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Prevention of suicidal behaviour in people with sexual identity disorders

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Abstract. The study of mental health in LGBT populations has increased recently with the goal of expanding knowledge and awareness of this specific issue and suggesting specific interventions. Research has shown that depression is the leading cause of disability and a significant cause of disease worldwide. Research objectives were to identify the level of depression and suicide risk in people with sexual identity disorders or with a different sexual orientation than that related to their biological gender and study of the relationships between the level of depression, self-acceptance and suicide risk of people with sexual identity disorders. 68 people between the ages of 14 and 40 participated in this research. Only people who belong to the LGBTQI community were selected, addressing exclusively the gay and trans communities in Romania. We obtain moderate, negative and significant correlation between the level of depression and the unconditional acceptance of one's own person; people with moderate to high depression also show a significantly lower level of unconditional acceptance of their own person.

Keywords. mental health, people with sexual identity disorders

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I. Introduction

I. 1. Perspectives on the suicidal tendencies in people with sexual identity disorders. The Mental Health Study of LGBT Populations

The study of mental health in LGBT populations has increased recently with the goal of expanding knowledge and awareness of this specific issue and suggesting specific interventions. Subsequent studies showed no difference between heterosexual and homosexual groups in measuring cognitive abilities (Tuttle & Pillard, 1991) and psychological well-being and self-esteem (Coyle, 1993; Herek, 1990; Savin-Williams, 1990). Fox (1996) found no evidence of any psychopathology in non-clinical studies of bisexual women and bisexual men.

When studies have reported differences between homosexual and heterosexual subjects in psychological functioning (DiPlacido, 1998; Ross, 1990; Rotheram-Borus, Hunter, & Rosario, 1994; Savin-Williams, 1994), these differences have been attributed to the effects of stress caused by the stigma suffered by the subjects based on their sexual orientation. This stress can lead to an increased risk of suicide attempts, substance abuse and emotional disorders.

Gender identity disorder, as a diagnosis in the DSM, brings another level of self-esteem to transgender individuals and presents additional difficulties during adolescence (Baker, 2002). If, with regard to homosexuality and bisexuality, things are approaching an exhaustive clarification, transsexuality is still the subject of a real debate. Listed in the manual of mental disorders as gender identity disorder transsexuality is more of an umbrella term for people whose gender identity does not conform to what is typically associated with the sex were born with. (American Psychiatric Association, 2000) Transgender people have an inner sense that they belong to the other sex than the one they were biologically born with. The issue of gender identity involves a deep sense of discomfort and a resulting impairment in functioning, traits that frequently characterize transgender youth. However, it is very likely that many or most of these symptoms come from negative attitudes, prejudices and transphobia; if society accepted more of the law abiding norms and transgender individuals, perhaps we would see a decrease in the mental health risks they are prone to. (Rotaru, T.S., 2019)

Gender dysphoria (DSM V, APA-2003) – diagnostic criteria:

A. Marked incongruence between a person's lived/expressed gender and assigned gender, lasting at least 6 months, manifested by at least two of the following:

1- marked incongruity between lived/expressed gender and primary/secondary sexual characteristics;
2- intense desire to get rid of one's own primary/secondary characteristics;
3- desire to have primary/secondary sexual characteristics of the opposite sex;
4- the desire to belong to the opposite sex;
5- the desire to be treated as if they were of the opposite sex;
6- the individual's firm conviction that they present the typical feelings and reactions of the opposite sex.

B. The condition is associated with discomfort and deficit, clinically significant in important areas of functioning – social, professional area, etc. Transsexual, transgender and gender non-conforming people are not sick by default. Conversely, the negative impact of gender dysphoria is, when present, the cause of concern for which an individual may be diagnosed with dysphoria, with various available treatment options. And having a diagnosis for this condition often

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facilitates access to medical care and may direct future research towards effective treatments.

I.2. Mood states and traits associated with LGBTQI people. Depression

The global prevalence of depressive symptoms and disorders has increased over the past few decades. Research has shown that depression is the leading cause of disability and a significant cause of disease worldwide. The lifetime prevalence of depression ranges from 20% to 25% in women and 7% to 12% in men. In recent years, several studies have examined depression in LGBT populations and come to the same conclusion: community stressors lead to increased levels of depression. It is obviously important to note that mental illness and emotional disorders are not inherent to LGBTQ orientations and identities, but rather result from the identity stigmatization of sexual and gender minorities. More frequent experiences of victimization, threat of violence, and lack of social support are related to these dysfunctions. Adolescents are more likely to experience a type of depression specific to young people, namely inferiority depression. A first manifested sign is the excessive decrease in self-esteem and the appearance of inferiority complexes. Therefore, the teenager begins to feel that he is not accepted and understood by those around him (Marcelli, D., Berthaut, E.,2007). It is particularly important to provide specialist support to teenagers who have had at least one suicide attempt, as the risk of this behavior repeating itself is always very high. Sheffar and his collaborators, following a study they carried out in 1996, found that 30% of teenagers who completed the idea of suicide had had at least one previous attempt (Wilmshurst, L.,2007).

