

ORIGINAL ARTICLE

Minority stressors and suicidal ideation in sexual and gender minority youth assigned female at birth: Prospective associations and racial differences

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Abstract

Introduction: Suicidal ideation (SI) disproportionately affects sexual and gender minority (SGM) versus cisgender/heterosexual youth, likely due to the minority stressors (MS) they face. Research has shown cross-sectional associations between SGM MS and suicidality; however, few studies have used longitudinal data or examined racial differences in the effects of MS on SI. The current study tested whether MS prospectively predict next-year SI and whether race moderates these prospective associations.

Method: Three hundred and sixty-nine Black, Latinx, and White SGM youth completed baseline measures of MS, SI, and demographics, and SI 6 and 12 months later.

Results: Internalized stigma, microaggressions, and low support from family and from significant others demonstrated associations with next-year SI. When controlling for baseline SI, however, only low significant other support predicted next-year SI. Moderation analyses indicated that internalized stigma predicted SI for White, but not Black or Latinx, individuals and that lower friend support was associated with SI for Latinx, but not White or Black, individuals.

Conclusions: Though minority stressors appear to raise risk for SI among SGM, effects may differ by race. Internalized stigma may be particularly influential for SI among White SGM whereas lack of support from friends may be most influential for SI among Latinx SGM youth.

KEYWORDS

LGBTQ, minority stress, racial differences, suicidal ideation, suicidality

INTRODUCTION

Suicidal ideation (SI) disproportionately affects sexual and gender minority youth (SGM) compared with cisgender/heterosexual youth (Bostwick et al., 2014; Haas et al., 2011;

King et al., 2008; Russell & Joyner, 2001). According to Minority Stress Theory (Meyer, 2003), this disparity is rooted in the unique stressors, labeled minority stressors, that SGM face due to stigma (Meyer, 2003; Williams & Williams-Morris, 2000). Minority stressors include

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experiences of stigma enacted by others, such as anti-SGM discrimination, microaggressions, and victimization events, as well as internalized stigma (defined as a negative view of one's own SGM identity), each of which has been cross-sectionally associated with greater likelihood of SI in SGM individuals (Lea et al., 2014; Liu & Mustanski, 2012; Plöderl & Fartacek, 2005; Russell & Joyner, 2001; Walls et al., 2008). In addition, low social support is frequently conceptualized as a sexual minority stressor, given that SGM often face rejection from key sources of social support (e.g., family, friends) due to their SGM identity (e.g., Katz-Wise & Hyde, 2012; Ryan et al., 2009). Low social support, especially lack of family support and family rejection, has also shown concurrent associations with SI in young SGM individuals (Liu & Mustanski, 2012; Plöderl & Fartacek, 2005; Ryan et al., 2009).

Only three longitudinal studies to date have examined whether SGM minority stressors prospectively predict SI among SGM (Liu & Mustanski, 2012; Rabasco & Andover, 2021; Smith et al., 2020). Two studies found that certain minority stressors, namely SGM victimization, discrimination and low social support, longitudinally predicted SI (Liu & Mustanski, 2012; Rabasco & Andover, 2021). The other study found that everyday discrimination predicted suicidal behaviors (such as suicide attempts) 6 months later, but neither everyday discrimination, acceptance concerns, internalized stigma, nor family support/strain predicted SI (Smith et al., 2020). Of these, only one utilized a racially diverse sample (Liu & Mustanski, 2012), calling into question whether the aforementioned results apply to SGM people of color (POC). Further, no research to date has examined whether the effects of SGM minority stressors on suicidality differ among SGM youth of different races.

Compared with White SGM, SGM POC have unique experiences that may impact their mental health. All SGM individuals hold at least one minority identity related to their gender (e.g., transgender, non-binary, etc.) or sexual (e.g., gay, bisexual, pansexual, etc.) identity, whereas SGM POC hold at least two minority identities: their gender or sexual identity and their racial or ethnic identity. Research has increasingly called for examining SGM mental health outcomes in ways that also account for other identities, such as race/ethnicity, given that SGM POC are experiencing additional prejudice compared with White SGM (Balsam et al., 2011). However, many studies of SGM youth do not have high enough numbers of ethnic/racial minorities to examine group differences in a statistically meaningful way (Haas et al., 2011), leaving a large gap in the literature on how minority stressors may impact mental health outcomes by race/ethnicity.

