Suicidality among sexual and gender minority youth

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CHAPTER 1

General introduction

Sexual and gender minority (SGM) adolescents and young adults are at higher risk of poorer physical and mental health than cisgender, heterosexual adolescents and young adults. For example, SGM individuals are at higher risk for suicidal ideation and attempts, depressive symptoms, anxiety, and substance use (Kiekens et al., 2020; Kuyper, 2015; Lucassen et al., 2017; Marshal et al., 2011; Salway et al., 2021; Williams et al., 2021). This dissertation centers around suicidal ideation and suicide attempts among SGM adolescents and young adults. The dissertation consists of four studies that focus on risk and protective factors for suicidal ideation and suicide attempts among SGM adolescents and young adults, as well as what can be improved in mental healthcare and social support to better support SGM individuals with suicidal ideation or prevent suicidal ideation and attempts in SGM individuals. In Chapter 1 General introduction and Chapter 6 General discussion, I use *youth* to indicate adolescents and young adults, and throughout the dissertation, I use *suicidality* as an umbrella term to indicate suicidal ideation (i.e., thoughts of suicide) and attempts.

Gender identity and sexual orientation

There are several terms related to sexual orientation and gender that are important in my dissertation. Gender identity refers to how someone identifies in terms of gender (American Psychological Association, 2021). The terms cisgender and transgender are often used to indicate whether an individual identifies with the sex assigned at birth. Cisgender refers to when one's sex assigned at birth matches their gender identity, for example, when the sex assigned at birth is female and someone identifies as a woman. Transgender is an umbrella term that is often used to refer to individuals whose gender identity does not match the sex assigned at birth. It includes a diversity of gender identity labels or terms, for example, genderqueer person, gender nonbinary person, transgender man, and transgender woman. Genderqueer and nonbinary refer to when someone does not identify as man *or* woman, identifies as both or is fluid herein. Transgender woman refers to when one's sex assigned at birth is male but they identify as a woman. Transgender man refers to when one's sex assigned at birth is female but they identify as a man. It is important to note that there is a variety of gender identity labels, and gender identity can be fluid and is experienced differently by individuals. For the readability of this dissertation, I mainly use the terms cisgender, transgender, genderqueer, and nonbinary individuals.

Sexual orientation refers to whom someone is romantically, sexually or emotionally attracted to (American Psychological Association, 2021). Most used terms for sexual orientation in this dissertation are gay, lesbian, bisexual, pansexual, and queer. Whereas gay, bisexual and lesbian are well-known terms, pansexual and queer are less known terms. Gay refers to attraction to the same gender, bisexual refers to attraction to multiple genders, and lesbian refers to the attraction of women to women.

Further, pansexual refers to sexual, romantic, and/or emotional attraction regardless of gender. Queer could also refer to sexual, romantic, and/or emotional attraction that is not limited to one gender but is also used by individuals who do not identify as heterosexual or cisgender (American Psychological Association, 2021). In this dissertation, to indicate individuals who are not heterosexual and/or cisgender, I use the term sexual and gender minority (SGM) individuals.

Sexual and gender minority stress

Theoretical models on minority stress

The mechanisms behind health disparities in suicidality between SGM individuals and cisgender, heterosexual individuals are explained in several models on minority stress (Hatzenbuehler, 2009; Hendricks & Testa, 2012; Meyer, 2003). These models posit that SGM individuals may experience excess stress related to their sexual or gender identity, and this stress is additional to general stressors. Minority stress includes prejudice events resulting from stigma from a cisnormative and heteronormative society. Cisnormativity and heteronormativity refer to the assumption that being cisgender and heterosexual is the norm and this shapes how the world is viewed and society is organized (American Psychological Association, 2021; Bauer et al., 2009). Experiencing gender or sexual minority stress contributes to elevated mental health problems among SGM individuals (Hatzenbuehler, 2009; Hendricks & Testa, 2012; Meyer, 2003).

One of the founders of minority stress theory was Virginia Brooks (See V. R. Brooks, 1981), and subsequent minority stress models were built upon this minority stress theory (Rich et al., 2020). One model that is often used in literature and research on SGM individuals is Meyer's (2003) minority stress framework on the processes of minority stress and mental and physical health. This model distinguishes between proximal and distal stressors. Distal (external) stressors are environmental (individuals, families, society) prejudice events related to one's sexual orientation, for example, victimization, violence, stigma, and rejection. Proximal (internal) stressors are intrapersonal processes, for example, expectations that prejudice events like rejection or victimization will occur, or internalization of societal negative norms and values about gender expression or being non-heterosexual (internalized homonegativity) (Meyer, 2003). In addition, this framework includes factors that could mitigate or enhance the impact of minority stress on mental health, for example, coping and social support.

