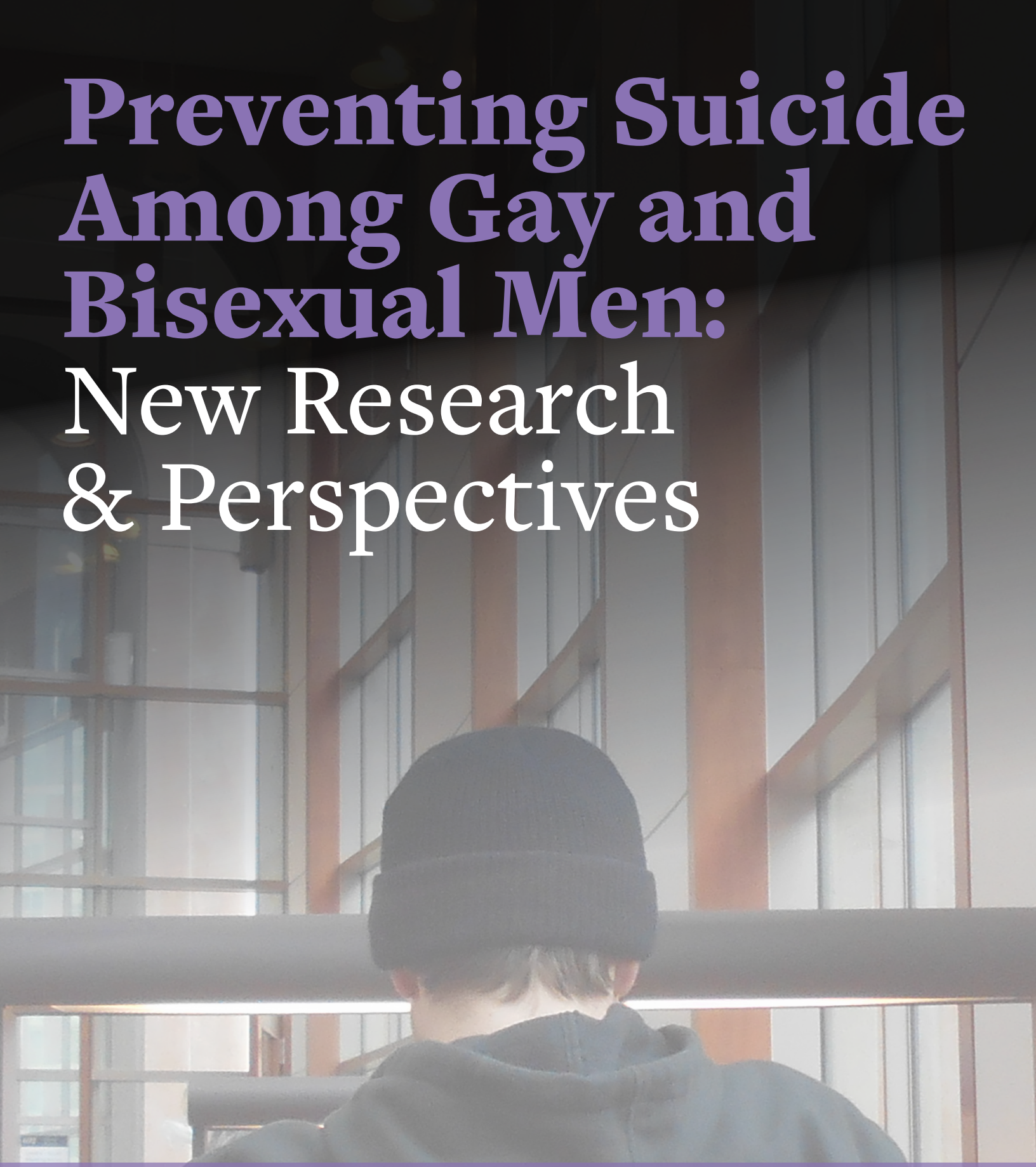
Preventing Suicide Among Gay and Bisexual Men: New Research & Perspectives



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1 Introduction: New opportunities in understanding and preventing suicide among gay and bisexual Canadians

Suicide is the ninth leading cause of death in Canada, responsible for nearly 4,000 deaths each year (Navaneelan, 2012). While everyone is susceptible to the feelings of hopelessness and despair that precede suicide, for some groups suicide is a more common reality. As one striking example, rates of suicide are five times higher in indigenous communities than in non-indigenous peoples in Canada. Rates are also higher among those who are unemployed or who lack social support—from partners, close friends, or family. A common theme in the societal patterning of suicide is one of social marginalization. People who are excluded or disconnected are more likely to end their lives early.

