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Suicide acceptability and sexual orientation among a nationally representative sample of US adults: Results from the General Social Survey 2008-2014

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Abstract

Objectives: Lesbian, gay, and bisexual (LGB) individuals have higher prevalence of lifetime suicide ideation and attempt than their heterosexual peers, but less is known about differences in suicide acceptability (i.e., believing suicide is a viable answer to a problem). The purpose of this study was to examine if LGB adults had greater suicide acceptability than heterosexual adults.

Methods: Four items in the General Social Surveys from 2008–2014 assessed whether a nationally representative sample of US adult respondents (n=5,037) thought it acceptable for individuals to kill themselves if one: goes bankrupt, dishonors their family, is tired of living, or has an incurable disease. Multiple logistic regression analyses were used to assess the association of sexual orientation with suicide acceptability items after adjusting for confounding factors.

Results: Compared with heterosexuals, lesbians/gays had higher odds of reporting suicide acceptability if one goes bankrupt (OR=1.92; 95% CI: 1.06, 3.46), dishonors family (OR=1.83; 95% CI: 1.01, 3.28), or is tired of living (OR=2.25; 95% CI: 1.30, 3.90). Bisexual and heterosexual groups were largely similar across the 4 suicide acceptability items. No sexual orientation differences were observed for reporting acceptability of suicide in the instance of an incurable disease. Post hoc analyses revealed significant interactions between sex and sexual

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orientation, such that differences in suicide acceptability seemed to be driven by sexual minority women rather than by sexual minority men.

Conclusion: Suicide acceptability differs by sexual orientation, and community-level interventions around changing norms about suicide may be a prevention strategy for sexual minority individuals.

Keywords

sexual orientation; suicide acceptability; sexual minority; General Social Survey

INTRODUCTION

From 1999 through 2014, suicide deaths increased consistently in the US (Curtin, Warner, & Hedegaard, 2016), and while other leading causes of death (e.g., heart disease, cancer, diabetes) declined from 2013–2014, deaths by suicide increased by 3.2% (Murphy, Kochanek, Xu, & Arias, 2015). Consequently, suicide prevention continues to be a national public health priority, and particular populations of concern are lesbian, gay, and bisexual (LGB) communities (U.S. Department of Health and Human Services, Office of the Surgeon General, & Prevention, 2012). Research is concordant that, in population-based studies, LGB individuals have 2- to 4-fold increased risks of lifetime suicide ideation and attempt compared to their heterosexual peers (Haas et al., 2010). Less is known about potential sexual orientation differences in suicide acceptability (i.e., the belief that suicide is a viable answer to a problem), a construct related to suicide risk (Feigelman, Rosen, & Gorman, 2014), which may reveal different community norms and beliefs about suicide and inform prevention and intervention efforts.

A recent meta-analysis, including both community-based and population-based samples, clearly established sexual orientation-based disparities in suicide morbidity (i.e., suicide ideation, planning, and attempt) (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016). Furthermore, Hottes et al. (2016) found that bisexual individuals were more likely to endorse that they had attempted suicide than gay men and lesbian women. Unfortunately, potential sexual-orientation disparities in suicide mortality remain limited because of a general lack of mortality data including sexual orientation (Haas et al., 2010; Haas & Lane, 2015). The disparities in suicide morbidity among sexual minority populations has fueled calls to better understand risk factors around which to design intervention efforts (U.S. Department of Health and Human Services et al., 2012).