Hendricks and Testa (2012) proposed an adaption of the minority stress framework to make it better applicable to gender minority individuals. Gender minority individuals also encounter stressors related to their gender identities such as gender-related victimization, non-affirmation of their gender identity, and internalized transphobia (internalized transnegativity) (Hendricks & Testa, 2012; Testa et al., 2015). This model also includes resilience factors such as community connectedness and pride in one's

identity (Testa et al., 2015).

Next, the psychological mediation framework explains the psychological processes that could take place after experiences with stigma-related stressors such as discrimination and victimization (Hatzenbuehler, 2009). The framework posits that sexual minority individuals may experience increased stress because of stigma. This stress affects coping and emotion regulation (e.g., rumination), social and interpersonal processes (e.g., social isolation), and cognitive processes (e.g., negative self-schemas, hopelessness), which subsequently affects mental health (Hatzenbuehler, 2009).

Recently, Toomey (2021) has advocated for an adaptation of the minority stress models of Meyer (2003) and Hendricks and Testa (2012) regarding gender minority youth. Toomey suggested that these models are focused on adults rather than children or adolescents, and that developmental aspects should be taken into account when examining health disparities among gender minority youth. For example, children and adolescents do not have full autonomy and control over minority stressors, and coping and resilience are likely to change during adolescence. In addition, cisnormativity is present in several contexts of gender minority youth's lives (Toomey, 2021). The model proposed by Toomey (2021) includes two additional categories of minority stress 1) gender dysphoria emerging from physical anatomy and non-affirmation of gender identity and 2) access and use of healthcare.

In Figure 1.1, I combined the minority stress models that are described above and visualized the factors that are important in this dissertation.