One school of thought—the risk hypothesis—holds that having multiple minority identities puts SGM POC

at “double jeopardy” for experiencing negative outcomes from these two sets of minority stressors (Meyer, 2010) in comparison with White SGM who may face only one set of minority stressors. Thus, the risk hypothesis proposes that suicidality in SGM POC will be more prevalent and more strongly affected by experiences of SGM discrimination than are White SGM individuals. Contrary to this idea, some studies have found that holding a racial minority identity does not increase risk for SI among SGM (Blosnich & Bossarte, 2012; Mereish et al., 2014). Some speculate that having multiple minority identities may render an individual more resilient to new experiences of prejudice, because they have learned coping mechanisms that allow them to better process further instances of discrimination (Bowleg et al., 2003; Moradi et al., 2010)—a position known as the resilience hypothesis. From a resilience perspective, we might expect that experiencing SGM stigma has less of an impact on mental health for SGM POC compared with White SGM because of their more practiced coping skills. Further research is needed to examine these two conflicting perspectives in SGM people.

Research within the majority heterosexual/cisgender literature points to potential racial differences in risk and protective factors for SI. For example, social support has been found to be a stronger protective factor for suicidality among Black female youth compared with White female youth, perhaps because Black female youth have learned to use social support to help cope with experiences of racism (Borowsky et al., 2001; Clark, 2006; Langhinrichsen-Rohling et al., 2009)—a perspective that is in line with the resilience hypothesis. Similarly, family rejection may be a particularly potent suicidality risk factor for Latinx youth because of the traditional emphasis Latinx families place on family unity (Zayas & Pilat, 2008). Despite these associations potentially holding true for SGM POC as well, no studies identified have looked at how race may interact with any SGM minority stressor when predicting suicidality.

Current study

The current study builds upon existing literature by examining the prospective effects of minority stressors on SGM SI in the following year, using a sample diverse in race/ethnicity, gender identity, and sexual identity. We focused exclusively on SGM people assigned female at birth (AFAB), an understudied population within the SGM community (Coulter et al., 2014). Further, we examine whether the impact of SGM minority stressors on SI differs by race, in keeping with calls to describe differences in individuals' experiences based on their intersecting social identities (e.g., Cheshire, 2013).

MATERIALS AND METHODS

Participants and procedure

FAB 400 is an ongoing cohort study of 488 young sexual and gender minorities AFAB, focused on their health, development, and intimate relationships. FAB 400 includes two cohorts: (1) a late adolescent cohort recruited for FAB400 in 2016–2017 ($N = 400$; 16–20 years old at baseline), and (2) a young adult cohort comprised of SGM-AFAB participants from Project Q2, a study of SGM youth that began in 2007 ($N = 88$; 23–32 years old at the FAB400 baseline assessment). Inclusion criteria at initial recruitment required participants to be AFAB, 16–20 years old, speak English, and either identify with a sexual or gender minority label, report same-gender attractions, or same-gender sexual behavior. Each cohort was recruited using an incentivized snowball sampling approach, in which participants were recruited directly from various SGM venues and online social media advertisements. Enrolled participants could refer up to five peers to the study and were paid \$10 for each peer they successfully recruited.

In 2016–2017, all 488 participants completed the FAB 400 baseline assessment and returned every 6 months for follow-up assessments. Participants were paid \$50 at each wave for completing a battery of self-report measures using computer-assisted self-interview. The study protocol was approved by the Institutional Review Board (IRB) at Northwestern University with a waiver of parental permission for participants under 18 years of age under 45 CFR 46, 408(c). Participants provided written informed consent, and we used mechanisms to safeguard confidentiality (i.e., federal certificate of confidentiality).