Given that gay and bisexual men continue to face pervasive sexual stigma (homophobia)—e.g., in Canada gay and bisexual men experience 2.5 times the rate of violent assault as do heterosexuals (Beauchamp, 2008)—it is not surprising that we also have disproportionately high rates of suicide in our communities. Depending on the geographic location (i.e., social context) and other personal attributes (gender, socioeconomic status, etc.) of the persons studied, at least 10%, but as many as 40% of LGBT people will attempt suicide at least once in their lifetime (Hottes, 2015; King et al., 2008; Marshal et al., 2011). Suicide affects gay and bisexual men of all ages, and continues to affect gay and bisexual men today, in spite of important gains in legal protections for sexual minorities in some countries. Suicide thus remains a major cause of death for gay and bisexual men. In 2011, it is estimated that as many Canadian gay and bisexual men died from suicide as died from HIV (Hottes, Ferlatte and Gesink, 2015).

Suicide is preventable. People who are thinking about suicide are experiencing severe emotional pain, but there are ways to alleviate this pain or to help people cope with it. We still have much to learn about how and why gay and bisexual men consider suicide, and in this report we present some recent findings from Canadian research on this urgent public health issue. We share this research with the goal of creating and improving suicide prevention activities for gay and bisexual men in Canada. We believe that data creates action, and at the end of this report we offer some potential ways forward for gay communities to address this important health inequity.

Across the chapters of this report, a few themes stand out. First, within gay and bisexual men, we are not all affected equally. Social positions—for example, those related to income, education, and sexual identity (e.g., gay, bisexual)—intersect with sexual minority status to increase the risk of suicide, as shown in sections 2 and 3 of this report.

Second, rates of gay and bisexual suicide attempts are determined by social context—that is, the time and place in which we live. In section 3, we show that the prevalence of suicide attempts in adults in North America and Europe has been decreasing over time, suggesting that the LGBT suicide inequity is amenable to change through improved societal conditions, including institutional policies and programs. This has also been found to be true for youth in British Columbia. In a recent survey of BC high schools, schools that had implemented queer-straight alliances (support group programs for LGBT students) or anti-bullying policies that explicitly named homophobia as a cause of bullying showed meaningful decreases in suicidal behaviour among LGB youth (Saewyc, Konishi, Rose and Homma, 2014).

Third, while most research on the topic of gay and bisexual suicide has focused on youth, the research we present in this report highlights that rates of suicide attempts remain elevated for gay and bisexual men throughout the life course. As demonstrated in section 3, the average lifetime prevalence of suicide attempts in gay and bisexual adults in North America is 17%.

Fourth, suicide-related thoughts and behaviours don't occur in a vacuum. They are closely related to experiences of anti-gay marginalization (bullying, violence, and discrimination) and to other health issues like drug use and sexually transmitted infections (section 4).

Other factors may be important for understanding gay and bisexual men suicide but were not addressed in this report. These include some life course factors such as events related to changes in relationships and careers. We also acknowledge the high rates of HIV that continue to affect gay and bisexual men in Canada, particularly older men. HIV positive persons continue to experience elevated rates of suicide in Canada (Gurm et al., 2015), and this is likely an important factor in understanding suicide among gay and bisexual men.

In the light of the research presented in this report, we see several opportunities to intervene to prevent this critical public health issue. To start, by describing and investigating gay and bisexual men suicide we can raise awareness. At CBRC we have presented the research from this report in panel presentations at the 2014 BC Gay Men's Health Summit and at the 2015 Pacific AIDS Network Conference. In Canada and BC, comprehensive mental health strategies are in ongoing development (BC Ministry of Health, 2011; Mental Health Commission of Canada, 2012). Many of the triggers of suicide for gay and bisexual people may look different from those for heterosexual people. By better understanding these triggers, we can help inform these government strategies and add specific mechanisms (programs and guidelines) to prevent suicide among gay and bisexual men.

We hope this report will add to your understanding of suicide among gay and bisexual men but also inspire questions and ideas. We'd love to hear your feedback at: *info@cbrc.net*.

2 Suicide among gay and bisexual men —an Intersectionality perspective

Suicide, like many other health inequities, is unevenly distributed among the population, with marginalized groups being most affected. In Canada, suicide has been found to particularly affect gay and bisexual men, aboriginal people and people living in rural and remote communities.

While the populations affected by suicide are not mutually exclusive – for example someone can be a bisexual Aboriginal man living in a remote community – much of the suicide prevention literature tends to treat these groups as such. Moreso, very little attention is given in suicide prevention research to diversity within groups: for example, we know very little about which gay and bisexual men are most at risk of attempting suicide. This situation creates a vacuum of knowledge about suicide among gay and bisexual and deprives us of critical information for the development of effective suicide prevention activities.