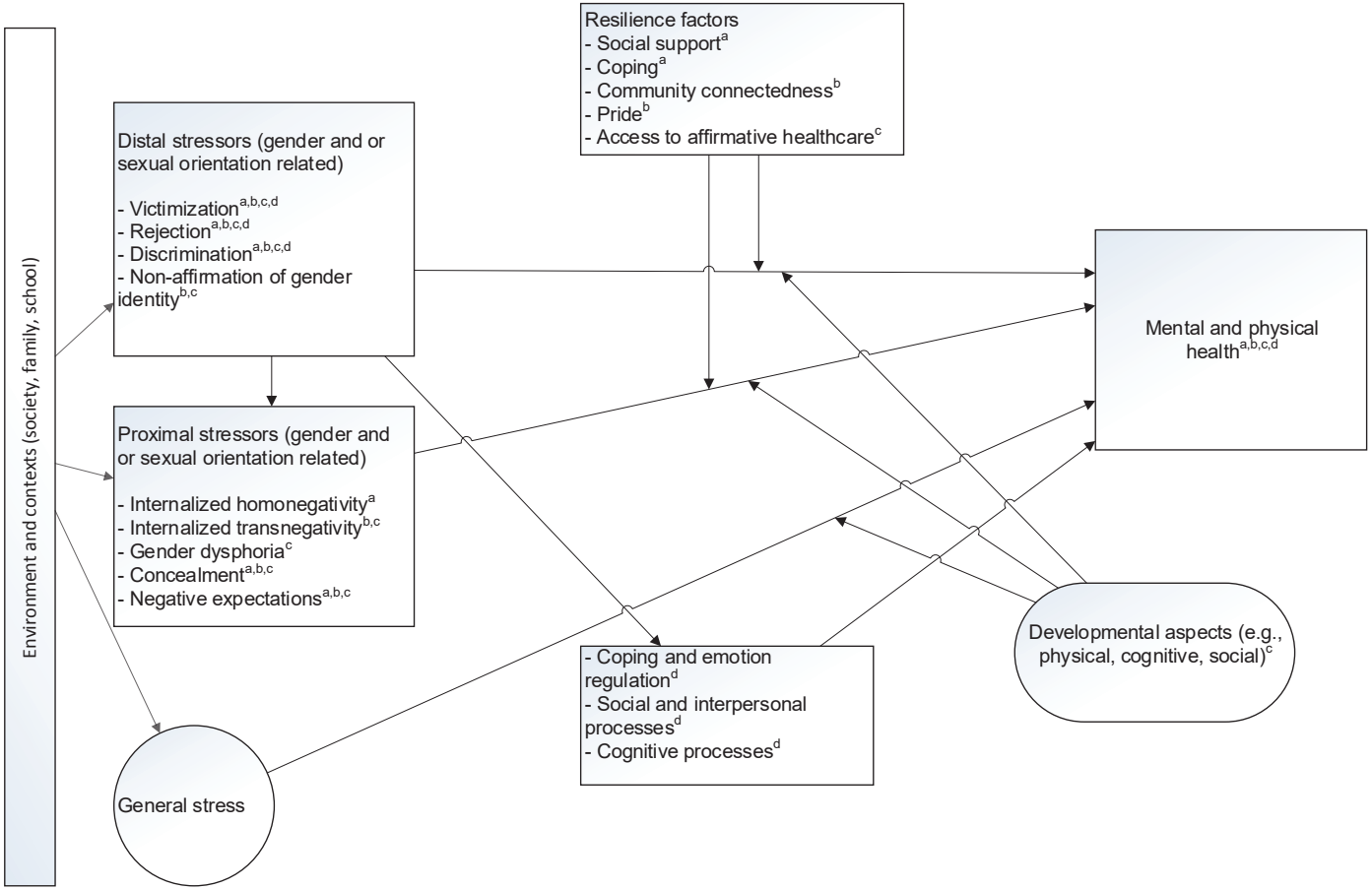

Figure 1.1 Visualization of the primary aspects of the minority stress models combined, with a. Meyer (2003), b. Hendricks and Testa (2012), c. Toomey (2021), and d. Hatzenbuehler (2009).

Empirical research on minority stress and mental health

Associations between different types of minority stress and adverse mental health outcomes such as anxiety, depression, psychological distress have been demonstrated by previous studies (Baams et al., 2015; Goldbach et al., 2017; Hall, 2018; Kaufman et al., 2020; Lea et al., 2014; Ryan et al., 2009; Tankersley et al., 2021). For example, distal stressors such as stigma, victimization, and family rejection were associated with more depressive symptoms and anxiety among sexual and gender minority youth (Baams et al., 2015; Chodzen et al., 2019; Goldbach et al., 2017; Hall, 2018; Kaniuka et al., 2019; Kaufman et al., 2020; Mustanski et al., 2016; Pariseau et al., 2019; Ryan et al., 2009; Tankersley et al., 2021). Proximal stressors such as internalized homonegativity (Goldbach et al., 2017; Newcomb & Mustanski, 2010), internalized transnegativity (Chodzen et al., 2019; Scandurra et al., 2018), and concealment of sexual or gender identity (Brennan et al., 2021; Testa et al., 2015) were also associated with more depressive symptoms and internalizing mental health problems. Taken together, research has demonstrated that various minority stressors are associated with depression and anxiety among SGM adolescents and young adults. Depression and anxiety are found to be associated with higher levels of suicidal ideation among SGM youth (Kaniuka et al., 2019; Mustanski & Liu, 2013). Because this dissertation has a focus on suicidal ideation and attempts among SGM youth, I will discuss theoretical models concerning suicidality and empirical research on minority stress and suicidal ideation and attempts in the next section.

Suicidal ideation and suicide attempts

Theoretical models on suicidal ideation and suicide attempts

Suicidal ideation is multifaceted, complex, and multiple factors play a role in the development of suicidal ideation (Joiner, 2005; Klonsky & May, 2015; O'Connor & Kirtley, 2018). Building on prior theoretical and empirical research, several theoretical models describe the development of suicidal ideation and attempts. Three of these models are described in this section and aspects of these models recur throughout this dissertation.

First, the integrated motivational-volitional model (IVM) of suicidal behavior (O'Connor & Kirtley, 2018) suggests that the pathway towards suicidal ideation and suicide attempts occurs in three phases. An important asset of this model is that it distinguishes between the phases of suicidal ideation and suicide attempts. The first phase is the pre-motivational phase, which describes background, intrapersonal and interpersonal factors (e.g., life events, individual vulnerabilities) that put an individual at risk of developing suicidal ideation. Background factors and interpersonal factors may lead to defeat and humiliation, which is described in phase two 'the motivational phase'. Several factors can affect defeat and humiliation, for example, maladaptive coping, rumination, and memory biases (threat to self-moderators), and this could lead to entrapment. Subsequently, factors such as lack of resilience, lack of social support,

and perceived burdensomeness affect entrapment and may lead to suicidal ideation and intent. Then, in the third phase, the volitional phase, factors such as impulsivity, access to means of suicide, exposure to suicide (volitional moderators) are described that affect the transition from suicidal ideation to suicide attempts (O'Connor & Kirtley, 2018).