For this study, we used data from the baseline assessment and from the 6- and 12-month follow-ups. We selected the 417 FAB 400 participants who identified as either Black, Latinx, or White at baseline because the numbers of participants identifying as other racial/ethnic identities were too small for adequately powered tests of racial differences. We excluded participants who did not complete questions about suicidality at baseline ($N = 21$) or at either the 6- or 12-month follow-up ($N = 31$). Thus, the final analytic sample consisted of 369 participants. See [Table 1](#) for demographic characteristics of the analytic sample.

Measures

The following measures were administered at baseline: SI, demographics (age, gender identity, sexual identity, and race), and minority stressors (internalized stigma, SGM victimization, microaggressions, and family, friend, and significant other support). Suicidal ideation was also assessed

TABLE 1 Baseline demographics

Demographics	<i>N</i>	%
Cohort		
2016 Cohort	315	85.4
2007 Cohort	54	14.6
Sexual identity		
Gay/Lesbian	85	23.0
Bisexual/Pansexual	211	57.2
Other sexual identity	73	19.8
Queer	42	11.4
Unsure/Questioning	16	4.3
Straight/Heterosexual	4	1.1
Asexual	7	1.9
Not listed	4	1.1
Participant gender		
Cisgender woman	280	75.9
Gender minority	89	24.1
Male	12	3.3
Transgender	13	3.5
Gender non-conforming	22	6.0
Gender Queer	23	6.2
Non-binary	13	3.5
Not listed	6	1.6
Race/Ethnicity		
Black/African American	148	40.1
Latinx/Hispanic	108	29.3
White	113	30.6
Age (<i>M, SD</i>)	19.72 (3.36)	

at 6- and 12-month follow-ups. Due to low base-rates of suicidality, we aggregated responses across 6- and 12-month follow-up by recoding responses into participants who endorsed SI at either of the follow-ups and participants who did not endorse SI at any point in the follow-up period.

Suicidal ideation

Participants answered the question “during the past 6 months, did you ever seriously consider attempting suicide?” with either yes or no.

Demographics

Age

Participants entered their birthdates at baseline. Their ages were then calculated based on the date at which the survey was taken.

Gender identity

Participants reported their gender identity with the following options: Male, female, transgender, gender non-conforming, genderqueer, non-binary, and not listed (please specify). Participants were then assigned to one of two groups: cisgender women (self-identified as female) and gender minorities (self-identified as any other gender identity).

Sexual identity

Participants reported on their sexual identity with the options: gay, lesbian, bisexual, queer, unsure/questioning, straight/heterosexual, pansexual, asexual, and not listed (please specify). Sexual identity was recoded into three categories: monosexual (gay or lesbian), non-monosexual (bisexual/pansexual), and other.

Race

Participants selected the option(s) that best described their race from the following: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, or other (please specify). Participants also indicated if they identified as Hispanic or Latino/Latina/Latinx, regardless of race. As recommended by the National Institutes of Health (2001), all those who selected a Latinx ethnicity were classified as Latinx regardless of race.

Minority stressors

Internalized stigma

On the Desire to Be Heterosexual subscale of the internalized stigma measure (Puckett et al., 2017), participants indicated their agreement with eight items on a 4-point Likert scale from 1 (Strongly disagree) to 4 (Strongly agree) (e.g., “Sometimes I think that if I were straight, I would probably be happier.”) Scores reflect the mean of responses ($\alpha = 0.88$), with higher scores indicating greater internalized stigma.

SGM victimization

Participants indicated the frequency of victimization experienced because of their SGM identity on 10 items using a 6-point Likert scale from 0 (never) to 5 (more than 10 times) (Pilkington & D’Augelli, 1995). An example item is “How often have you been verbally insulted (yelled at, criticized) because you are, or were thought to be gay, lesbian, bisexual, or trans*?” Scores reflect the mean frequency of responses ($\alpha = 0.68$).

Microaggressions

Nineteen items assessed sexual-identity microaggressions based on sexual identity were drawn from the

Sexual Orientation Microaggression Inventory (Swann et al., 2016), along with four items assessing microaggressions unique to SGM-AFAB individuals. Participants rated how often in the past month they experienced each item on a 5-point Likert scale from 1 (Not at all) to 5 (21–30 times [almost every day]) (e.g., “Someone said homosexuality or bisexuality is a sin or immoral.”) Scores reflect the mean of responses ($\alpha = 0.94$), with a higher score indicating a greater frequency of past-month microaggressions.