Psychotherapy is a method that helps the individual with suicidal ideation to overcome their problems. Apart from therapy, there are also drug treatments that are administered by the specialist to people with suicide attempts. Drug treatment is prescribed in the context in which the person suffers from mental disorders such as: schizophrenia, affective disorders, personality disorders or anxiety disorders. Administration of antidepressants, lithium and antipsychotics can significantly reduce the risk of suicide in these individuals. A special medication for treating suicidal ideation does not exist and probably could never exist, because suicide is not determined by a single trigger factor, but most of the time, there are multiple factors that determine it and they are not always biological (Cosman, D.,2008).

I.3. The level of self-esteem and self-assessment

Self-esteem, self-worth and self-image are all synonymous of the umbrella term 'Self'. They are constructs that denote how we view ourselves, perceive ourselves as individual entities and display our personalities to the world. Confidence is the key to a fulfilling life and having high self-esteem is how it all starts. Self-esteem develops from childhood.

How we interact, observe and listen to the communication patterns of others can play a significant role in shaping how we come to see and feel about ourselves. Building self-esteem and self-confidence is a matter of concern today, and thanks to recent advances in science and literature, we now have the right answers to it. There has been a lot of work around how we can help ourselves and others to develop an expanding Self system. When we think about ourselves, we are more drawn to contemplate the things that went wrong than to rejoice in the things that went right. Self-esteem and self-worth begin with accepting ourselves–including our weaknesses and accomplishments. And this is what it means to accept and commit to therapy for giving clients a

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new vision. Early childhood experiences play a vital role in building and shaping our self-esteem. Emotional and physical abuse or growing up in a traumatic or unappreciative environment may prove fatal to a child's self-esteem and overall development. Teenagers are often victims of low self-esteem in today's social media driven world. From having an attractive body to having an ideal relationship, teenagers carry a considerable burden of being "perfect".

A significant part of self-image resides in how we perceive our physical appearance. Especially for young people, how they look often decides how they see themselves. Along with social norms and beauty standards, body image affects our self-image, but only to a small extent. Self-esteem and confidence pertain to all aspects of our lives. From academic achievement to social connections, with the right self-system, we can flourish and seek happiness from within. As they say, "to fall in love with yourself is the first secret to happiness."

Knowledge about self-confidence and self-esteem can prepare us for the journey and accelerate our success. Self-esteem and coming-out may influence the outcomes of psychological distress related to sexual minority status. Greene and Britton (2013) explored the influence of forgiveness of damaged self-esteem and shame in LBGT. Forgiveness was an important mechanism to reduce shame and increase self-esteem in the transgender community. Coming out is another factor that is related to self-esteem.

People who are part of the LGBTQI community have a very low level of self-esteem, which often starts from the rejection felt even in the core family. Things that are often insignificant, but experienced in a misunderstood way, have a long-term negative impact in creating one's own self-image. The moment when identification with the other sex begins or the first sexual desires for the opposite sex are manifested comes with a strong fear of rejection for who they are, how they can be perceived and the rejection of their own identity is accentuated. Consequently, we can speak within this community of low self-esteem and a very negative level of self-evaluation.

I.4. Mental disorders-a stigma associated with LGBTQI people

Across the population, mental disorders are the greatest risk factor for suicidal behaviour, and studies around the world have also reported a strong association between mental disorders and LGBTQ people, adolescents, and adults, and higher rates of suicide attempts reported among young people who were identified as part of the LGBTQ community. These individuals were associated with significantly higher rates of depression, generalized anxiety disorder and conduct disorder than were observed among heterosexuals. LGBTQ youth were also six times more likely to have multiple mental disorders. A recent analysis of these data (Bostwick et al., 2010) confirmed a higher prevalence of daily stress mood and anxiety disorders among participants who identified as LGBTQ compared to those who identified themselves as heterosexuals.

Men who reported same-sex sexual behavior or same-sex attraction reported a higher prevalence of most mood and anxiety disorders. However, among women, those who reported only female sexual partners had a lower prevalence of each tested disorder compared to women who reported only attraction to men or both men and women as sexual partners, or who were not sexually active. Similarly, women who reported sexual attraction only to women had the lowest rates of most mood and anxiety disorders compared to other defined groups (attracted only to men, mostly men, or both men as well as women and mostly female). Most studies have shown an association between mental disorders and suicide attempts in LGBTQ respondents who report

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suicidal behavior.

