different from the self-identified lesbian and gay youth that have comprised earlier studies (Russell & Seif, 2002).

Within sexual minority status group, comparisons have been made with data from the U.S. National Longitudinal Study of Adolescent Health (the "Add Health" Study), the only national data source in the United States that includes indicators of sexual minority status for adolescents. Reports from that study show that (a) youth reporting romantic attractions to or relationships with the

same sex or both sexes are at greater risk for suicidal thoughts and attempts (Russell & Joyner, 2001) and (b) boys with same-sex relationship partners and girls with partners of both sexes are more likely than youth in other-sex relationships to report suicidal thoughts (Udry & Chantala, 2002).

One additional recent study links same-sex identity or behavior in young adulthood (age 21) to adolescent suicide ideation and attempts. Drawn from the Christchurch Health and Development Study, a study of a New Zealand birth cohort (Fergusson et al., 1999), this study is important because it is the only known large-scale prospective study of adolescent sexual minority status and suicide risk.

## MEASURING SEXUAL MINORITY STATUS

A second fundamental challenge for the field has been the measurement of sexual minority status (Gonsiorek, Sell, & Weinrich, 1995). Early studies were based on opportunistic samples of self-identified gay, lesbian, or bisexual adolescents (e.g., Martin & Hetrick, 1988); many of these studies were limited to adolescent gay men (e.g., Remafedi et al., 1991; Roesler & Deisher, 1972). This sampling approach was necessary due to problems identifying samples based on a characteristic that is both highly marginalized and can be hidden. In the past decade, understanding of same-sex sexuality has broadened beyond an exclusive focus on sexual self-identity to include attention to same-sex sexual behavior and same-sex sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994; Savin-William, 1989). Measures of sexual minority status in more recent studies have included same-sex sexual identity (e.g., Fergusson et al., 1999; Garofalo et al., 1998, 1999) as well as same-sex sexual contact (e.g., Faulkner & Cranston, 1998), same-sex and both-sex romantic attraction or relationship(s) (e.g., Russell & Joyner, 2001), and same-sex and both-sex romantic relationship(s) (e.g., Udry & Chantala, 2002). One recent study categorized subjects as homosexual, bisexual, and heterosexual based on a cluster analysis of questionnaire items about sexual activity, intimacy, and sexual fantasy (Van Heeringen & Vincke, 2000). Regardless of the measure used, sexual minority adolescents in each study were found to be at greater risk than non–sexual minority youth for suicidal thoughts or attempts (for specific exceptions, see Udry & Chantala, 2002; Van Heeringen & Vincke, 2000).

The use of different indicators of sexual minority status is an important step in broadening the understanding of the risk for suicide as experienced by sexual minority youth. At the same time, the use of different measures limits the ability to compare results across studies. Few studies include more than one indicator of sexual minority status. No existing studies include attention to three key dimensions of sexual minority status: sexual behavior, orientation, and identity.

## MEASURING THE RISK FOR SUICIDE

Like all studies of youth suicide, research on the risk for suicide among sexual minority adolescents must first contend with challenges in defining and measuring suicide risk. Existing studies have been based on multiple self-reported indicators of suicidality, including suicidal thoughts, suicide intent, suicide plans, suicide attempts, number of suicide attempts, and severity of suicide attempts. Attention to these measures of suicidality is important because "(a) suicidal ideation . . . almost invariably precedes a suicide attempt or a suicide; (b) a past history of suicide attempt represents the strongest known risk factor for future suicide attempts and completions; and (c) studying completed suicides is very difficult and costly given their low base rates" (Lewinsohn, Rohde, & Seeley, 1996, p. 26). The general conceptual and methodological issues in the measurement of suicide and suicidality are beyond the scope of this article and have been discussed elsewhere (O'Carroll et al., 1996). However, what is important is that most studies, particularly those based on representative samples, are predicated on single-item indicators that have questionable validity (Meehan, Lamb, Saltzman, & O'Carroll, 1992).