A robust literature shows persistent positive associations of suicide acceptability (and a related construct of the lack of moral objections to suicide [MOS]) with suicide ideation, suicide planning, suicide attempt, and suicide death (Dervic, Grunebaum, Burke, Mann, & Oquendo, 2006; Feigelman et al., 2014; Joe, Romer, & Jamieson, 2007; Kleiman, 2015; Lizardi et al., 2008; Richardson-Vejlgaard, Sher, Oquendo, Lizardi, & Stanley, 2009). For example, Feigelman et al. (2014) compared several characteristics between a sample of suicide and non-suicide decedents, finding that factors like historical unemployment, religious attendance, and marital status were not significantly predictive of suicide deaths, however previous indications of suicide acceptability were strongly and positively related to

eventual suicide deaths. Moreover, in a nationally representative sample of adolescents and young adults, Joe et al. (2007) noted that individuals with the highest level of suicide acceptability had nearly 13 times the odds of making plans for suicide, even after adjusting for socio-demographic factors, sensation-seeking, and symptoms of hopelessness. Thus, suicide acceptability is likely a unique, independent risk factor for self-directed violence, but, to date, research has not examined whether LGB populations may experience greater burdens of this risk factor.

Because of the unique characteristics of LGB communities, the Cultural Model of Suicide may be a useful framework to understand how suicide acceptability may be greater among LGB individuals than among their non-LGB peers (Chu, Goldblum, Floyd, & Bongar, 2010). Based on an in-depth review of literature about the cultural factors promoting suicide among minority groups (i.e., ethnic and sexual minorities), the Cultural Model of Suicide theory suggests that cultural sanctions (e.g., suicide acceptability and religious beliefs), idioms of distress (e.g., how suicidal ideation and behaviors are expressed), minority stress (e.g., internalized homonegativity), and social discord (e.g., family rejection) are the predominant risk factors for suicide ideation and attempt.

Of particular relevance is the concept of cultural sanctions, under which fits the erroneous notion that suicide is an understandable action (Cato & Canetto, 2003; Molloy & McLaren, 2004; Shahtahmasebi, Varbanov, Aleksandrov, & Pridmore, 2016), and there are at least two, mutually reinforcing reasons – we deem “position and prevalence” – for suspecting greater suicide acceptability among LGB populations. First, the stigmatized social position of LGB status may contribute to greater personal disconnection and devaluation (e.g., the concepts of perceived burdensomeness and thwarted belongingness from the Interpersonal Theory of Suicide (Van Orden et al., 2010)), stoking thoughts that suicide (i.e., a stigmatized behavior) among a stigmatized population is acceptable.

Second, the persistently high prevalence of suicide ideation and attempt among LGB populations may have an insidious effect of seeming to normalize self-destructive behavior by augmenting injunctive norms among LGB individuals (Reno, Cialdini, & Kallgren, 1993). Injunctive norms refer to actions that a specific group deems as acceptable or unacceptable. Consequently, if sexual minority populations are consistently branded as a “high-risk” group, it is possible this association, itself, plays a role in misunderstanding that self-directed violence is more typical than atypical; that it is, however unfortunate, a part of the group narrative (Cohler & Hammack, 2007; Kral, 1994; Russell, 2003). For example, there exists conjecture of a “suicidal script” – a conventional lore that self-harm is an expectation – that may contribute to elevated rates of self-directed violence among sexual minority populations (Bohan, Russell, & Montgomery, 2003; Martin, 1996; Savin-Williams, 2001). Molloy et al. noted that the acceptance of LGB suicide was greater among sexual minority college students than their heterosexual college peers, which may speak to these aforementioned reasons (Molloy & McLaren, 2004), however, potential sexual orientation-based differences in suicide acceptability have yet to be examined among representative, probability-based samples.

Despite ample evidence of sexual orientation-related disparities in suicide ideation and attempt (Haas et al., 2010), there is relatively scant information about differences in suicide acceptability. Moreover, suicide acceptability may be unique risk factor around which prevention and intervention efforts can be focused (e.g., changing community norms). Using a robust, probability-based dataset that included information about self-identified sexual identity, this project sought to test the hypothesis that lesbian/gay and bisexual individuals have greater acceptability of suicide when compared with their heterosexual peers.