Second, the interpersonal-psychological theory of suicide (IPTS) (Joiner, 2005; Van Orden et al., 2010), suggests that two proximal factors contribute to the development of suicidal ideation: thwarted belongingness and perceived burdensomeness. Thwarted belongingness refers to a low sense of belonging, and includes loneliness and lack of reciprocal care. Perceived burdensomeness refers to one's feeling of being a burden to people close to them or society and includes self-hate and liability (the belief that others are better off without them) (Van Orden et al., 2010). The IPTS suggests that a combination of thwarted belongingness and perceived burdensomeness can lead to suicidal desire (active suicidal ideation). In addition, acquired capability in combination with suicidal desire could lead to a suicide attempt. Acquired capability includes a "lowered fear of death" and an "elevated physical pain tolerance"(Van Orden et al., 2010, p. 586).

Last, the ideation-to-action framework (Klonsky & May, 2015), describes the pathway to suicidal ideation and attempts in three steps. The first step includes the development of suicidal ideation. A *combination* of emotional or psychological pain and hopelessness contributes to the development of suicidal ideation. Pain is not specified and could be any source of pain and it also includes factors such as low belonging and defeat and entrapment (Joiner, 2005; O'Connor & Kirtley, 2018). In the second step, connectedness (also listed by Joiner as thwarted belongingness and perceived burdensomeness) is proposed by Klonsky and May (2015) to be a protective factor against increasing levels of suicidal ideation among those who experience suicidal ideation. The ideation-to-action framework hypothesizes that when an individual's pain or hopelessness is lower than their connectedness, suicidal ideation or desire for suicide will not increase. The third step includes the potential transition from ideation to an attempt. The transition is dependent on three factors that affect suicide capacity. These factors are dispositional (e.g., pain sensitivity), acquired (e.g., increased tolerance for pain or fear), and practical (e.g., access to lethal means) (Klonsky & May, 2015).

Sexual orientation, gender identity, and suicidality

Prior research has shown that sexual and gender minority youth are more likely to report suicidal ideation and attempts than heterosexual, cisgender youth (Horwitz et al., 2020; Lefevor, Boyd-Rogers, et al., 2019; Marshal et al., 2011; Perez-Brumer et al., 2017; Rimes et al., 2019; Toomey, Syvertsen, et al., 2018; Williams et al., 2021). Prior studies also showed that there are differences in risk for suicidality by sexual orientation among sexual minority youth (Horwitz et al., 2020; Salway et al., 2019). For example,

meta-analytic studies found that bisexual individuals are at higher risk for suicidality than lesbian and gay (Hottes et al., 2016; Salway et al., 2019) or non-bisexual individuals (Marshal et al., 2011). Similar to these meta-analytic studies, a study among college students found that pansexual and bisexual students were more likely to report suicidal ideation (Horwitz et al., 2020). Horwitz (2020) included a broader measure of sexual orientation that included queer and pansexual; however, there is limited research that examined differences in risk for suicidality by sexual orientation that included queer and pansexual orientations.

In addition, differences in risk for suicidal ideation and attempts by gender identity among gender minority youth are under-researched, and results are inconclusive (Horwitz et al., 2020; Lefevor, Boyd-Rogers, et al., 2019; Rimes et al., 2019; Thoma et al., 2019; Toomey, Syvertsen, et al., 2018). For example, one study found that transgender young men were more likely than nonbinary youth to report suicidal ideation (Thoma et al., 2019), while other studies did not find differences in risk for youth with different minority gender identities (Horwitz et al., 2020; Lefevor, Boyd-Rogers, et al., 2019; Rimes et al., 2019). Similar inconclusive results were found for suicide attempts: some studies found differences in risk for suicide attempts among gender minority youth (Rimes et al., 2019; Thoma et al., 2019; Toomey, Syvertsen, et al., 2018), while other studies did not find differences for risk in suicide attempts (Horwitz et al., 2020). In addition, most studies examining differences in risk for suicidality compared SGM to non-SGM individuals, or compared gender minority individuals to cisgender individuals. Because both gender minority and sexual minority youth are at higher risk for suicidal ideation and attempts than non-SGM youth (Marshal et al., 2011; Perez-Brumer et al., 2017; Salway et al., 2021), it is also important to examine differences in risk among SGM youth, including differences among sexual minority and among gender minority youth.