Published studies on completed suicide (Shaffer, Fisher, Hicks, & Gould, 1995) and on suicide attempt severity (Savin-Williams, 2001) have challenged past work based on measures of suicidality. First, no existing studies link completed suicide with adolescent sexual minority status. The only published study of sexual minority status among adolescents who completed suicide concluded that there was "no evidence that suicide is a common characteristic of gay youth" (Shaffer et al., 1995, p. 64). The study was based on interviews with parents, friends or siblings, and teachers of 95 male cases of completed suicide, compared to 116 controls randomly sampled by telephone and selected to match the suicide sample based on sex, age, and race. The authors defined sexual minority status (using the term homosexuality) as having had "homosexual experiences" or having "declared a homosexual orientation." Based on this criterion for classification, no subjects in the control group were homosexual (0%), whereas three suicide cases were classified as homosexual (3.2%). The authors concluded that there were no significant differences between the suicide and control samples (Shaffer et al., 1995).

There are two important limitations of this study. The first is that the sample was very small; significant group differences may have been detectable were the sample larger. The second and more important limitation relates to the measure of sexual minority status. Coming to terms with same-sex sexuality is typically a stressful process (Rotheram-Borus & Fernandez, 1995) that may be characterized by denial and suppression of one's sexual or emotional feelings. In fact, one recent study demonstrated that suicide attempts among lesbian, gay, and bisexual youth most often followed same-sex awareness and preceded disclosure of sexual orientation to others (D'Augelli, Hershberger, & Pilkington, 2001). It is

therefore very likely that sexual minority youth who complete suicide may do so never having disclosed their sexual orientation, identity, or behaviors to others. This would be particularly true given that the suicides under study took place nearly 20 years ago (between 1984 and 1986), at a time when fewer sexual minority individuals disclosed sexual minority status during adolescence (e.g., Paul et al., 2002).

A more recent study (Savin-Williams, 2001) challenges the accumulated evidence linking adolescent sexual minority status to indicators of suicidality, arguing that past studies have been inaccurate because they have not taken into account suicide attempt severity. Savin-Williams's (2001) approach was to investigate the severity of self-reported suicide attempts among sexual minority women (Study 1 included 83 women ranging in age from 18 to 25) and among a group of 266 college students (Study 2 compared 126 "at least slightly homosexual" students to 140 "exclusively heterosexual" students, ranging in age from 17 to 25). "True attempts" were those that resulted in injury; "false attempts" were those characterized by ideation, a suicide plan, or having a method but not carrying it out; and "life-threatening attempts" were true attempts with injury requiring medical attention. Analyses of Study 1 indicate that 23% of the sexual minority women reported suicide attempts, 17% reported true attempts, and 5% reported life-threatening attempts. Using the same approach, analyses of Study 2 indicate that sexual minorities (men and women) reported significantly more suicide attempts than heterosexuals. Significant differences were not found for true and life-threatening attempts. The author concludes that sexual minority youth are not at greater risk for suicide but rather that they consistently overreport suicide attempts, most of which are exaggerated.

Although Savin-Williams (2001) offers an advance in measuring suicide risk, the study typifies the critical sampling and sexual minority status measurement limitations present in earlier published reports. Although Study 2 includes a comparison group of heterosexuals, the sample size is so small that it obscures otherwise strong sexual minority status differences among men (true attempts were reported by 9% of sexual minority men in comparison to 2% of heterosexual men, and life-threatening attempts were reported by 6% of sexual minority men in comparison to 0% of heterosexual men). Furthermore, the research is not comparable to past studies of suicide risk among sexual minority youth because

- it is based on a sample of young adults (ranging in age from 17 to 25 with a mean age 20.2),
- it is based on a measure that assigns sexual minority status to anyone who is not "exclusively heterosexual," resulting in a sample in which nearly 50% of the respondents are sexual minorities, and
- it is based on a sample of college students—the respondents were presumably more privileged compared to the adolescents in most past studies.