METHODS

This secondary analysis uses data from the 2008, 2010, 2012, and 2014 cross-sectional survey from the General Social Survey (GSS). The GSS began in 1972, and became a biennial survey in 1994. It is one the longest-running surveys of socio-demographic, behavioral, and attitudinal information in the US, and it employs a multi-stage sampling design to recruit non-institutionalized adults over the age of 18. Respondents completed computer-assisted personal interviews (Smith, Marsdent, Hout, & Kim, 2015). The response rates for the survey years included in this analysis were 70.4% in 2008, 70.3% in 2010, 71.4% in 2012, and 69.2% in 2014. More detailed information about the survey, methodology, sampling, and representativeness is available from the GSS website (<http://gss.norc.org>).

Beginning in 2008, the GSS included an item gauging self-identified sexual orientation: “Which of the following best describes you?” Respondents could select *gay, lesbian, or homosexual; bisexual; heterosexual or straight*. Because of the relatively small number of LGB respondents in each survey year (e.g., 33 lesbian/gay and 27 bisexual individuals in 2008), data were combined from 2008–2014.

The key dependent variables were 4 separate suicide acceptability items. Respondents were asked a stem question followed by 4 scenarios: “Do you think a person has the right to end his or her own life if this person...(1) has an incurable disease, (2) has gone bankrupt, (3) has dishonored his or her family, (4) is tired of living and ready to die?” Respondents answered each scenario with *yes* or *no*.

Other key independent variables included demographic data on sex (male/female); racial/ethnic identity (white, black, other), age, education (1–12 years of education vs. >12 years of education), and marital status (married, formerly married, and never married). We also included information about whether respondents had any children, which was dichotomously coded as yes or no. Finally, religiosity was included because of its strong protective association against suicide (Koenig, 2009). Respondents were asked, “To what extent do you consider yourself a religious person? Are you very religious, moderately religious, slightly religious, or not religious at all?” Responses were coded categorically with the very religious group as the reference category.

Univariate percentages and means were used to characterize all variables in the sample across the three sexual orientation groups of lesbian/gay, bisexual, and heterosexual. Group comparisons were investigated using weighted Pearson chi-square tests (design-based F) for

all categorical variables, and age was examined using a weighted adjusted Wald test to compare mean ages between the three groups. The heterosexual group was the reference category against which the lesbian/gay and the bisexual groups were compared. Multiple logistic regression models were used to examine the association of sexual identity with each of the 4 suicide acceptability items, controlling for selected socio-demographics and survey year. We first conducted main effects only models for each of the 4 suicide acceptability items, followed by models with interactions between sex and sexual orientation. All analyses were conducted in Stata/SE Version 13 and were weighted to account for the complex sampling design of the GSS.

RESULTS

The analytic sample included 5,037 adults, of whom 85 were lesbian/gay and 112 were bisexual, accounting for weighted percentages of 1.5% and 1.9%, respectively. Overall, small percentages of participants reported that suicide is acceptable if one goes bankrupt (10.3%) or if one dishonors family (10.4%). A slightly greater percentage of participants reported that suicide is acceptable if one is tired of living (18.1%), and the majority of participants reported that suicide is acceptable if one has an incurable disease (60.1%) (data not shown). Lesbian/gay and bisexual participants were more likely than heterosexuals to report that suicide is acceptable if one goes bankrupt, dishonors family, is tired of living, or has an incurable disease (Table 1).

Main effects.

Models including only main effects and adjusting for socio-demographics showed that lesbian/gay participants had higher odds than heterosexuals of reporting that suicide is acceptable if one goes bankrupt, dishonors family, or is tired of living, but did not significantly differ about reporting that suicide is acceptable if one has an incurable disease (Table 2). Bisexuals did not have significantly different odds than heterosexuals of reporting that suicide is acceptable if one goes bankrupt, dishonors family, is tired of living, or has an incurable disease. In terms of sex, overall, men had higher odds than women of reporting that suicide is acceptable if one is tired of living (OR=1.22; 95% CI: 1.02, 1.46) or has an incurable disease (OR=1.21; 95% CI: 1.05, 1.40), but did not significantly differ about reporting that suicide is acceptable if one goes bankrupt (OR=1.23; 95% CI: 0.99, 1.53) or dishonors family (OR=1.20; 95% CI: 0.97, 1.49) (data not shown).