Social support

Participants responded to 12 items (e.g., “My family really tried to help me”) on a 7-point Likert scale from 1 (Very strongly disagree) to 7 (Very strongly agree) reflecting the three subscales of The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988): Family Support ($\alpha = 0.93$), Friends Support ($\alpha = 0.95$), and Significant Other Support ($\alpha = 0.95$). Subscale scores reflect the mean of the responses.

Analytic plan

Prior to hypothesis testing, we used chi-square tests and *t*-tests to assess associations between demographic factors and SI during the follow-up year. Those with significant associations ($p < 0.05$) were included in hypothesis tests as control variables.

To test bivariate associations between each minority stressor and SI in the following year, we first conducted separate logistic regression models for each minority stressor in which the given baseline minority stressor was used to predict the presence or absence of SI during the following year. Next, to determine if each minority stressor predicted change in SI over the following year, we ran adjusted models in which we regressed follow-up SI onto baseline SI and demographic controls in the first step, and the given minority stressor in the second step. Lastly, we used PROCESS (Hayes, 2013) Model 1 to test whether race moderated the association between each minority stressor and SI in the following year. Two dummy variables were created for race (one for Black, one for Latinx, with White as the reference group). Then, to test for differences between Black and Latinx participants, we created new dummy variables for Latinx and White, with Black as the reference group. In PROCESS, interaction terms were calculated by multiplying each dummy race variable with the centered minority stressor. If an interaction term was significant, we decomposed the interaction, generating separate odds ratios (which represent the change in likelihood of SI in the following year based on a one-point increase in the baseline minority stressor) for each racial/ethnic group.

RESULTS

Table 2 shows minority stressors at baseline, as well as SI at baseline and follow-up, for the full sample and for each racial/ethnic group separately. SI was present in 22.8% of the sample at baseline and 19.2% over the follow-up period. SI did not differ by race at baseline or over follow-up. Notably, 43.1% of participants reported no incidents of SGM victimization in the past 6 months; thus, we transformed this variable using a square root to correct for positive skew. Microaggressions, family support, friend support, and significant other support differed between Black and White participants, such that Black participants experienced more microaggressions and less social support than White participants. Black participants also experienced less friend and significant other support than Latinx participants. Age was the only demographic variable significantly related to SI and thus was used as a control variable in subsequent analyses.

Associations between minority stressors and suicidality

The associations (odds ratios) between each minority stressor and next-year SI from unadjusted (bivariate) and adjusted models (controlling for baseline SI and age) are shown in Table 3. Results of the unadjusted models revealed significant bivariate associations between baseline internalized stigma, microaggressions, low family support, and low significant other support and follow-up SI. In the adjusted models, baseline SI and age accounted

for 16.2% of variance in follow-up SI (Nagelkerke R^2). Participants who reported SI in the past 6 months at baseline were more than five times as likely to report SI in the following year compared with those who did not report baseline SI, when controlling for age. Thus, baseline SI was highly predictive of follow-up SI, but there was still variance unaccounted for in the model. The only baseline minority stressor that significantly predicted SI in the following year controlling for baseline SI was support from a significant other. Each one-point increase on the support from a significant other scale was associated with a 16% reduction in SI likelihood in the following year when controlling for baseline SI and age. None of the other minority stressors were significantly associated with SI in the following year when controlling for baseline levels.

