

LETTERS

ON RELIABILITY AND CULTURAL COMPETENCE IN STUDIES OF SEXUAL MINORITY SUICIDALITY

Paul et al. published in the August 2002 issue of the Journal a potentially misleading assertion, specifically, that literature concerning sexual orientation and suicide risks has been “primarily based on opportunistic samples.”¹ The assertion is neither new nor correct. Similar criticisms were made in 1995 by attendees at a workshop convened by the Centers for Disease Control and Prevention, the National Institute of Mental Health, and the American Association of Suicidology. These critics argued that the absence of population-based studies made unreliable the emerging findings of elevated risks of suicidality among sexual minority youths. Several years ago, Remafedi noted that the critics’ assertion was premature²: at least 6 peer-reviewed, population-based, or twin-control studies had been published by 1999. All had corroborated the findings of earlier studies.

The quantity and quality of population-based, peer-reviewed research specific to sexual orientation and suicidality published since 1998³ make problematic any assertion that could lead readers or researchers to doubt the aggregate reliability of findings on this topic.⁴ On the basis of the reliability of the relationship between sexual orientation and suicide risks found in the peer-reviewed literature,⁵ a num-

ber of us have begun to study the extent to which the findings can be generalized to sexual minorities in other parts of the world⁶ as well as ethnically diverse populations in the United States.⁷ Our initial attempts may well have to rely on “convenience” or “opportunistic” samples—until decision makers include in more population-based surveys questions specific to both sexual orientation and mental health.

Paul et al. addressed another important aspect of generalizability, specifically, age cohort effects. One would hope that future researchers will demonstrate a somewhat greater degree of sensitivity to the influence of cultural contexts for psychological issues in gay and lesbian studies.⁸ It makes little sense to impose 10-year intervals on data to examine cohort effects among a minority group that has experienced substantial oppression, discrimination, and stigma. It would be more sensible to examine cohorts that reached varying developmental life stages (e.g., adolescence or onset of middle adulthood at age 40) during culturally significant health-related events (e.g., the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders [DSM]* in 1973 or the removal of ego-dystonic homosexuality from the *DSM* in 1987). This tactic is essential for evaluating the extent to which variations in oppression moderate the relationship between sexual orientation and stress-related disorders.⁹ ■

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References

1. Paul JP, Catania J, Pollack L, et al. Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. *Am J Public Health.* 2002;92:1338–1345.
2. Remafedi G. Suicide and sexual orientation: nearing the end of controversy? *Arch Gen Psychiatry.* 1999; 56:885–886.
3. Remafedi G, French S, Story M, Resnick M, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health.* 1998;88:57–60.
4. Sell RL, Becker JB. Sexual orientation data collec-

tion and progress toward Healthy People 2010. *Am J Public Health.* 2001;91:876–882.

5. Remafedi G. Sexual orientation and youth suicide. *JAMA.* 1999;282:1291–1292.

6. Mathy RM. Suicidality and sexual orientation in five continents: Asia, Australia, Europe, North America, and South America. *Int J Sexuality Gender Stud.* 2002; 7:215–225.

7. Mays VM, Yancey AK, Cochran SD, Weber M, Fielding JE. Heterogeneity of health disparities among African American, Hispanic, and Asian American Women: unrecognized influences of sexual orientation. *Am J Public Health.* 2002;92:632–639.

8. Mathy RM. Psychology. In: Murphy T, ed. *Reader's Guide to Lesbian and Gay Studies.* Chicago, Ill: Fitzroy-Dearborn; 2000.

9. Cochran SD, Mays VM. Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the US population. *Am J Epidemiol.* 2000;151:516–523.