The author concludes that sexual minority youth are either systematically untruthful compared to heterosexual youth or simply do not understand the

questions as well as heterosexual youth. To date, there is no support for the first conclusion in prior research. Rather, there are validity concerns regarding self-report of suicide attempts by all young people (Centers for Disease Control [CDC], 1992; Meehan et al., 1992). There is only limited support for the second conclusion; a recent study reported that boys who reported same-sex romantic relationships had lower verbal IQ than boys who reported other-sex relationships (Udry & Chantala, 2002). Finally, the author suggests that there may be a "suffering suicidal script" (Savin-Williams, 2001, p. 7) that leads youth to believe that to be gay one must be suicidal; no empirical support of this conclusion is offered. However, regardless of the empirical validity of each of these explanations, the conclusions fundamentally trivialize suicide ideation and the mental health needs of sexual minority youth (particularly those who self-identify as gay or lesbian). By concluding that sexual minority youth are not at increased risk for suicide based on these data, the author implies that self-reported suicide attempts are somehow unimportant, thereby contradicting the widely held clinical perspective that suicide ideation is an important risk factor for suicide attempt (Lewinsohn et al., 1996).

## RISK AND PROTECTIVE FACTORS

Because the evidence so strongly supports the conclusion that sexual minority youth are a group at risk for suicidality, we must begin to ask why. Past studies of sexual minority youth indicate that they report compromised family relationships (D'Augelli & Hart, 1987; Remafedi, 1987) and hostile school (Gonsiorek, 1988; Price & Telljohann, 1991) and peer environments (Radkowsky & Siegel, 1997; Russell, Seif, & Truong, 2001). Sexual minority youth who experience lack of support or hostility in these critical developmental contexts may suffer emotionally and turn to suicidality in response to a hostile environment and culture (Rotheram-Borus & Fernandez, 1995).

Several studies have focused on risk factors for suicide among sexual minority youth, either in comparison to non–sexual minority youth or in samples limited to sexual minorities. These risks may be normative, that is, experienced by all youth, or they may be unique to sexual minority adolescents. Sexual minority status group differences in normative risk factors may be important because these differences may largely account for the suicide risk disparities observed in past studies. Few studies have examined unique risk factors for sexual minorities, and even fewer have examined either normative or unique protective factors.

Much is known about normative risks for suicide among adolescents. Past research indicates that for all young people, critical adolescent suicide risk factors include depression (Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983; Kumar & Steer, 1995; Wagner, Cole, & Schwartzman, 1995), substance abuse (Brent & Perper, 1995; Felts, Chenier, & Barnes, 1992), the recent suicide

or attempted suicide of a family member or friend (Sorenson & Rutter, 1991), and problems or conflict with parents (Wagner et al., 1995). In published studies, sexual minority youth have been shown to have high levels of each of these risks: depression (Gonsiorek, 1988; Rothblum, 1990; Russell & Joyner, 2001), substance abuse (Garofalo et al., 1998; Remafedi et al., 1991; Russell, Driscoll, & Truong, 2001), recent suicide attempt by family member or friend (Rotheram-Borus, Hunter, & Rosario, 1994; Russell & Joyner, 2001), and conflict with parents (Hammelman, 1993; Russell, Seif, & Truong, 2001). Knowing that sexual minority youth disproportionately experience these risk factors will not help us understand their risk for suicidality unless these factors can account for the elevated rates of suicidality among sexual minority youth. A recent study by Russell and Joyner (2001) demonstrates that depression, alcohol abuse, and family suicide history largely explain the elevated rates of suicidality among sexual minority boys, whereas for girls the difference is largely explained by depression, alcohol abuse, and suicide history among friends.

In the past 10 years, researchers have begun to examine risk factors for suicide that may be unique to sexual minority youth; these factors are particularly important because they may provide explanations for the elevated levels of normative suicide risks experienced by sexual minorities. For example, although victimization may be a risk factor for suicide for all young people, past research suggests not only that sexual minority youth experience more frequent and more violent victimization (Russell, Franz, & Driscoll, 2001) but that the kinds of victimization they experience are qualitatively different because they are reactions to sexual minority status (D'Augelli, Pilkington, & Hershberger, 2002). A significant body of research demonstrates that victimization plays an important role in suicidality for sexual minority youth (Bontempo & D'Augelli, 2002; Hammelman, 1993; Hershberger & D'Augelli, 1995; Hershberger et al., 1997).