Results of the moderation analyses indicated racial differences in the prospective effects of internalized stigma and friend support on SI. The effect of internalized stigma on SI differed between Latinx and Black individuals, $z(7) = -2.01, p = 0.04$, and between Latinx and White individuals $z(7) = -2.68, p = 0.01$. As shown in Table 4, simple slopes analysis indicated that higher internalized stigma predicted greater likelihood of SI in the following year for White youth (OR = 2.56, $p = 0.03$), but not for Black (OR = 1.52) or Latinx (OR = 0.48) individuals. The effect of friend support on SI also differed by between Latinx and White youth, $z(7) = -2.05, p = 0.04$: Higher friend support was associated with less likelihood of SI in the following year for Latinx individuals (OR = 0.63, $p = 0.02$) but not for White (OR = 1.22) or Black (OR = 0.93) individuals. Lastly, although there was no significant difference by race in the effect of significant other support on SI, greater

TABLE 2 Baseline minority stressors and SI descriptives

	N	M	SD	Observed range	Black	Latinx	White
					M (SD)	M (SD)	M (SD)
Internalized stigma*	365	1.71	0.61	1.00–3.63	1.66 (0.64)	1.73 (0.60)	1.76 (0.59)
SGM victimization	369	0.24	0.34	0.00–2.50	0.27 (0.37)	0.24 (0.38)	0.20 (0.26)
Microaggressions*	365	1.78	0.65	1.00–4.57	1.87 (0.77) ^a	1.77 (0.61) ^{a,b}	1.67 (0.51) ^b
Family support	369	4.23	1.67	1.00–7.00	3.87 (1.78) ^a	4.25 (1.57) ^{a,b}	4.55 (1.56) ^b
Friend support	369	5.48	1.44	1.00–7.00	5.18 (1.70) ^a	5.56 (1.24) ^b	5.78 (1.18) ^b
Significant other support	369	5.67	1.48	1.00–7.00	5.42 (1.68) ^a	5.90 (1.20) ^b	5.80 (1.39) ^b
Percent endorsed							
		Overall			Black	Latinx	White
Baseline SI	22.8			19.6		26.9	23.0
Follow-Up SI	17.9			17.6		21.3	19.5

*The four people who identified as straight/heterosexual were not asked these questions because they did not identify as a sexual minority.

^{a,b}Racial groups with the same superscript indicate that the means are statistically equivalent; differing superscripts indicate significant differences between groups. When all three groups are statistically equivalent, no superscript appears.

TABLE 3 Associations (odds ratios) between baseline minority stressors and SI in the following year

Minority stressors	Unadjusted	Adjusted
Internalized stigma	1.56*	1.29
SGM victimization	1.32	0.91
Microaggressions	1.50*	1.18
Family support	0.78**	0.85
Friend support	0.90	0.89
Significant other support	0.83*	0.84*

Note. Adjusted analyses controlled for age and baseline SI.

* $p < 0.05$, ** $p < 0.01$.

TABLE 4 Associations (odds ratios) between baseline minority stressors and SI in the following year, by race

Minority stressor	Black	Latinx	White
Internalized stigma	1.52 ^a	0.48 ^b	2.56^a
SGM victimization	1.15	0.56	1.04
Microaggressions	0.99	1.21	1.88
Family support	0.82	0.79	0.94
Friend support	0.93 ^{a,b}	0.63^a	1.22 ^b
Significant other support	0.75	0.87	0.98

Note. Analyses controlled for baseline SI and age. Bold indicates that the odds ratio for a given racial group is significant at $p < 0.05$.

^{a,b}Racial groups with the same superscript indicate that the odds ratios are statistically equivalent; differing superscripts indicate significant differences between groups. When all three groups are statistically equivalent, no superscript appears.

significant other support was associated with less likelihood of SI for Black individuals (OR = 0.75, $p = 0.02$), but not for White (OR = 0.98) or Latinx (OR = 0.87) individuals. Race did not moderate the associations between SGM victimization, microaggressions, or family support and SI in the following year.

DISCUSSION

The current study aimed to determine whether SGM minority stressors act as risk factors for next-year SI in SGM-AFAB youth. As in previous cross-sectional studies (e.g., Lea et al., 2014), a number of minority stressors were identified as risk factors for SI when not accounting for baseline suicidality; fewer minority stressors remained risk factors after baseline SI was taken into account. Further, findings indicate that while SI prevalence does not differ by race/ethnicity, the effects of some SGM minority stressors on future SI do. These findings highlight important nuances in how minority stressors may function as risk factors for SI among SGM youth.