We therefore investigated within the *Sex Now Survey*, which gay and bisexual men are at increased risk of reporting a recent suicide attempt. We used data from the 2011/12 survey. The large sample of gay and bisexual men with 8493 participants allows for this unique analysis focused on the multiple, intersecting identities of the survey participants.

We conducted our analysis according to the principles of intersectionality. Intersectionality is a research framework that rejects the idea that a singular factor (such as sexuality) can explain health inequities. Rather, it sees health inequities as shaped by the intersections of multiple social identities (such as sexuality, class, gender, ethnicity, geography, aboriginal status) and systems of oppressions and power (homophobia, classism, sexism, racism, colonialism) (Bowleg, 2012; Hankivsky, 2012). Insights of intersectionality guided our research by helping us measure the impact of multiple aspects of social identities and by looking at how aspects of identities intersect to increase or decrease suicide risk (To learn more about intersectionality: *http://www.sfu.ca/iirp/resources.html*).

In Sex Now 2011/12, about 1 in 50 men reported a suicide attempt in the last 12 months (2%). As predicted by intersectionality, we found that not all gay and bisexual men were equally affected by suicide but rather some groups were more vulnerable.

First we found that gay and bisexual men who were Aboriginal (First Nation, Metis or Inuit) reported a higher number of suicide attempts: 1 in 25 Aboriginal men said they attempted to end their life in the last 12 months (4%).

We also found that men that had both a lower education and a lower income were at significantly higher risk of suicide (see figure 1). Lower income and lower education appear to work together so that men who find themselves at the intersections of these two social categories reported suicide attempts in a proportion of 1 in 25 (4%). Meanwhile, men who had either a lower education but high income, or lower income but high education (or neither) were *not* at increased risk of suicide attempts; about 1% of these men reported a suicide attempts in the last 12 months.

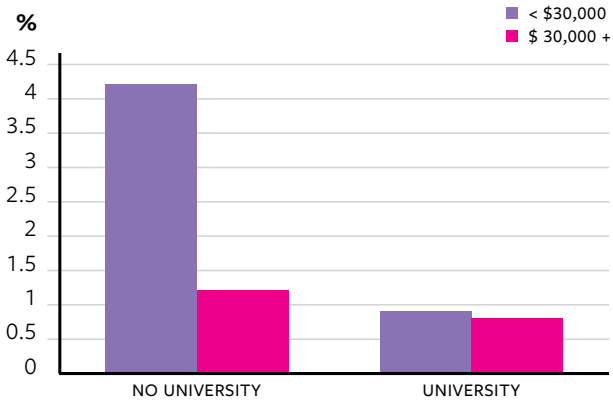

Figure 1: Recent suicide attempts by education and income

Our analysis also revealed that partnership status affected the vulnerability of bisexual men while it had no effect on gay men (see figure 2). Among Bisexual men, 4% (1 in 25) of those who were in a relationship with a man reported a suicide attempt in the last 12 months. Differently, bisexual men partnered with a woman appear to report suicide risk less frequently; 1 in 125 reported having attempted to end their own lives in the last year (less than 1%). Further research should examine the intersection between partner gender and sexual identity and explore possible reasons for these differences, including the ways in which heterosexual partnerships may reduce exposure to homophobia and biphobia—stressors that are generally associated with suicide behaviour.

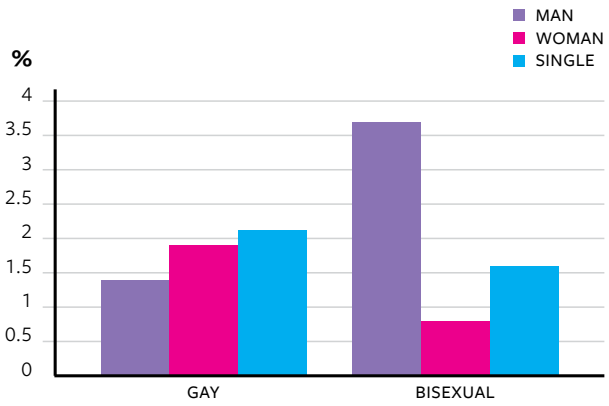

Figure 2: Recent suicide attempts by sexual orientation and partnership status

We also found that the impact of lower education and lower income may have a more profound effect on men living in urban centers in comparison to men living in the suburbs and in remote and rural communities.