However, mental disorders do not seem to fully explain the increased rates of suicide attempts in these individuals. An unpublished analysis of NESARC data found that after reducing the symptoms of mental disorders, suicide attempt rates among LGBTQ people generally remained two to three times higher than among heterosexual respondents. (Suicide and Suicide Risk in Lesbian,Gay, Bisexual,and Transgender Populations-Amber Hollibaugh & Paula J. Clayton MD(2010). So, most of the time, the association of these people with the existence of mental disorders has determined over time a causality in the suicidal behavior, without having a mental disorder as a consequence of sexual identity.

II. Research methodology

II.1. The purpose of the research

Through this study, we are trying to highlight the fact that people with different sexual orientation or with sexual identity disorders have an increased risk of suicide, due to the predisposition to depressive states and the non-acceptance of one's own person.

The aim of our research was to establish a possible correlation between the risk of suicide in people with different sexual orientation or with sexual identity disorders and a number of factors, such as: the level of depression and non-acceptance of one's own person and the reduction of the risk of suicide through therapeutic prevention programs.

II. 2. Research objectives

- Identifying the level of depression and self-acceptance **in people with sexual identity disorders** or with a different sexual orientation than that related to their biological gender
- Implementation of a psychotherapeutic intervention programme to reduce depression and increase self-confidence for people with gender identity disorder;
- Reassess suicide risk and depression levels after the implementation of the psychotherapeutic programme for people with gender identity disorder or other sexual orientation.

II.3. Research participants

68 people between the ages of 14 and 40 participated in this research. Only people who belong to the LGBTQI community were selected, addressing exclusively the gay and trans communities in Romania. We mention that the first participants were preselected from the young people who were undergoing therapy and who voluntarily presented themselves at Individual Psychology Office as people with a different sexual orientation and with sexual identity disorders, who, in turn, using the "snow-ball" method, invited other young people from their community to participate in this study, by completing the online questionnaires. We also received the support of the ACCEPT Romania association, the first non-governmental organization for human rights in Romania, which defends and promotes LGBT (lesbian, gay, bisexual, transgender) rights at national level. The origin of the participants in the study is distributed throughout the country. The sample was based on convenience (voluntary participation) and informed consent. Participants were assured of their voluntary agreement and that it could be withdrawn at any time without any negative consequences. The participants were also informed about the purpose of this research, all of the subjects being assured of the confidentiality of the results. In conducting this research, we took into account the

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principle of respect for human dignity, the confidentiality standards, while respecting the principle of equality for all participants, without any forms of discrimination.

II.4. Research methods

To fulfill the objectives and verify the hypothes, we used the following working tools:

- ✓ Beck Depression Inventory
- ✓ Unconditional Self Acceptance Questionnaire (USAQ)

II.5. Research results

Hypothesis no.1

There is a relationship between the level of depression and unconditional acceptance of one's own person in people with sexual identity disorders

We will analyze the baseline indicators and frequency distribution for the variables: "level of depression" and "unconditional acceptance of one's own person".

		Depression.level	unconditional acceptance_of_one 's _own_person
N	Valid	68	68
	Missing	0	0
Mean		30,3676	80,4412
Median		30,5000	81,0000
Mode		45,00	90,00
Std. Deviation		15,69666	14,68412
Skewness		-,096	-,071
Std. Error of Skewness		,291	,291
Kurtosis		-,827	-,303
Std. Error of Kurtosis		,574	,574
Minimum		2,00	45,00
Maximum		63,00	113,00

Table 1. Baseline indicators for the variables "level of depression" and "unconditional acceptance of one's own person"

The results obtained by the participants in the study reveal that the scores for the questionnaire of **unconditional acceptance of one's own person** vary between a minimum of 45 and a maximum of 113, which means that the amplitude is equal to 68. The maximum frequency of occurrence corresponds to the score of 90, the distribution being unimodal. The mean score for all participants in the study is 80.44, which means that the participants in the study present a low level of self-acceptance, the benchmark of scores being a higher level than 99. The possible scores vary between the values of 20 (minimum score) –140 (maximum score).

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One-Sample Kolmogorov-Smirnov Test		
		Unconditionalacceptance_of_one's_own_person
N		68
Normal Parameters[a,b]	Mean	80,4412
	Std. Deviation	14,68412
Most Extreme Differences	Absolute	,064
	Positive	,052
	Negative	-,064
Kolmogorov-Smirnov Z		,527
Asymp. Sig. (2-tailed)		,944
a. Test distribution is Normal.		
b. Calculated from data.		

Table. 2 The Kolmogorov-Smirnov normality test for the distribution of scores in the case of the variable "unconditional acceptance of one's own person".