Beyond victimization, the concepts of "minority stress" (Meyer, 1995) and "gay-related stress" (Rosario, Rotheram-Borus, & Reid, 1996; Rotheram-Borus, Hunter, & Rosario, 1994) are important recent advances in the field. The study of stressors unique to sexual minorities can provide context for understanding the ways that suicide risk and risk factors may have unique origins and implications for sexual minorities. For example, gender nonconformity or gender atypicality has been identified as a risk factor for suicide among LGB youth (D'Augelli et al., 2002; Remafedi et al., 1991). Although it is true that gender nonconformity is not exclusive to sexual minority youth, the strict gender expectations of the adolescent period may be particularly problematic for sexual minority youth as they come of age (Olson & King, 1995). Past research has identified additional suicide risk factors that are unique to sexual minority youth: coming out (Hershberger et al., 1997) and coming out at young ages (Remafedi et al., 1991), unsatisfying gay friendships (Van Heeringen & Vincke, 2000) or rejection when coming out (Hammelman, 1993; Hershberger et al., 1997; Schneider et al., 1989), gay-related victimization (Hershberger et al.,

1997), and indices of gay-related stress (Rosario et al., 1996; Rotheram-Borus, Hunter, & Rosario, 1994).

Finally, exciting work is beginning to move beyond risk—that is, examining not simply the opposite of risk factors but characteristics that promote health and well-being. Certainly in the area of youth suicide, much less attention has been given to protective factors in comparison to risk factors. There are, however, a small number of studies that point to protective factors that are unique to sexual minority adolescents. Although unsatisfying relationships with sexual minority peers have been shown to be a risk factor (Van Heeringen & Vincke, 2000), social support from LGB peers has been linked to positive self-esteem (Anderson, 1998). In addition, family support and self-acceptance have been linked to fewer mental health problems among LGB youth (Hershberger et al., 1997). In terms of suicide, Hershberger and D'Augelli (1995) reported that self-acceptance (self-esteem and comfort with sexual identity) was associated with positive mental health, which in turn was protective against suicidality.

## PREVENTION AND INTERVENTION

Unfortunately, there is little to say about published research on suicide prevention and intervention for sexual minority youth populations. Most young people rarely hear adults talk openly about sexual minority status. A first step is integrating basic attention to same-sex sexuality in prevention and intervention efforts. In recent years, there has been increased attention to strategies for supporting sexual minority youth within the fields of education and health (McDaniel, Purcell, & D'Augelli, 2001; Stoelb & Chiriboga, 1998). However, studies of educators (Fontaine, 1998; Price & Telljohann, 1991; Sears, 1991) and mental health providers (Kourany, 1987) indicate that these key supports in the lives of youth are not equipped to address the needs of sexual minority youth. At the same time, there is evidence that in contexts where educators are sensitive to sexual minority issues, sexual minority youth are at lower risk. A recent study based on the 1995 Massachusetts YRBS documented that GLB youth who attend schools with gay-sensitive HIV instruction (teacher-rated confidence, adequacy, and appropriateness of HIV instruction for GLB students) score lower on multiple indicators of health risk (Blake et al., 2001). The few published studies of prevention efforts for sexual minorities focus on HIV/AIDS and sexual risk. These studies show that strategies involving health care access and peer support and education networks promote self-esteem (Wright, Gonzales, Werner, Laughner, & Wallace, 1998) and sexual health (Kegeles, Hays, & Coates, 1996; Remafedi, 1994; Rotheram-Borus, Reid, & Rosario, 1994; Rotheram-Borus, Rosario, Reid, & Koopman, 1995; Wright et al., 1998).