Our research has some important implications for suicide prevention and research. The key message for prevention is that with 1 in 50 gay and bisexual men having attempted suicide in a 12 months period, a national prevention strategy for gay and bisexual men is urgently needed. Moreso this strategy needs to take into account the unique experiences of those most vulnerable to suicide, including aboriginal gay and bisexual men, those with a lower income, and same-sex partnered bisexual men.

Finally, suicide among sexual minorities is largely under researched. More research is needed to inform prevention and how we can avoid these tragic deaths in our community. Research, like prevention, should take into account diversity and the intersecting effects of social categories to provide a more nuanced understanding of how suicide affects our community.

3 What factors explain variation in rates of suicide attempts among gay, lesbian, and bisexual adults? A systematic review

More than 50 epidemiologic studies from North America and Europe have demonstrated higher rates of suicide attempts in lesbian, gay, and bisexual (LGB) people, as compared to heterosexual people. The size of this health disparity, however, is quite different depending on the study or sample. In some studies we see that 1 in 10 (10%) of LGB persons has attempted suicide in their lifetime—a rate already twice as high as that in most heterosexual samples. In others the rate is 1 in 3 (33%)!

What could explain the variability in these estimates? As noted in the Introduction of this report, we might expect that both broader social context and individual attributes explain the variability in rates of suicide reported in studies of LGB people. By social context, we mean time and place. Policies, legal protections, and social attitudes toward LGB people change over time, and are different from country to country, or even province to province. If these social conditions shape how LGB people think about their own selves, we might expect the rates of suicide to change along with them.

Individual attributes, or 'intersecting' social identities, surely matter too. In the previous chapter we described how an intersectionality framework can help to understand individual gay and bi men who are more likely to turn to suicide. This may also be true when looking across study samples.

In addition to these two categories of factors, we know that the way in which we sample LGB people—our study methods—makes a difference in how we measure the size of health problems that affect us. In particular, who is doing the survey, the level of anonymity, and the medium of the survey (online, on the phone, or in person) seem to matter.

With these factors in mind, we undertook a systematic review of the literature on LGB suicide to explore the relationship between these factors and the lifetime prevalence of suicide attempts reported across studies. By lifetime prevalence we mean the proportion of LGB people who have attempted suicide during their lifetime. We searched five commonly used medical, nursing, psychology, and social science research databases and reviewed more than 1600 papers related to the topic of LGB suicide. Ultimately we were able to use 30 of these studies that reported on lifetime prevalence of suicide attempts of adults living in the community, in order to explore the factors identified above.

We excluded studies that were done in clinics or support groups because these settings are known to see higher rates of mental health struggles to begin with. We also excluded studies focused on youth because other reviews have already addressed this population (Marshal, 2011). The studies were conducted between 1985 and 2008 in the US, Canada, and Western Europe. Below we present a few main findings from this review.

1. The lifetime prevalence of suicide attempts among 21,201 lesbian, gay, and bisexual adults was 17%. By comparison, the lifetime prevalence of suicide attempts among heterosexual adults in the same studies was 5%.

2. Methods: As predicted, the way in which LGB persons were sampled affected the prevalence. If we look only at the studies that sampled LGB people through general population surveys (what health researchers call "random population samples"),

we would estimate that 11% have attempted suicide. By comparison, if we use studies that sampled LGB people through LGB community spaces (bars, Pride events, or LGB-specific websites), we would estimate that 20% have attempted suicide.

3 Social context: The prevalence of suicide attempts decreased over time. In 1985 the average prevalence of suicide attempts for LGB people was 22%. By 2005 it had decreased to 15%.

4 Sexual identity: Previous reviews have suggested that bisexual people may experience higher rates of suicide attempts than gay or lesbian-identified people. In this review 19% of bisexual people had attempted suicide, as compared to 17% of gay and lesbian people.

The results of this review are important in at least two ways for those of us working to prevent LGB suicide. First, this review underscores that the prevalence of suicide remains high for adults, even after adolescence. Particular factors that increase the risk of suicide in LGB adults are not well understood, though the research presented in the next chapter of this report offers some suggestions. Second, the findings of this review remind us that while stigmatized sexuality increases the risk of suicide, other contextual factors matter too, and LGB sexual identities should not be considered singular or isolated identities. The methodological difference identified in this study is being used by LGB health researchers to improve the ways in which we study LGB people.