Risk and protective factors for suicidality

Several studies have shown associations between various minority stressors and suicidality among SGM youth (Hatchel, Polanin, et al., 2019; Testa et al., 2017; Williams et al., 2021). Studies demonstrated that proximal stressors such as victimization, bullying, family rejection, and stigma were associated with suicidal ideation and attempts (Baams et al., 2015; Mustanski & Liu, 2013; Perez-Brumer et al., 2017; Ryan et al., 2009; Taliaferro & Muehlenkamp, 2017; Van Bergen et al., 2013), and distal factors such as internalized homophobia and transphobia were associated with suicidal ideation (Kuper et al., 2018; Lea et al., 2014). No association was found for internalized homonegativity or internalized transnegativity and suicide attempts (Kuper et al., 2018; Livingston et al., 2015).

In addition, empirical research among SGM individuals has shown direct associations of social support and coping with mental health and suicidality (Bos et al.,

2014; Shilo & Mor, 2014; Taliaferro & Muehlenkamp, 2017; Toomey, Ryan, et al., 2018). Studies found that maladaptive coping strategies such as avoidant coping, emotion-oriented coping, and denial were associated with poorer mental health outcomes (Bos et al., 2014; Budge et al., 2014; Lehavot, 2012). Adaptive coping strategies such as problem-oriented coping, acceptance, and LGBT-specific coping were associated with less depressive symptoms or less psychological distress (Bos et al., 2014; Lehavot, 2012; Toomey, Ryan, et al., 2018). Further, studies among SGM youth found that support from family, parents, and peers or friends was associated with a lower likelihood for depression (Parra et al., 2018; Watson et al., 2019). Parent support, parents connectedness, and parent acceptance were associated with lower odds of suicidal ideation and attempts (Bauer et al., 2015; Gower et al., 2018; Ryan et al., 2010; Taliaferro & Muehlenkamp, 2017).

The minority stress models of Meyer (2003) and Hendricks and Testa (2012) suggest that factors such as coping and social support attenuate or exacerbate the impact of minority stress on mental health. However, research on whether coping attenuates or exacerbates the impact of minority stress on mental health is limited, especially regarding suicidality. Studies among sexual minority adults that did examine this, did not find that avoidant or problem-oriented coping attenuated or exacerbated the association between homophobic violence and mental health (D'haese et al., 2016), or the associations between internalized heterosexism, heterosexist events and psychological distress (Szymanski, 2009; Szymanski & Owens, 2008).

Further, few studies examined whether social support attenuated or exacerbated the impact of minority stress on suicidality. A study that did examine it, indicated that social support attenuates the impact of minority stress on suicidal ideation and attempts (Trujillo et al., 2017). For example, a study among transgender individuals demonstrated that social support from friends and a significant other mitigated the association between harassment and suicidal ideation. However, social support from family did not mitigate the association (Trujillo et al., 2017). In another study among transgender individuals, family support also did not attenuate the association between gender-related discrimination and suicidal ideation (Scandurra et al., 2017). In addition, a study among sexual minority young adults examined whether social support attenuated the association between entrapment and suicidal ideation (Parra et al., 2021). This study demonstrated that family belongingness attenuated the association between entrapment and suicidal ideation, and friend belongingness and sexual minority community belongingness did not attenuate this association (Parra et al., 2021).

In sum, research on whether coping or social support attenuates or exacerbates the impact of minority stress on suicidal ideation or attempts is limited and findings are inconclusive. To optimize suicide prevention efforts among SGM youth it is important to understand the possible risk factors and protective factors but is it also important to learn what the mental healthcare needs of SGM youth are.

Mental healthcare for SGM youth

Since SGM youth are at risk for suicidal ideation and attempts, SGM youth with suicidal ideation must receive adequate mental healthcare. Up to now, there has been limited research regarding SGM youth's mental healthcare needs. Research that did examine healthcare needs has shown that mental and physical healthcare do not yet meet the needs of SGM young individuals (Fuzzell et al., 2016; Goldberg et al., 2019; Macapagal et al., 2016; White & Fontenot, 2019). SGM youth experienced, for example, barriers to disclosing their SGM identity in healthcare settings (H. Brooks et al., 2018), such as confidentiality concerns, fear of discrimination, and the use of non-inclusive language (H. Brooks et al., 2018). Further, gender minority youth reported that mental health professionals had a lack of knowledge about being transgender (Goldberg et al., 2019; Schimmel-Bristow et al., 2018), and SGM youth experienced disrespectful behavior and non-affirmation of their gender identity by physicians and pediatrics (Goldberg et al., 2019; Gridley et al., 2016; Snyder et al., 2017).