Although there are no published studies of the efficacy of suicide prevention and intervention programs that target sexual minority youth, the best available

evidence suggests that efforts that include a peer component (Anderson, 1998; Garofalo et al., 1998) and that focus on coping with stress and stigma (Hunter, 1999; McDaniel et al., 2001) would be effective for interventions for sexual minority youth who may be at risk for suicide.

## CONCLUSION

Nearly three decades of research from multiple disciplines and using multiple methods (community samples, regionally and nationally representative random samples, and a prospective cohort study, employing measures of sexual identity, sexual behavior, and sexual orientation) have repeatedly documented the link between suicidality and sexual minority status among adolescents. The best available evidence indicates that self-identified gay male youth are among those most at risk. Youth who engage in same-sex behavior and youth with same-sex orientations are also at risk compared to heterosexual youth, but their risk appears to be lower than self-identified LGB youth. At the same time, there is no evidence that sexual minorities are overrepresented among completed adolescent suicides.

The findings of several studies of adults that include adolescents in their samples are consistent with the research on sexual minority youth and suicide risk. In a recent study of adult male twins in the United States, those that had male sex partners reported higher suicidal thoughts and more attempts (Herrell et al., 1999). In addition, several recent population-based studies have documented the link between sexual minority status and suicidality in adults. These include studies of

- men ages 18 to 27 whose behavior or identity were "homosexual or bisexual" in Calgary, Canada (Bagley & Tremblay, 1997),
- adult men ages 17 to 59 with male sex partners in a U.S. national sample (Cochran & Mays, 2000),
- adult men and women ages 15 to 54 reporting same-sex partners in a U.S. national sample (Gilman et al., 2001), and
- adult urban gay men ages 18 and older in samples drawn from four U.S. cities (Paul et al., 2002).

The recent study of adult urban gay men is particularly important because the authors are able to demonstrate that nearly all of the reported suicide attempts by the gay men in the study (age 18 or older) occurred when the respondents were age 25 or younger. Furthermore, analyses by age indicate that "prevalence of parasuicide during gay and bisexual males' younger years may be increasing rather than declining" (Paul et al., 2002, p. 1343).

## DISCUSSION

During adolescence, dealing with emerging sexuality becomes a critical developmental task (Petersen, Leffert, & Graham, 1995). The normal difficulties associated with this developmental process are heightened for sexual minority youth who must simultaneously negotiate the stigma of homosexuality (Rotheram-Borus & Fernandez, 1995). Adolescence is defined by multiple developmental transitions; past studies indicated that multiple stressful transitions put adolescents at risk (Petersen et al., 1995). This is a useful lens through which to view the developing awareness of same-sex sexuality. Managing the transition into the awareness of sexual minority status is stressful like all adolescent developmental challenges but more so because it potentially involves fundamental changes in the significant relationships that structure adolescents' lives: family, friends and peers, teachers, and other caring adults. This may be especially true for young men, who experience more strict expectations around gender (Olson & King, 1995). Developing a strong same-sex awareness may be less stressful for young women, for whom coming out might be protective. Past research indicates that self-identified lesbians may be at lower risk for suicidality than gay men (Garofalo et al., 1999; Remafedi et al., 1998), but absent of self-identity labels, same-sex attracted girls and boys are equally at risk for suicidality (Russell & Joyner, 2001). Finally, it must be remembered that sexual orientation, identity, and behavior are fundamentally in development during the adolescent period. Researchers should avoid categorizations or assumptions that do not acknowledge the developmental natures of contemporary adolescent sexuality. For sexual minority youth and those questioning their sexual identities and orientations, growing up in a culture that is characterized by sexual prejudice and that is overtly hostile toward homosexuality is likely to produce chronic anxiety and stress and therefore to have negative effects on mental health. These young people lack role models and visions of a healthy future (Olson & King, 1995; Rotheram-Borus & Fernandez, 1995).

