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A Mediator of Mental Wellness Discrepancies in Sexual Minority Youth

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ABSTRACT: One hundred ninety-seven adolescents (14-19 years of age; 70% female; 29% sexual minority) completed sexual minority-specific victimization, depressive symptoms, and suicidality steps at six months apart at two stages. Sexual minority adolescents reported higher levels of sexual minority-specific victimization, depressive symptoms, and suicidality relative to heterosexual youth. The influence of sexual minority status on depressive symptoms and suicide was significantly mediated by sexual minority-specific victimization. The findings support the theory of minority stress that targeted harassment and victimization are partly responsible for the higher levels of depressive symptoms and suicidality observed in young people living in sexual minorities. This study supports policies in public policy that minimize bullying and hate crimes because mitigating victimization can have a direct effect on the health and well-being of youth of sexual minorities.

KEYWORDS: Centers for Disease Control and Prevention (CDC), Institute Of Medicine (IOM), Sexual Minority Youth (SMY), Youth Risk Behavior Survey (YRBS).

I. INTRODUCTION

Sexual minority youth (SMY; young people who are attracted to the same sex, engage in same-sex sexual activity, or promote a gay/lesbian/bisexual identity) and heterosexual youth have major mental health differences. A new meta-analysis of 24 SMY mental health research found that SMY has higher rates of depression and higher rates of suicidality than heterosexual youth (suicide ideation and suicide attempts). In particular, as the severity of the suicidality measure increased, the effect size for the relation between sexual minority status and suicidality increased (e.g., a larger effect size for actual suicide attempts than for having suicidal thoughts). SMY was nearly twice as likely to report suicidal ideation compared to heterosexual teens, more than three times as likely to report suicide attempts, and more than four times as likely to report a suicide attempt that needed medical attention [1]. This result is particularly concerning since it demonstrates that there is not only a large and general difference in SMY's mental health, but the disparity is highest among the most extreme outcomes of mental health (e.g., attempted suicide). In addition, a new study found that in the past 12 months, 22 percent of SMY in the 11th grade attempted suicide, compared to 4 percent of heterosexual teens. Research clearly indicates strong differences in depression and suicide outcomes between SMY and heterosexual young people.

However, the differences are not confined to depression and suicide. A new study by the Centers for Disease Control and Prevention (CDC) showed that in 7 out of 10 health behavior categories (violence, attempted suicide, tobacco use, alcohol use, other substance use, sexual habits, and weight management, SMY has a higher prevalence of health-risk behaviors compared to heterosexual youth. There is a clear and pressing need for more research in SMY health disparities, a need reiterated by the Healthy People 2020 initiative and a recent report by the Institute of Medicine (IOM) commissioned by the National Institutes of Health. In particular, there is a need for research which identifies explanatory mechanisms for these disparities[2].

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The present study explores the hypothesis of minority stress as an explanatory mechanism for understanding the differences between SMY in depression and suicidality. The root causes of the SMY inequalities have only just started to be studied. The theory of minority stress contends that the stigma, racism, and inequality faced by lesbian, gay, and bisexual people produce a hostile social atmosphere that can contribute to chronic stress and issues with mental health [3]. Most research to date has therefore centered on victimization based on sexual minority status (i.e. being targeted for bullying and harassment, ranging from verbal slurs to physical assault based on one's real or perceived sexual identity) on the cause(s) of the mental health inequalities among SMY[4].

Some aspects of the minority stress model have been tested through cross-sectional research and the findings usually support the model. For instance, SMY was 1.7 times more likely to report being attacked at school in a recent meta-analysis and 2.4 times more likely to report skipping school due to fear. In addition, sexual identity-based victimization was found to have a significant effect on SMY's mental health. SMY with higher levels of victimization is 2.6 times more likely to experience depression and 5.6 times more likely to attempt suicide than SMY with lower levels of victimization; and SMY with higher levels of victimization is more likely to participate in health risk behaviors than SMY with lower levels of victimization and heterosexual youth, with the latter two categories not varying[5].

The adverse effects of victimization based on the identity of a sexual minority are not confined to those young people who are currently classified as a sexual minority. Swearer et.al used cross-sectional evidence and found that, regardless of their real sexual orientation, boys bullied by being labeled "gay" were more likely to encounter psychosocial stress than those bullied for other reasons. Similar findings were observed in one longitudinal sample. Specifically, even after adjusting for anxiety and depression identified a year earlier, boys who are abused based on actual or perceived sexual identity experience greater levels of anxiety and depression. Neither study, however, assessed sexual minority status, so they could not establish if SMY was disproportionately impacted by sexual minority-specific victimization. Taken together, current evidence shows that the victimization encountered by being a sexual minority that is responsible for these negative effects is not the sexual minority status that causes mental health and adjustment issues[6].

A few studies have used indicators of sexual minority status, victimization and prejudice, and mental health to test cross-sectional mediation models of the minority stress hypothesis in youth (14-18 years of age), the findings of which have generally validated the hypothesis. Almeida et.al, for instance, used cross-sectional data to illustrate that perceived prejudice partly clarified the association between sexual minority status and emotional distress. In order to demonstrate that victimization partly explains the association between sexual minority status and externalizing activities (e.g., violence, behavioral issues, and delinquency), Williams et.al. also used cross-sectional evidence. Notably, to test the minority stress hypothesis, both of these studies used cross-sectional data. By testing the minority stress hypothesis in SMY using a longitudinal model, a sexual minority-specific stress variable, and a heterosexual comparison group, we aim to broaden their results by testing all the requisite components to more thoroughly evaluate the key tenets of the hypothesis of minority stress[7].