A longer form of this report can be found at: *http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303088*

4 Suicide and Syndemics among gay and bisexual men

Gay and bisexual men are four times more likely to attempt suicide than heterosexual men. Because of this large discrepancy, we were interested in investigating the potential underlying causes of suicide among this population using syndemic theory to guide our research. A syndemic occurs when health problems in a population interact with one another to make the overall burden of disease within that population worse (Singer, 1994; Singer, 2009; Walkup et al., 2008). It has been theorized that syndemics exist in populations that experience marginalization based on identities such as race, gender, sexual orientation, and others (Klein, 2011; Singer, 2009). Thus we believed that because of the marginalization that gay and bisexual men experience due to their sexual orientation, a syndemic may be occurring in this population with the various psychosocial and health issues that exist in these communities interacting with one another to influence the high rates of suicidal ideation and attempts in these groups.

Our data comes from the 2011/2012 Sex Now Survey, a nation-wide cross-sectional survey conducted in both English and French. The survey includes questions on sexual behaviour, health measures, relationships, healthcare services, working conditions, community participation, social support, and experiences of homophobia. The variables we were interested in for our study were: the lifetime experiences of marginalization (verbal violence, physical violence, bullying, sexual violence, and work discrimination): the psychosocial and health issues experienced in the last 12 months (smoking, party drugs, depression, anxiety, STIs, HIV-positive diagnosis, and condomless anal intercourse); and suicidality in the last 12 months (thoughts about suicide and suicide attempts).

We had 8382 gay and bisexual men answer our survey. Among them 17% had thought about suicide in the last 12 months, with 2% having attempted suicide in the last 12 months. We found that most experiences of marginalization were related to an increase in both suicidal ideation and suicide attempts (See table 1). That is, those who experienced some form of marginalization during their lives (e.g. bullying) were more likely to think about suicide or attempt suicide than those who did not experience any form of marginalization during their life. We also found that as the number of different types of experiences of marginalization in our sample increased (e.g. experiencing both verbal and physical violence versus experiencing verbal violence alone) so too did the likelihood of thinking about or attempting suicide (see figure3).

We also examined relationships between the various psychosocial and health issues. We found that almost all of our psychosocial and health issues were interacting with one another, lending credence to our hypothesis that a syndemic may indeed exist. We then investigated whether or not suicidal ideation and suicide attempts were associated with these psychosocial or health issues. We found that overall most participants who had either thought about or attempted suicide in the last 12 months were more likely to have another psychosocial or health issue than those who did not attempt or think about suicide in the last 12 months: for example, those who attempted suicide were more likely to smoke than those who did not attempt suicide. Like marginalization, we also found that the more psychosocial or health issues that gay and bisexual men reported (e.g. anxiety and depression versus depression alone) the more likely they were to also report thinking about or attempting suicide (figure 4).

Table 1 Relationship between marginalization and suicide ideation and attempts

	% REPORTING SUICIDE IDEATION OR ATTEMPTS	
SUICIDE IDEATION IN LAST 12 MONTHS	Among those marginalized	Among those NOT marginalized
Verbal Violence	**22%**	13%
Physical Violence	**27%**	16%
Bullying	**22%**	13%
Sexual Violence	**20%**	17%
Work discrimination	**25%**	15%
SUICIDE ATTEMPTS IN LAST 12 MONTHS	Among those marginalized	Among those NOT marginalized
Verbal Violence	**2%**	1%
Physical Violence	**5%**	1%
Bullying	**2%**	1%
Sexual Violence	**4%**	1%
Work discrimination	**4%**	1%

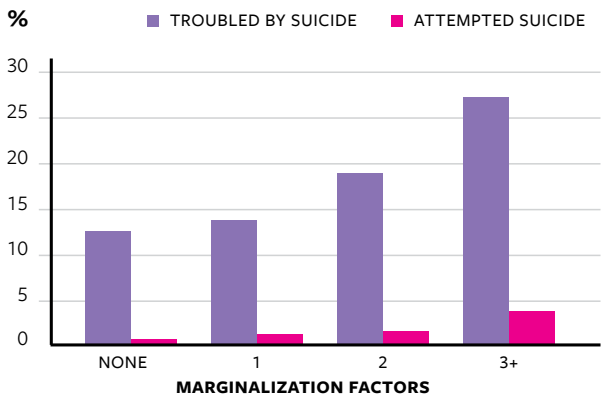

Figure 3: Prevalence of suicide ideation and attempts by numbers of anti-gay marginalization indicators

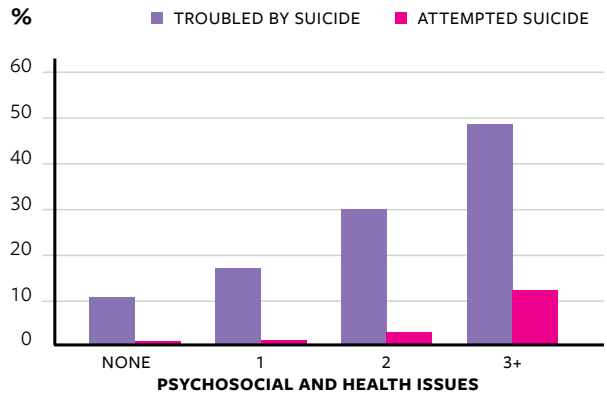

Figure 4: Prevalence of suicide ideation and attempts by number of psychosocial and health issues