Further, to provide mental healthcare that fulfills the needs of SGM youth it is also important to know professionals' and parents' perspectives on mental healthcare for SGM youth. However, limited research is conducted on professionals' and parents' perspectives. A study among mental health professionals demonstrated that not all professionals felt competent in working with SGM youth (Hughes et al., 2018), and mental health professionals and pediatric residents felt they lacked knowledge or confidence in discussing SGM youth's issues (Hughes et al., 2018; Zelin et al., 2019). In addition, in a study among caregivers of a transgender child, caregivers articulated the need for support concerning the transitioning process of the child (Schimmel-Bristow et al., 2018). However, not much is known about parents' needs in supporting their SGM child with suicidal ideation. In short, healthcare does not meet the needs of SGM youth, and the needs of SGM youth with suicidal ideation are not yet known.

The current study and outline of the dissertation

To better understand what is needed to optimize suicide prevention efforts, mental healthcare, and social support for SGM youth, this dissertation aims to identify risk and protective factors for suicidal ideation and attempts among SGM youth as well as needs for mental healthcare and social support.

This dissertation contributes to the literature by addressing research gaps regarding suicidal ideation and attempts among SGM youth.

The following research questions are examined:

1. To what extent are minority stressors associated with suicidal ideation and suicide attempts among sexual and gender minority adolescents and young adults?

2. Are there differences by gender identity in risk for suicidal ideation and suicide attempts among SGM young adults? And is the association between gender identity and suicidal ideation and attempts moderated by social support?

3. Are coping styles (active, avoidant, and passive) associated with suicidal ideation and attempts among SGM young adults, and is the association between victimization, internalized homonegativity, and stigma consciousness and suicidal ideation and attempts moderated by coping style?

4. What are the experiences and needs of SGM young adults with a history of suicidal ideation, parents of SGM youth, and professionals and volunteers regarding formal mental healthcare and informal social support for SGM youth with suicidal ideation?

These research questions are answered in chapters 2 to 5.

Chapter 2 "Minority stress and suicidal ideation and suicide attempts among lesbian, gay, bisexual, and transgender adolescents and young adults: A meta-analysis". This chapter presents a meta-analytic study on minority stressors and suicidal ideation and suicide attempts among SGM adolescents and young adults. Ten separate three-level meta-analyses were conducted for the associations between six minority stressors (LGBT bias-based victimization, discrimination, bullying, general victimization, internalized homophobia and transphobia, and negative family treatment) and two suicidality outcomes (suicidal ideation and suicide attempts). Further, we examined whether sampling strategy moderated the associations between minority stressors and suicidal ideation and attempts.

Chapter 3 "Differences in risk for suicidal ideation and attempts among sexual and gender minority young adults and the moderating role of social support". This chapter presents a study that focused on differences in risk for suicidal ideation and attempts among SGM young adults by gender identity. We examined differences in risk for lifetime suicidal ideation, past-year suicidal ideation, and lifetime suicide attempts among transgender women, transgender men, genderqueer individuals assigned female at birth, genderqueer individuals assigned male at birth, cisgender women, and cisgender men. In addition, in this study, we examined whether social support (heterosexual friends, LGBT friends, family, and LGBT community) moderated the association between gender identity and suicidal ideation and attempts.

Chapter 4 "The moderating role of coping in the association between minority stress and suicidal ideation and attempts among sexual and gender minority young adults".

This chapter presents a study that focused on the associations of minority stressors (LGBT-related victimization, internalized homonegativity, and stigma consciousness) and coping styles (active, avoidant, and passive) with suicidal ideation and attempts among SGM young adults, and whether these coping styles moderated the associations of LGBT-related victimization, internalized homonegativity, and stigma consciousness with suicidal ideation and attempts. We assessed this for sexual and gender minority young adults separately.

Chapter 5 “Experiences and needs of sexual and gender minority young adults with a history of suicidal ideation regarding formal and informal mental healthcare”. This chapter presents a qualitative study that examined perceptions and needs of mental healthcare and informal social support for SGM youth with suicidal ideation. This was examined within three groups: 1) SGM young adults with a history of suicidal ideation, 2) parents of SGM youth with suicidal ideation, and 3) professionals and volunteers who worked with SGM youth with suicidal ideation.

Last, in **Chapter 6** “General discussion” I summarize, review, and discuss the findings of all four studies in light of the minority stress and suicidality frameworks, and discuss implications for practice and future research.