II. HYPOTHESES AND OVERVIEW

In order to explicitly test the minority stress hypothesis, our research used a six-month longitudinal design, specifically that SMY experiences greater sexual minority-specific victimization than heterosexual youth and that such victimization is at least partially responsible in SMY for elevated levels of depression and suicidality. We anticipated that, relative to heterosexual adolescents, SMY would show more sexual minority-specific victimization, depressive symptomatology, and suicidality, and that these variables would be positively associated. We also predicted that the association between sexual minority status and mental health outcomes will be clarified by greater sexual minority-specific victimization. We used a mediation model to evaluate this prediction, which is a statistical method used to classify causal mechanisms for the impact of a predictor (e.g., sexual minority status) on an outcome (e.g., depressive symptoms / suicidality) (e.g., sexual minority specific victimization)[7].

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III. DISCUSSION

SMY has been described as an at-risk demographic by recent studies and government reports and has reported mental health inequalities in this population. In order to extend this study, the current project was designed to use a longitudinal method to define one factor that is at least partly responsible for SMY mental health inequalities. In particular, the present research explored the model of minority stress as an explanatory mechanism for the understanding of the possible causes of SMY inequalities. The model of minority stress indicates that the oppression and abuse faced by sexual minorities, among other factors, contribute to negative health outcomes. The findings were consistent with previous studies in that more sexual minority-specific victimization and a higher prevalence of depressive symptoms and suicidality were identified by SMY relative to heterosexual peers. The minority stress hypothesis was validated by experimental mediation models and found that the higher incidence of depressive symptoms and suicidality in SMY were partially responsible for elevated levels of sexual minority-specific victimization[8].

It was clear the mediation paradigm for depressive symptomatology. Sexual minority-specific victimization mediated the relationship between sexual minority status and depressive symptoms 6 months later by adjusting for depressive symptoms assessed six months prior. The model of mediation for suicidality was less evident. Due to a baseline calculation constraint, the recent history of suicidality in the model could not be monitored. Therefore, two models of mediation were run: one controlling depressive symptoms for recent history and other controlling suicidality for life history, the former of which was important while the latter was not. Suicidality in small samples is a difficult construct to research because it has a low base rate, making statistical modeling hard. Furthermore, only slight changes in suicidality rates or severity over a six-month time period may occur that are difficult to capture without performing a more in-depth clinical interview with participants that was outside the reach of this research. However, because of its seriousness, it is an important construct to study; any degree of suicidality is harmful and can potentially lead to loss of life if left unrecognized or untreated. Results suggest that the relationship between sexual minority status and suicidality is partly explained by sexual minority-specific victimization; however, the intensity of the effect is possibly lower than that observed for depressive symptoms[9].

In recent years, the victimization of children, particularly in the form of bullying, has become a priority of public health officials in the United States. Bullying is associated with a number of adverse effects, including increased school absence, lower grades, decreased school ownership (suicide safety factor) and the risk of sexually transmitted infections (STIs), including HIV. Bullying, in its severe, is widely cited as a contributing factor in youth suicide in media studies. Our findings support the connection between bullying and suicide, at least among young people who are thinking about suicide or surviving a suicide attempt. There is no research of suicide finishers that has explored victimization. However, study using the Youth Risk Behavior Survey (YRBS) has also found that a major indicator of suicide attempts is victimization. Moreover, meta-analytic studies indicate that as the incidence of suicidality increases, the difference between SMY and heterosexual youth for suicidality increases. For instance, while SMY is about twice as likely to report suicidal ideation, they are more than four times as likely to report a suicide attempt requiring medical treatment. It may be that these serious attempts are motivated by feelings of hopelessness that can be induced or compounded by victimization unique to the sexual minority[10].

Beyond the scope of this study is the basic mechanism(s) which explains how sexual minority-specific victimization contributes to increased depressive symptoms and suicidality. Some recent research, however, has delved into these relationships more deeply. A cross-sectional study of adults with sexual minorities, for example, found that internalized homo-negativity (internalization of derogatory social beliefs about homosexuality) and rejection sensitivity mediate the relationship between victimization and depressive symptoms unique to sexual minorities. Taken together, this research and the present study indicate that SMY develops negative feelings about who they are as an individual by experiencing sexual minority-specific victimization, and learns to anticipate intolerance and rejection, which can lead to increased depression and suicidality.

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IV. CONCLUSION

This research is not without restrictions. We used a sub-sample of young people from a larger NIH-funded ongoing study with an open enrollment design that will employ a total of 400 young people over a recruitment period of 4-5 years. Although the current subsample reflects just half of the total projected enrollment, with less statistical power than we would have at the end of the enrollment, statistically significant results are noteworthy even after the control of demographic covariates. At present, the sample size of the present study is too limited to look at SMY subgroups. Not all subgroups of the sexual minority face the same risk level. Research has found that SMYs who identify as bisexual and "mostly heterosexual" are at higher risk of drug use and depression than young people who identify as "100% heterosexual or "100% homosexual. It is possible to look at discrepancies between SMY subgroups, but to divide any minority group into subgroups needs very large sample sizes. In addition, SMY can experience different risk factors for racial/ethnic minorities than SMY for non-racial/ethnic minorities. The sample was overwhelmingly African American in the current study (63%), but it is not known if African American SMY varies from other racial/ethnic SMY groups on the studied variables in substantive ways. A benefit of this research over other comparable studies is the compilation of longitudinal data. While the longitudinal design is definitely strength, only 6 months was the period of time between measurement points. Future studies may look at SMY victimization and mental wellbeing over longer periods of time, and can use the technique of person trend modeling (e.g. latent growth curve modeling) to assess whether victimization continues to increase or decrease and whether the effects over time persist or dissipate.

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