Based on our findings, anti-gay violence and discrimination seem to increase suicidal ideation and suicide attempts in gay and bisexual men. In addition, psychosocial and health issues seem to be interacting with one another and are associated with suicidality in gay and bisexual men. This provides support for a syndemic model of suicide in gay and bisexual men as the largest effects are seen when psychosocial and health issues begin to accumulate. More research and attention needs to be focused on suicide in gay and bisexual men, and there should be more interventions in place not just for suicide, but for some of these other issues that may exist, as they seem to have an influence on one another. Lastly, the underlying factors influencing suicide and other psychosocial health issues in gay and bisexual men appear to be the heterosexism and homophobia that exists within society. Solutions addressing these structural issues are paramount in order to decrease the rates of suicide and other health issues in these communities.

A longer form of this report can be find at: *http://www.biomedcentral.com/1471-2458/15/597*

5 Recommendations and further reading

The research presented in this report is only a small selection of what we know on the topic of suicide among gay and bisexual men, and more importantly, only a small selection of what needs to be investigated to move toward a more robust suicide prevention strategy for our community. Below we offer some recommendations, both for researchers and for practitioners and policy-makers, based on the work we have shared. We also provide a few suggested readings for those who want to learn more about this issue.

Recommendations for research

- Research on suicide among gay and bisexual (and other sexual and gender minority groups) needs to meaningfully account for intersecting identities, notably including ethnicity, rurality/area of residence, income, education, sexual identity, and partnership status. This may be achieved by focusing research on groups known to be at higher risk (e.g., Aboriginal persons with gay, bisexual, or two-spirit identities), or by collecting large and diverse samples that enable researchers to analyze sub-groups.

- This report has relied upon quantitative methods and demonstrated multiple ways in which surveys and other existing data-sets can elucidate patterns of suicidal behaviour among gay and bisexual men. Qualitative (and mixed quantitative/qualitative) methods offer a way to gain a more in-depth and nuanced understanding of the meanings and experiences of suicide attempts in the lives of gay and bisexual men (Kral, Links, & Bergmans, 2012). To-date, qualitative methods have been used infrequently to study suicide among LGB people (Fenaughty and Harré, 2003).

- Evidence for a disparity in suicide attempts between LGB and heterosexual populations is robust (as shown in section 3). Researchers must move beyond estimating rates of suicidal behaviour in sexual minorities and try to understand why and how suicide attempts are experienced. This may include in-depth qualitative studies, as well as quantitative 'path' or 'mediation' studies that aim to identify important factors that lie on the pathway from experiences related to sexual minority status (e.g., identities, experiences of stigma, etc.) to suicidal thoughts and attempts.

- Research on LGB suicide has disproportionately focused on youth (Hottes et al, 2016). Additional studies are needed to understand how ageing gay and bisexual men experience suicide-related thoughts and attempts. Such analysis likely requires attention to both age-related processes (experiences of illness, adulthood life events, changing relationships/social connections) as well as 'cohort'-related experiences (e.g., life course-accumulated experiences of the 'AIDS generation', who came out before and during the AIDS crisis of the 1980s and 90s).

- Finally, community-based research offers a way to meaningfully include those marginalized from research and practice, as well as those most affected by an issue. In this case, more research is needed that includes gay and bisexual men who have experience with suicide ideation/attempts, as well as other mental health struggles.

Recommendations for practice and policy

Most significantly, these results highlight the need for national and provincial strategies to address the LGBT suicide disparities in Canada. Groundwork for such strategies can be found in existing policy documents, including the *BC Provincial Health Officer's Report on HIV among Gay and Bisexual Men* (*http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/hiv-stigma-and-society.pdf*)and the BC *Healthy Minds, Healthy People* report (*http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/hiv-stigma-and-society.pdf*). The next step is for community actors and policy-makers to work together to develop specific initiatives to address this disparity.

- In the meantime, provincial (Healthy Minds, Healthy People) and national policies should explicitly acknowledge the evidence regarding the LGBT suicide disparity, and where possible, should suggest ways to prioritize suicide prevention resources for this community.

- The syndemic analysis presented in section 4 suggests that the most successful strategies will work in collaboration with other sectors in order to link, for example, HIV prevention initiatives, addictions services, and mental health supports, in ways that acknowledge baseline experiences of sexual/antigay stigma in the population of gay and bisexual men.