Some have argued that there is a new sexual script of the gay adolescent and that this script is defined by depression and suicide (Bohan & Russell, 2002; Savin-Williams, 2001). In fact, several studies suggest that gay youth perceive gay people as unhappy (Bell, Weinberg, & Hammersmith, 1981; Paroski, 1987). Anecdotally, the author has presented many workshops across the United States (and one in Australia) for youth and youth professionals over the past 5 years on understanding sexual minority youth. Each session begins with the question, "What do you know about sexual minority youth?" With only one exception, the first answer has always been "They are at risk for suicide." It does seem that suicidality among sexual minority youth is a research finding that has become part of the public lexicon surrounding same-sex sexuality. Perhaps a suicidal script for and among sexual minority youth does drive part of the research results

that have been reported over the past 30 years. If so, what are the implications for this field of research? Are sexual minority youth so different from other young people that their self-reported suicidality should not be taken as seriously or that it should warrant less attention and support? Further research may help clarify these questions, but ultimately it is the value we place on young people that will help us develop the answers.

Several directions for future research would help advance the next generation of research on adolescent sexual minority status and suicide risk. At the community level, more research on effective prevention and intervention for sexual minority youth is needed. At the same time, we need to better understand the systems that shape the lives of sexual minority youth and the ways that they support or hinder development. There is growing attention being given to the study of the school environment—the degree to which school climates and policies make a difference in the lives of sexual minority youth. There are fewer studies of the family and no known studies of religion or voluntary youth organizations; each of these systems should play key roles either in placing sexual minority youth at risk or in buffering them from it.

At the individual level, much more information is needed on the degree to which mental health and suicide risk vary across and within sexual minority statuses. First, although several large-scale representative studies are now including items on sexual minority status, a next major step would include multiple measures in the same study. This would finally allow researchers to compare same-sex identities, behaviors, and orientations as they are associated with suicide risk and other critical youth outcomes. Consensus as to what those questions should be is hard to reach, as will be achieving success in integrating such questions into the standard demographic questions on public surveys.

Related to diversity within sexual minority status is the need for research on individuals from diverse backgrounds. Much has been said about the need for more research on sexual minority women and the need to better understand adolescent bisexuality (whether based in identity, behavior, or orientation) as it relates to same-sex sexuality. There is almost no existing research that documents the health and well-being of transgender young people. Also, there are very few published studies of sexual minority youth of color (for exceptions, see Rosario et al., 1996; Russell & Truong, 2001), few studies of rural sexual minority youth, and no known studies of sexual minority status among immigrant youth, even though these young people make up a growing proportion of youth in the United States. Studies of the nexus of gender, ethnic, racial, and religious identities with sexual minority status are needed to further understand sexual orientation and suicide risk.

Additional research is needed on the degree to which the well-documented normative risks in the lives of sexual minority youth mediate the link between sexual minority status and suicidality. At the same time, important advances would come from studies that explore sexual minority-specific risks for emotional distress and suicide. Recent research documents the unique stressors

facing sexual minority adults who experience societal marginalization and stigma (Herek, Gillis, Cogan, & Glunt, 1997; Meyer, 1995). Multiple methods could be employed in this area, including in-depth studies limited to sexual minority populations as well as studies that compare sexual minorities to their heterosexual peers. By using large and diverse populations, questions about experiences of discrimination and marginalization can be asked in ways that allow young people to identify their perceptions of the motivations for these experiences (e.g., Wong, Eccles, & Sameroff, 2002). Such methods could enhance this field by documenting the prevalence and connections between varied harassment and discrimination experiences in the lives of young people.

Finally, research is needed on protective factors, both those that are normative and those that may be unique to sexual minority youth. In the anecdote given above about responses to the question, "What do you know about sexual minority youth," the single exception was at a youth conference. A young person answered, "We have all the fun!" This statement beautifully illustrates the resilience that characterizes the lives of most sexual minority youth. Thus, although we can easily identify the additional research that is critically needed to understand risk in the lives of sexual minority youth, there is a whole new field to build for understanding the factors that promote positive youth development.

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