Interactions between sexual orientation and sex.

Tests for interactions between sexual orientation and sex are presented in Table 2. The differences between bisexual and heterosexual participants were significantly different among men compared with women for reporting that suicide is acceptable if one goes bankrupt, dishonors family, or is tired of living. Conversely, lesbian women seemed to drive the differences among the gay/lesbian group, as the gay men and heterosexual men did not significantly differ, but lesbian women had much greater odds of reported suicide acceptability if one goes bankrupt, dishonors family, or is tired of living. There was no interaction between sexual orientation and sex for reporting that suicide is acceptable if one has an incurable disease. Results of the covariate-adjusted analyses (Table 2) are similar to,

but less biased by confounding than, estimates produced in crude models that were unadjusted for covariates (see Supplemental Table A). For instance, for the model assessing “suicide is acceptable if a person is tired of living,” the estimates for the interaction terms in the unadjusted model were: (OR=0.41, 95%CI:0.14–1.17) and (OR=0.20, 95%CI:0.06–0.63), which were similar to the fully adjusted estimates reported in Table 2 (AOR=0.34, 95%CI: 0.11–1.02) and (AOR=0.25, 95%CI:0.08–0.83).

Table 3 illustrates the interactions by presenting the adjusted prevalence of suicide acceptability by sexual orientation and sex, which were calculated post-hoc with Stata’s margins command. For example, 18.3% (95%CI:16.2%, 20.5%) of heterosexual men versus 9.0% (3.4%, 21.8%) of bisexual men reported that suicide is acceptable if one is tired of living. The relationship was in the opposite direction for women: 14.9% (13.3%, 16.5%) of heterosexual women versus 23.5% (15.1%, 34.7%) of bisexual women and 42.4% (24.5%, 62.5%) of lesbian women endorsed this concept. Results are similar for reporting that suicide is acceptable if one dishonors family or goes bankrupt. Overall, the adjusted prevalence estimates suggest that the sexual orientation differences observed in Table 1 seemed to be primarily driven by the sexual minority women rather than by sexual minority men.

We conducted a post hoc sensitivity analysis using a behavioral measure of sexual orientation. The GSS survey includes an item that reads, “Have your sex partners in the last five years been...” with response options of exclusively male, both male and female, and exclusively female. By crossing this variable with the respondent’s sex, we generated categories of same-sex (e.g., male who reported having sex exclusively with males), opposite sex (e.g., male who reported sex exclusively with females), and both sexes. There were 104 respondents who indicated exclusively same-sex sexual behavior, 84 who indicated sexual behavior with both sexes, and 4,083 who indicated exclusively opposite-sex sexual behavior. We identified similar patterns of differences in prevalence of suicide acceptability for incurable disease (same-sex=73.9%; both-sex=74.1%; opposite sex=62.1%, $p=.016$), bankruptcy (same-sex=18.1%; both-sex=20.3%; opposite sex=10.5%, $p=.005$), dishonors family (same-sex=16.9%; both-sex=22.0%; opposite sex=10.8%, $p=.004$), and being tired of living (same-sex=28.0%; both-sex=33.8%; opposite sex=18.3%, $p<.001$) (data not shown).

DISCUSSION

This study is among the first to use a robust sample of adults to explore whether sexual orientation differences exist among suicide acceptability. Bisexual and gay/lesbian adults were more likely to endorse suicide acceptability than their heterosexual peers. Additionally, there were significant sex by sexual orientation interactions, and, although sexual minority men and women were not statistically different in endorsing suicide acceptability, the pattern of results suggested that sexual minority women comprised the majority of the sexual orientation differences between gay/lesbian, bisexual, and heterosexual groups.