Minority stressors and suicidal ideation

Four minority stressors (internalized stigma, microaggressions, and low family and significant other support) showed bivariate associations with next-year SI. These findings lend partial support to minority stress theory's assertion that experiencing minority stressors may lead to greater mental health problems, including SI (Meyer, 2003). That is, experiencing certain sexual minority stressors raised SGM-AFAB youth's risk for experiencing next-year SI. However, results did not support all minority stressors as risk factors for SI; specifically, SGM victimization and low friend support were not associated with SI in the following year. These findings suggest that it may be important to differentiate between various minority stress experiences when using minority stress theory to understand SI in this population.

The present pattern of findings suggest that minority stressors reflecting "everyday" experiences, including microaggressions and perceived social support, maybe more powerful in predicting SI than are acute victimization events, such as being physically assaulted based on one's SGM identity. As such, they are consistent with the integrative model of psychosocial stress (Wagner et al., 1988), which holds that chronic but not acute negative events are directly related to increased psychopathology. Previous research in SGM populations has similarly found that "everyday discrimination" has a greater impact on some mental health concerns than does victimization (e.g., Scandurra et al., 2017; Woodford et al., 2014), in keeping with this model of psychosocial stress. Although preventing acute incidents such as hate crimes is certainly a worthy endeavor, these results speak to the importance of promoting a more welcoming environment overall to SGM people, even in "smaller" ways, when looking to prevent suicidality.

Racial/Ethnic differences

A novel contribution of this study is the identification of racial differences in minority stress risk factors for SI among SGM youth. First, Latinx (vs. White or Black) participants were more strongly affected by a lack of support from friends. According to the risk hypothesis (e.g., Meyer, 2010), this finding may reflect that Latinx SGM youth experience worse psychological effects of rejection by peers or friends than White SGM youth, because they are simultaneously experiencing racism due to their racial minority identity (though it does not explain the difference with Black SGM youth). It is surprising that this racial difference emerged for friend support, given that much of

the literature on mental health problems and Latinx youth focuses on their strong connection to their families rather than friends (Zayas & Pilat, 2008). However, such theorizing was based on cisgender, heterosexual youth; it may be that SGM Latinx youth turn to their friends in the place of family if they face rejection from family members due to their SGM identity.

Second, findings suggest that support from a significant other may be a particularly important protective factor against SI for Black, versus White or Latinx, SGM youth. This is consistent with evidence from the general population that low social support is a stronger predictor of suicidality for Black vs. White female youth because Black youth may rely on social support cope with racial discrimination (e.g., Langhinrichsen-Rohling et al., 2009). It is not clear why this racial difference was specific to social support coming from a significant other, versus family or friends, especially given the importance that U.S. Black culture often places on family, including extended or fictive kin networks, in efforts to cope with discrimination (Billingsley & Caldwell, 1991; Follins et al., 2014; Sarkisian & Gerstel, 2004). Nevertheless, it broadly supports the importance of building social support in efforts to prevent suicidality in Black SGM youth.

Finally, internalized stigma was associated with SI only for White SGM-AFAB, and not their Black or Latinx counterparts. This finding is consistent with past studies that have found White SGM people to be at higher risk than SGM POC of experiencing the negative effects of internalized stigma (e.g., Moradi et al., 2010). Some have suggested that one method by which SGM POC cope with SGM discrimination is through active self-acceptance (Della et al., 2002; Moradi et al., 2010), a process which White SGM youth may not be accustomed to given that they have not had to learn to affirm their racial identity. Thus, consistent with the resilience hypothesis (Bowleg et al., 2003), SGM POC may have developed a coping mechanism against internalized stigma from exposure to racism, which White SGM have not.

Clinical implications

Because history of SI was the strongest predictor of follow-up SI, SGM clients with a recent history of suicidality should be closely monitored for recurrence in the following year. Some treatments that have shown efficacy in reducing SI in adults include cognitive therapy for suicide prevention (Brown et al., 2005), cognitive behavioral therapy (Stewart et al., 2009), and psychodynamic interpersonal therapy (Guthrie et al., 2001). For adolescents with families willing to participate in treatment, attachment-based family therapy may reduce SI (Diamond et al., 2010).