- Prevention practice: Existing suicide prevention programs must be rigorously evaluated to determine which approaches are most effective; such evaluation is currently underway in Canada, and should be bolstered (Crawford, 2015). Once effective programs are identified, they must be tailored to be culturally relevant and culturally safe for all communities that experience higher rates of suicide and suicide attempts: this includes, for example, indigenous communities and LGBT communities (Wexler & Gone, 2012).

- Policy: A BC study of school-based anti-homophobic-bullying policies and gay/queer straight alliances has demonstrated the promise of structural policies to reduce suicidal behaviours among sexual minorities (Saewyc, Konishi, Rose and Homma, 2014). Similar analyses in the United States have shown the effect of state-wide policy related to LGB discrimination on rates of mental distress among adults (Hatzenbuehler, McLaughlin, Keyes & Hasin, 2009; Hatzenbuehler, Keyes, and Hasin, 2010). Additional policy opportunities should be examined and evaluated within Canada, with a specific aim of diminishing sexual minority stress and in turn mental distress among LGB people of all ages, including adults.

Further reading

Dorais M. (2004). *Dead Boys Can't Dance: Sexual Orientation, Masculinity, and Suicide*. McGill-Queens University Press

Fenaughty J, Harré N. (2003). Life on the seesaw: a qualitative study of suicide resiliency factors for young gay men. *J Homosex*.;45:1–22. doi:10.1300/J082v45n01_01.

Ferlatte O, Dulai J, Hottes TS, Trussler T, Marchand R. (2015). Suicide related ideation and behaviour among Canadian gay and bisexual men: a syndemic analysis. *BMC Public Health*, 15:597, *http://www.biomedcentral.com/1471-2458/15/597/abstract*

Hottes TS (2014). *Suicide is a major cause of death for gay and bisexual men*. Community-Based Research Centre for Gay Men's Health: *http://cbrc.net/articles/09-2014/suicide-major-cause-death-gay-and-bisexual-men*

Hottes TS, Ferlatte O, Gesink D (2015). Suicide and HIV as leading causes of death among gay and bisexual men: A comparison of estimated mortality and published research. *Critical Public Health*, 25(5):513-526. *https://www.academia.edu/8590609/Suicide_and_HIV_as_leading_causes_of_death_among_gay_and_bisexual_men_a_comparison_of_estimated_mortality_and_published_research*

Hottes TS, Bogaert L, Rhodes AE, Brennan DJ, Gesink D (2016). Lifetime prevalence of suicide attempts among sexual minority adults by study sampling strategies: A systematic review and meta-analysis. *American Journal of Public Health*, 106(5):e1-e12. *http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303088*

Haas AP, Eliason M, Mays VM, et al. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. ;58:10–51. doi:10.1080/00918369.2011.534038.

Hatzenbuehler ML. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychol Bull*.;135:707–730. doi:10.1037/a0016441.

Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. (2014). Structural stigma and all-cause mortality in sexual minority populations. *Soc Sci Med*.;103:33–41. doi:10.1016/j.socscimed.2013.06.005.

Institute of Medicine (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Available at: *http://www.ncbi.nlm.nih.gov/books/NBK64806/*

King M, Semlyen J, Tai SS, et al. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*.;8(1):70. doi:10.1186/1471-244X-8-70. *http://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-8-70*

Meyer IH, Teylan M, Schwartz S. (2014). The Role of Help-Seeking in Preventing Suicide Attempts among Lesbians, Gay Men, and Bisexuals. *Suicide Life Threat Behav*. doi:10.1111/sltb.12104.

Ploderl M, Wagenmakers EJ, Tremblay P, et al. Suicide risk and sexual orientation: a critical review. *Arch Sex Behav*. 2013;42(5):715–727. doi: *http://dx.doi.org/10.1007/s10508-012-0056-y*.

Ploderl M, Sellmeier M, Fartacek C, Pichler E, Fartacek R, Kralovec K (2014). Explaining the suicide risk of sexual minority individuals by contrasting the minority stress model with suicide models. *Arch Sex Behav*. doi: *http://dx.doi.org/10.1007/s10508-014-0268-4*.

Rofes E. (1983). *I Thought People Like That Killed Themselves: Lesbians, Gay Men, and Suicide*. City Light Books, San Francisco.

References

Beauchamp DL (2008). *Sexual Orientation and Victimization*. Ottawa, ON. Available at: *http://www.statcan.gc.ca/pub/85f0033m/85f0033m2008016-eng.htm*.