That sexual minority respondents were more likely to endorse suicide acceptability is not necessarily surprising, especially because sexual minority populations are much more likely to report suicide ideation and attempt than their heterosexual peers (Hottes et al., 2016),

indicating that suicidal distress, generally, is more common. Furthermore, these results appear consistent with the notion of cultural sanctions regarding suicide, a key component of the Cultural Model of Suicide (Chu et al., 2010). While, the measures of suicide acceptability in this study incorporated 4 specific hypothetical scenarios commonly associated as social stressors precipitating suicidal risk (e.g., bankruptcy(Kidger, Gunnell, Jarvik, Overstreet, & Hollingworth, 2011), familial shame(Hastings, Northman, & Tangney, 2002)), the scenarios do not explicitly include wording for reasons that are more commonly associated with suicide risk, such as depression and hopelessness. However, the items may be interpreted as mapping onto theorized concepts of suicide risk, such as hopelessness being captured by the item worded “tired of living and ready to die” or perceived burdensomeness being implicated in bankruptcy (Van Orden et al., 2010).

However, the sex differences among sexual minority groups – specifically that lesbian-identified women seemed to endorse the greatest suicide acceptability – were less expected. One potential explanation is that lesbian women may have elevated rates of distress because of the unique combination of heterosexism, sexism, and internalized heterosexism they experience or greater levels of social and community isolation (Kertzner, Meyer, Frost, & Stirratt, 2009; Rothblum, 2010; Szymanski, 2005). The increased unique psychological distress may contribute to hopelessness that could, in turn, incite thoughts that suicide is a viable option to life problems. It should be noted, however, that the interaction analyses had very small cell sizes, which limited statistical power, and these results should be viewed with caution. Further research is needed to explore how gender may moderate suicide acceptability among sexual minority communities.

Interventions to address distress and suicide risk among sexual minorities have typically focused on individual-level treatment (e.g., cognitive-behavioral therapy [CBT]) (Craig, Austin, & Alessi, 2013; Rabinovitch, Perrin, Tabaac, & Brewster, 2015; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007). The present results, however, suggest a potential strategy of additional levels of intervention around the individual, targeting norms about suicide and hearkening back to the Cultural Model of Suicide (Chu et al., 2010) and theoretical frameworks around changing social norms to change human behavior (Cialdini, Kallgren, & Reno, 1991). Several suicide prevention programs have integrated components of changing social norms, specifically around help-seeking (Knox, Litts, Talcott, Feig, & Caine, 2003; Molock, Matlin, Barksdale, Puri, & Lyles, 2008; Pisani et al., 2012). For example, Sources of Strength, a school-based suicide prevention program, has been associated with promoting help-seeking by changing norms among students (Pisani et al., 2012; Wyman et al., 2010). It may be possible to tailor such an intervention for sexual minority youth and enhancing the problem-solving aspect of the program to specifically address beliefs about suicide (e.g., challenging notions that suicide is an acceptable option to life problems, and introducing coping and help-seeking strategies that counter cultural sanctions), which could have lasting effects into adulthood. Another example of school-based structural intervention strategy may be the implementation of gay-straight alliance clubs and using such venues to address beliefs about suicide among sexual minority youth(Saewyc, Konishi, Rose, & Homma, 2014).

Another potential form of community-level intervention could be directed mass media messages around suicide prevention in a manner similar to efforts combatting societal homophobia (Hull et al., 2017). Finally, in a related effort, a social media campaign born from highly-publicized suicides of sexual minority youth – “It Gets Better” – provided web-based video testimonials from sexual minority adults encouraging sexual minority youth to persevere through their current problems (Muller, 2012). The campaign was neither designed nor intended to be a scientifically-developed and tested prevention program, and though well-intentioned, was met with criticism (Grzanka & Mann, 2014). Nevertheless, the campaign could be viewed as striving to interrupt the seemingly pervasive media narrative around suicide and bullying among sexual minority youth. Though clearly complex and ambitious endeavors, community-based norming interventions are a nascent area of future research for suicide prevention tailored to sexual minority populations.