Table 2 shows that the distribution is normal, the significance threshold of the test being greater than 0.05 ($p > 0.05$). As it can be seen, the results obtained allow us to appreciate that the distribution is symmetrical, which means that we will apply a parametric method, namely the Pearson correlation coefficient. After entering the raw scores of the two instruments, namely the level of depression and the USAQ questionnaire that measures the unconditional acceptance of one's own person, we performed a correlation using the Pearson coefficient and the following result was provided to us:

Correlations			
		Depression_level	Unconditional acceptance of one's own_person
Depression_level	Pearson Correlation	1	-,565**
	Sig. (2-tailed)		,000
	N	68	68
Unconditional acceptance_of_one's_own_person	Pearson Correlation	-,565**	1
	Sig. (2-tailed)	,000	
	N	68	68
**. Correlation is significant at the 0.01 level (2-tailed).			

Table 3: Correlation between the variables "level of depression" and "unconditional acceptance of one's own person"

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The coefficient obtained is r =.-565, a significant correlation at a significance threshold of less than 0.01, as it can be seen from the table. We can appreciate that there is a significant correlation because the significance threshold is less than 0.01. At the same time, the correlation is negative and moderate, aspects resulting from the sign of the correlation coefficient and its value. The effect size of this relationship is 0.319, or 31.9% of the variance of one variable can be explained by the other variable, the intensity of the effect being an average one.

We can, thus, affirm that there is a **moderate, negative** and significant correlation between the level of depression and the unconditional acceptance of one's own person; people with moderate to high depression also show a significantly lower level of unconditional acceptance of their own person. In other words, the more severe the depression, the **lower the level of self-acceptance**.

Hypothesis 2. It is assumed that there is a significant difference between the intensity of suicidal risk behaviours before and after participation in the therapeutic prevention programme.

Since the data distributions for the two variables met the conditions of normality, we used the Student's t-test for paired samples for statistical processing.

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Suicidal_risk	8,3382	68	1,65367	,20054
	Suicidal_risk_after_therapy	7,8382	68	1,31138	,15903

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Suicidal_risk & Suicidal_risk_after_therapy	68	,679	,000

Table 4. Mean scores for suicide risk level before and after completing the therapeutic programme

Variabiles	The value of t	Sig.	Difference between the averages
Suicidal_risk Suicidal_risk_after_therapy	3,358	,001	0,79

Table 5. Significant differences between the level of suicidal risk before and after completing the psychotherapy programme

The results are presented in three tables. The first table shows the descriptive statistics. The mean of suicidal risk behaviours before participation in the prevention programme is 8.33, with a standard deviation of 1.65 and a standard error of the mean of suicidal risk behaviours of 0.20. After participation in the prevention programme, the mean of suicidal risk behaviours decreases to 7.83, with a standard deviation of 1.31 and a standard error of the mean of 0.15. In fact, in the last

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table we see that the difference between the suicide risk before and after the programme is significant (t (67)=3.35; p<0.01), in the sense that the suicide risk decreased significantly after the 12 sessions.

Psychotherapeutic programme for the prevention of suicidal behaviour

Throughout the course of the suicide risk behaviour prevention programme we worked in groups, depending on the availability of the participants. The objectives proposed in the suicide risk prevention programme were considered by all members of the working group as necessary for a safe, accepting and confident way of life.

1. Increase self-esteem and implicitly the degree of unconditional acceptance of oneself;
2. Decrease in depression by gaining satisfaction and finding new motivation in life;
3. Obtaining existential satisfaction from things that bring pleasure and appreciation.

Problem-focused group therapy aims to increase young people's competence to identify problems, to discover and build realistic solutions to current problems and also to empower young people to participate in social and professional activities that bring them satisfaction and a higher level of self-esteem. The protocol included motivational enhancement, psychoeducation, emotional awareness exercise (through self-monitoring and mindfulness exercises), cognitive reappraisal, emotion-driven behaviours and emotional avoidance (identifying and modifying behaviours that prevent full exposure to strong emotions), awareness and tolerance of physical sensations (in general), interoceptive and situational exposure (to specific anxiety-provoking stimuli) and finally relapse prevention. Throughout the programme, participants gained knowledge about accepting and observing emotions, understanding cognitive issues, cognitive flexibility, emotional exposure and exposure to interoceptive stimuli.

II. Discussions & conclusions

We believe that the obtained results entitle us to say that our research has reached its purpose, leading to the fulfillment of our goal. In this context, the determining role of prevention, which, through its contribution, must influence decisively the development of both prevention and intervention programs in order to ensure and maintain a high level of mental and physical health, which materializes, in the end, by the increasing quality of life.

In an American study carried out longitudinally, over ten years (1975-1985), the importance of the feeling of non-acceptance and despair as a major predictor of suicidal behaviour is emphasized. The absence of a future perspective on one's own person was a common point in 91% of the subjects who then committed suicide (Beck, A.T. and others., 1985).

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