BC Ministry of Health, (2011). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia*. Victoria, BC. Available at: *http://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/healthy-minds-healthy-people*

Bowleg L (2012). The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267–1273. *http://doi.org/10.2105/AJPH.2012.300750*

Crawford A. (2015) A national suicide prevention strategy for Canadians—from research to policy and practice. *Canadian Journal of Psychiatry*; 60(6):239-241.

Fenaughty J, Harré N (2003). Life on the seesaw: a qualitative study of suicide resiliency factors for young gay men. *J Homosex* ;45:1–22. doi:10.1300/J082v45n01_01.

Gurm J, Samji H, Nophal A, et al. (2015) Suicide mortality among people accessing highly active antiretroviral therapy for HIV/AIDS in British Columbia: a retrospective analysis. *Canadian Medical Association Journal*; 3(2): *http://cmajopen.ca/content/3/2/E140.full.pdf+html*

Hankivsky O (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine*, 74(11), 1712–1720. *http://doi.org/10.1016/j.socscimed.2011.11.029*

Hatzenbuehler ML, Keyes KM, Hasin DS (2009) State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *Am J Public Health*; 99(12):2275-81.

Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS.(2010) The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *Am J Public Health*;100(3):452-9.

Hottes TS, Ferlatte O, Gesink D (2015) Suicide and HIV as leading causes of death among gay and bisexual men: A comparison of estimated mortality and published research. *Critical Public Health*, 25(5):513-526.

Hottes TS, Bogaert L, Rhodes AE, Brennan DJ, Gesink D (2016). Lifetime prevalence of suicide attempts among sexual minority adults by study sampling strategies: A systematic review and meta-analysis. *American Journal of Public Health*, 106(5):e1-e12. *http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303088*

King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, & Nazareth I (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8, 70.

Klein H (2011). Using a Syndemics Theory Approach to Study HIV Risk Taking in a Population of Men Who Use the Internet to Find Partners for Unprotected Sex. *American Journal of Men's Health*, 5(6), 466–476. http://doi.org/10.1177/1557988311398472

Kral MJ, Links PS, Bergmans Y. Suicide Studies and the Need for Mixed Methods Research. *J Mix Methods Res*. 2012;6:236–249. doi:10.1177/1558689811423914.

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., ... Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review. The *Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine*, 49(2), 115–23.

Mental Health Commision of Canada (2012). *Changing Directions, Changing Lives: The mental health strategy for Canada*. Calgary, AB. Available online at: *http://strategy.mentalhealthcommission.ca/*

Navaneelan T. *Suicide Rates: An Overview.* Ottawa, ON; 2012. Available at: *http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm*.

Saewyc EM, Konishi C, Rose HA, Homma Y (2014). School-Based strategies to reduce suicidal ideation, suicide attempts, and discrimination among sexual minority and heterosexual adolescents in western Canada. *International Journal of Child, Youth and Family Studies* 1: 89–112.

Singer M (1996). A Dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. Free Inquiry in Creative Sociology, 24(2), 99–110.

Singer M (2009). Introduction to Syndemics: a System Approach to Public and Community Health. San Francisco, CA: Jossey-Bass

Walkup J, Blank MB, Gonzalez, JS, Safren, S, Schwartz, R, Brown, L, et al. (2008). The Impact of Mental Health and Substance Abuse Factors on HIV Prevention and Treatment. JAIDS Journal of Acquired Immune Deficiency Syndromes, 47(Supplement 1), S15–S19. *http://doi.org/10.1097/QAI.0b013e3181605b26*

Wexler LM, Gone JP (2012). Culturally responsive suicide prevention in indigenous communities: unexamined assumptions and new possibilities. *American Journal of Public Health*;102(5):800-806.

cbrc
Community-Based Research Centre
for Gay Men's Health

The Community Based Research Centre for Gay Men's Health (CBRC) is a health promotion group created by and for gay men based in Vancouver, British Columbia. We are a non-profit charitable organization using community participatory research to develop knowledge about gay men's health and interventions addressing health and social issues. CBRC's core programs are currently leading a social determinants based approach to gay men's prevention through:

1. Knowledge transfer from *Sex Now* our periodic survey of gay men's health reaching eight thousand nation-wide every 2–3 years;
2. *cbrc.net*, our gay men's health theory & practice exchange website;
3. Our *BC Regional Gay Men's Health Network* prevention planning activities;
4. Our annual *Gay Men's Health Summit* conference addressing emerging themes; and
5. Our focus on gay youth with three main initiatives: *Investigaytors* our research training program for gay youth; *Totally Outright* our youth leadership program offered through local organizations across Canada; and *Resist Stigma*, a national social media campaign for gay and queer youth.

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