The results should be interpreted considering several limitations. First, although the GSS uses a robust sampling methodology, the relatively small samples may have limited generalizability and introduced imprecision and instability in estimates. Similarly, research suggests that sexual minorities are more comfortable with disclosing more information in community research studies than population-based studies (Hottes et al., 2016); therefore, these results are based on individuals who felt comfortable enough to identify as LGB. Moreover, the GSS was administered using computer-assisted personal interviews, so it unclear whether this kind of survey administration may effect self-disclosure of sexual identity versus, for instance, computer-assisted telephone-based interviews. The GSS does not collect information about suicidal ideation or attempt, so it was not possible to examine the association of suicide acceptability with explicit data on self-directed violence (e.g., suicide attempt). These data cannot be interpreted as causal; first, for the empirical reason that the data are cross-sectional, and in at a close second, there is no theoretical basis for why sexual orientation would cause elevated suicide acceptability. Rather, the causal agents likely include stigma and discrimination (Hatzenbuehler, 2009), which stoke feelings of hopelessness, disconnection, and burdensomeness.

Although suicide acceptability may seem like yet another disparity among a long list of suicide-related outcomes among sexual minority adults, its elucidation may offer a different view on prevention efforts built around mutable risk factors of self-directed violence among sexual minority communities.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Socio-demographics and suicide acceptability, by sexual orientation, General Social Survey 2008–2014

	<u>Lesbian/Gay</u>		<u>Bisexual</u>		<u>Heterosexual</u>		
	(n=85)		(n=112)		(n=4,840)		
Socio-demographics	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>P</i>
Sex							
Men	49	(58.8)	37	(32.3)	2,187	(45.9)	.003
Women	36	(41.2)	75	(67.7)	2,653	(54.1)	
Race							
White	70	(83.2)	80	(70.8)	3,687	(76.2)	.374
Black	8	(9.6)	18	(14.4)	723	(13.7)	
Other	7	(7.2)	14	(14.8)	430	(10.0)	
Religious							
Very religious	6	(4.7)	4	(1.8)	823	(17.3)	<.001
Moderately religious	28	(31.4)	46	(40.2)	1,967	(40.5)	
Slightly religious	29	(39.7)	26	(24.1)	1,094	(22.8)	
Not religious	22	(24.2)	36	(33.9)	931	(19.4)	
Years of Education							
≥12	20	(21.9)	40	(33.7)	2,024	(41.2)	.002
<12	65	(78.1)	72	(66.3)	2,811	(58.8)	
Marital status							
Married	3	(4.2)	26	(27.0)	2,218	(53.3)	<.001
Formerly married	12	(12.4)	26	(18.5)	1,302	(19.7)	
Never married	70	(83.4)	60	(54.5)	1,316	(27.0)	
Has children							
No	72	(86.8)	54	(48.9)	1,305	(27.5)	<.001
Yes	13	(13.2)	58	(51.1)	3,527	(72.5)	
Age (M, SD)	40.1	(1.47)	35.4	(1.14)	46.1	(0.22)	<.001
<u>Suicide is acceptable if one:</u>							
Goes bankrupt	22	(25.0)	15	(13.5)	521	(10.4)	<.001
Dishonors family	21	(24.3)	17	(15.0)	529	(10.4)	<.001
Is tired of living	34	(41.4)	29	(24.6)	884	(17.9)	<.001
Has an incurable disease	67	(76.3)	79	(74.2)	2,873	(61.2)	.002

Note. Frequencies are unweighted, percentages, means (M), and standard deviations (SD) are weighted. All analyses are weighted and adjusted for survey year.

Table 2.

