Why Are We Not Closing the Gap in Suicide Disparities for Sexual Minority Youth?

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In 2017, suicide was the second leading cause of death for individuals 10 to 24 years old.[1] After a stable period from 2000 to 2007, the suicide rate among 15- to 19-year-old youth increased 76% through 2017. Sexual minority youth (SMY) have been known to be at increased risk.[2] In this issue of *Pediatrics*, 2 groups of authors address the important question of whether the social progress toward acceptance of SMY has ameliorated this disparity. Liu et al[3] report on trends of suicidal ideation and behaviors across a 23-year period (1995–2017) using data from the Massachusetts Youth Risk Behavioral Surveillance. Rates of suicidal ideation and behaviors declined for both SMY and heterosexual youth, with a steeper decline for heterosexual youth; rates remained markedly high for SMY across the 23 years with upward of 40% reporting ideation, 41% a plan, and 33% an attempt. Raifman et al[4] expanded their consideration of suicide attempts among adolescents to include Youth Risk Behavioral Surveillance data (2009–2017) across 10 US states. Although suicide attempts declined among SMY, these youth were >3 times more likely to attempt suicide relative to heterosexual students in 2017.

Although decreases in suicidal ideation and behaviors in both studies is encouraging, limitations must be considered. First, Liu et al[3] examined data from 1 state, and the analyses from Raifman et al[4] were limited to 10 states in the Northeast and Midwest, which might not represent the experiences of SMY in other states, especially those who opt out of administering sexual orientation questions. Second, treatment of all SMY as 1 group and no analyses for transgender youth are limitations because we know rates of suicidal attempts vary within these groups.[5,6] Third, a paradoxical finding of these studies is their reporting of declines in self-reported suicide attempts, although deaths by suicide increased.[1] Whether these diverging results are explained by differences in data quality (eg, honesty in reporting, better cause of death characterization), increased lethality of means, or another explanation needs further investigation.

These studies point to future research directions. Most research on SMY has been focused on documenting disparities, and to a lesser extent mechanisms, but little research has been focused on developing, testing, or disseminating interventions.[7,8] With evidence-based suicide prevention programs available for the broader population of youth,[9–12] it is time to understand whether such universal interventions benefit SMY. One could posit greater relative benefit for SMY given their increased risk or decreased benefit because these universal interventions may not address their unique risk factors (eg, coming out, stigma). Such a study is currently underway, with results expected in the coming years.[13] An intermediate "inclusive" approach would be to

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incorporate content into universal interventions that is valuable to SMY or that normalizes same-sex relationships. However, to close these large disparities in suicide risk by sexual orientation, prevention and intervention programs designed specifically for SMY will be required. Several theoretical and developmental principals should be considered. First, multilevel perspectives have been advocated for addressing health disparities[14,15] and preventing suicide.[12] Multilevel approaches go beyond addressing individual challenges to address social determinants such as family acceptance and social policy. A recent meta-analysis revealed that the stressors experienced by SMY come from multiple sources including intrapersonal factors and interpersonal interactions with schools, families, and communities.[7] Second, interventions should take a life-course perspective that recognizes that an accumulation of events at each stage of life shapes how later events are experienced (eg, chronic bullying has different effects on SMY than a single experience[16]). This perspective also calls for developmentally timed interventions, and for SMY, that means interventions are in place before stressogenic events like first coming out. Here, the challenge is to reach SMY before they come out to others. Online approaches have considerable capacity in this regard.[17] Third, interventions should promote and build on natural resiliencies in the face of chronic stressors, without instilling coping skills that have short-term psychological benefits but long-term costs.[18] Fourth, a health equity versus health disparity perspective recognizes that for SMY to achieve optimal health, they may need more supports in some areas than their heterosexual peers. For example, healthy romantic relationships have been shown to reduce depression in SMY,[19] but as a minority group relatively small in size, they may need extra supports in finding romantic partners.

The trends reported here are not promising. Despite more youth identifying as SMY over time,[4] disparities in suicidality do not appear to be narrowing. We call for prioritization of intervention research with this population. SMY received only parenthetical mention in the recent national prioritized research agenda for suicide prevention[20] and the recent review of the National Institutes of Health portfolio found only 2.6% of 379 sexual and gender minority projects focused on suicide.[21] High-quality research proposals submitted to and funded by the National Institutes of Health and other funders are needed to address this scientific inequity that will allow us in turn to bend the curve on this currently unchanged disparity in SMY suicide attempts.

ABBREVIATION

SMY: sexual minority youth

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