There are few treatment studies targeting suicidality for SGM people in particular (Brown & Jager-Hyman, 2014), although there is preliminary support for the effectiveness of attachment-based family therapy for sexual minority adolescents (Diamond et al., 2012).

Further, findings suggest that clinicians working with SGM youth should assess for and monitor levels of internalized stigma, exposure to microaggressions, and a lack of social support, in addition to general-population risk factors, so that they can intervene in these areas to reduce risk for SI, if needed. Although evidence-based interventions to reduce minority stressors in SGM populations is lacking, there is some evidence for the effectiveness of affirmative cognitive behavioral and mindfulness therapies on reducing minority stress levels, both in individual and group settings (see Chaudoir et al., 2017 for a review). It is also important for clinicians to consider how stressors unrelated to a SGM client's gender or sexuality may be contributing to their suicidality, as SM adolescents in past studies have reported perceiving both minority stressors and other stressors as main contributors to their suicidality (Diamond et al., 2011).

Limitations and future directions

There were four main limitations to our study. First, the use of a convenience sample limits generalizability to other SGM-AFAB youth. Participants were living in a large city with more positive societal attitudes toward SGM than most other localities in the US (Persad, 2020). Thus, they may experience fewer SGM-related minority stressors and display different associations between minority stressors and suicidality than SGM-AFAB youth in more conservative parts of the country.

Second, although the diversity of our sample improved upon past research, we were not able to capture experiences for all SGM people. Due to lack of power and low numbers, we excluded participants who were not Black, Latinx, or White, and collapsed specific sexual and gender identities into categories. Future research should seek to include large enough numbers of other racial/ethnic, sexual, and gender identities to allow for examination of their unique minority stressors and SI experiences and potentially elucidate their unique clinical needs.

Third, though the assessment of SI at 6- and 12-month follow-up provided relatively rare and valuable prospective longitudinal data, the 6-month intervals between assessments are not ideal for capturing changes in SI, which can fluctuate dramatically over the course of days or even hours (Kleiman et al., 2017). Further, asking participants to recall the presence of SI over the past 6 months is subject to the problems associated with retrospective reporting.

Daily diaries or ecological momentary assessments would better capture real-time fluctuations in SI, and their potential within-person associations with minority stress in future research.

Fourth, though we conceptualized low social support as a minority stressor due to the rejection that young SGM commonly face from family (Ryan et al., 2009) and peers (Katz-Wise & Hyde, 2012) due to their SGM identity, we used a general measure of social support that was not specific to support for one's sexual or gender identity. Therefore, it is possible that the low social support putting participants at risk for elevated SI was unrelated to their SGM identity, and simply reflects risk the common, population-wide risk factor of low general social support (Miller et al., 2015; Scardera et al., 2020). Future research that specifically assesses low support due to one's stigmatized identity (e.g., family and peer rejection of one's non-heterosexuality) is needed to clarify whether this represents a sexual minority stressor or a common risk factor for SI across all young people.

CONCLUSIONS

This study extends the limited longitudinal research to date on SGM youth suicidality by examining the prospective effect of minority stressors on SI over the following year. Levels of internalized stigma, microaggressions, and low social support each predicted next-year SI for SGM-AFAB youth. Further, our findings suggest that low social support can predict SI beyond that accounted for by past SI, pointing to the particular importance of surrounding SGM youth with positive relationships. Lastly, findings indicate that certain minority stressors, such as internalized stigma and low friend support, operate as risk factors for suicidality for certain SGM youth of certain races (White and Latinx, respectively), but not others, highlighting the importance of attending to the unique, intersecting social identities of SGM youth in efforts to prevent and treat. Promoting support for SGM youth both on an individual level (i.e., via supportive family and friend relationships) and in society at large (i.e., to reduce exposure to microaggressions) may be important targets for reducing disparities in suicidality faced by SGM youth.

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CONFLICT OF INTEREST

We have no conflicts of interest to report

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, SW, upon reasonable request.

ETHICS STATEMENT

This study was approved by the IRB at Northwestern University.

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