Main effects and interaction effects of the associations of sexual orientation with suicide acceptability, General Social Survey 2008–2014

	Suicide is acceptable if one:							
	<u>Goes bankrupt</u>		<u>Dishonors family</u>		<u>Tired of living</u>		<u>Has an incurable disease</u>	
	(n=4,912)		(n=4,906)		(n=4,862)		(n=4,855)	
	aOR	(95% CI)	aOR	(95% CI)	aOR	(95% CI)	aOR	(95% CI)
<u>Main Effects</u> ¹								
Sexual orientation								
Heterosexual		ref		ref		ref		ref
Gay/Lesbian	1.91	(1.06–3.46) *	1.82	(1.01–3.29) *	2.25	(1.30–3.90) *	1.52	(0.82–2.82)
Bisexual	0.97	(0.51–1.81)	1.09	(0.60–1.97)	1.20	(0.73–1.96)	1.43	(0.87–2.33)
<u>Interaction Effects</u> ²								
Sex								
Women		ref		ref		ref		ref
Men	1.30 *	(1.04–1.63)	1.27 *	(1.01–1.58)	1.28 *	(1.06–1.54)	1.21 *	(1.05–1.41)
Sexual orientation								
Heterosexual		ref		ref		ref		ref
Gay/Lesbian	3.56 *	(1.57–8.06)	3.25 *	(1.42–7.41)	4.21 *	(1.84–9.64)	1.82	(0.65–5.10)
Bisexual	1.42	(0.70–2.88)	1.56	(0.80–3.03)	1.76 *	(1.00–3.08)	1.38	(0.77–2.46)
Sex × sexual orientation interactions								
Men × Lesbian/gay	0.35	(0.11–1.07)	0.38	(0.12–1.16)	0.34	(0.11–1.02)	0.72	(0.18–2.96)
Men × Bisexual	0.21 *	(0.05–0.90)	0.25 *	(0.07–0.92)	0.25 *	(0.08–0.83)	1.12	(0.38–3.29)

¹ = Analyses are weighted and adjusted for survey year, sex, race, religiosity, education, marital status, having children, and age.

² = Analyses are weighted and also adjusted for survey year, race, religiosity, education, marital status, having children, and age.

aOR=adjusted odds ratio. CI = confidence interval.

* =P<.05

Table 3.

Adjusted prevalence of suicide acceptability by sexual orientation and gender, General Social Survey 2008–2014

	Suicide is acceptable if one:							
	<u>Goes bankrupt</u>		<u>Dishonors family</u>		<u>Tired of living</u>		<u>Has an incurable disease</u>	
	Men % (95% CI)	Women % (95% CI)	Men % (95% CI)	Women % (95% CI)	Men % (95% CI)	Women % (95% CI)	Men % (95% CI)	Women % (95% CI)
<u>Sexual orientation</u>								
Heterosexual	9.9 (8.5–11.5)	7.7 (6.6–9.0)	9.7 (8.3–11.3)	7.8 (6.8–9.1)	18.3 (16.2–20.5)	14.9 (13.3–16.5)	65.3 (62.7–67.8)	60.7 (58.4–63.1)
Lesbian/gay	12.0 (5.8–22.9)	23.0 (11.8–40.0)	11.7 (5.7–22.3)	21.7 (11.0–38.3)	24.1 (13.3–39.7)	42.4 (24.5–62.5)	71.2 (51.7–85.1)	73.8 (50.2–88.7)
Bisexual	3.2 (0.9–10.4)	10.7 (5.6–19.3)	4.0 (1.3–11.4)	11.7 (6.5–20.3)	9.0 (3.4–21.8)	23.5 (15.1–34.7)	74.4 (53.9–87.8)	68.1 (54.7–79.0)

Note: All percentages and confidence intervals are weighted and adjusted for race/ethnicity, religiosity, education, marital status, age, whether respondent had children, and survey year. CI = confidence interval.