At the Intersection of Racism and Heterosexism: Mental Health Risks for Black Sexual Minorities Youth

by

Bashaina Dumerant

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Approved by

Dr. Brian Gillis, Chair, Assistant Professor, Department of Human Development & Family Science
Dr. Joshua Novak, Associate Professor, Department of Human Development & Family Science
Dr. Scott Ketring, Associate Professor, Department of Human Development & Family Science, Program and Clinic Director, Marriage and Family Therapy

Abstract

Black sexual minority (SM) youth experience elevated exposure to racism, heterosexism, and other forms of discrimination, placing them at increased risk for adverse mental health outcomes. The present study examined differences in internalizing symptoms and suicidality among Black SM youth, White SM youth, and Black heterosexual youth and investigated whether racial discrimination, sexual minority discrimination, or both were associated with mental health outcomes among Black SM youth. Results indicated significant group differences in internalizing symptoms and suicidality. White SM youth reported significantly higher internalizing symptoms than Black heterosexual youth, whereas Black SM youth demonstrated marginally higher internalizing symptoms than Black heterosexual youth. Both Black and White SM youth reported significantly higher rates of suicidality than Black heterosexual youth. However, Black and White SM youth did not differ significantly from one another on either outcome. Among Black SM youth, experiences of racial and sexual minority discrimination were not significantly associated with internalizing symptoms or suicidality. These findings highlight elevated mental health risks among sexual minority youth while underscoring the complexity of understanding the role of discrimination among Black SM youth.

Artificial Intelligence (AI) Use Disclosure Statement

In the preparation of this thesis, no Artificial Intelligence (AI) tools were used.

Digital Accessibility Use Disclosure Statement

In the preparation of this thesis, the following digital accessibility tools were used to ensure this document complies with federal requirements: Adobe Acrobat Pro. The author acknowledges full responsibility for the intellectual content of this work and has made a good faith effort to comply with digital accessibility requirements in publishing, wherein the nature of the content does not significantly change in order to do so. Furthermore, all content has been reviewed and revised to meet these requirements prior to final publication.

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List of Abbreviations

ABCD	Adolescent Brain Cognitive Development
AFAB	Assigned Female at Birth
AMAB	Assigned Male at Birth
ASAB	Assigned Sex at Birth
ANCOVA	Analysis of Covariance
CBCL	Child Behavior Checklist
HSD	Honestly Significant Difference
KSADS-5	Kiddie Schedule for Affective Disorders and Schizophrenia (DSM-5 version)
MST	Minority Stress Theory
NCAVP	National Coalition of Anti-Violence Programs
SES	Socioeconomic Status
SM(s)	Sexual Minorities
TIMS	Temporal Intersectional Minority Stress Model

Chapter 1: Introduction

Research consistently demonstrates that sexual minorities (SMs), defined as individuals whose sexual orientation is not exclusively heterosexual, are at elevated risk for multiple forms of interpersonal victimization compared to their heterosexual peers (Coulter et al., 2017; Meyer, 2003; Sterzing et al., 2017; Williams et al., 2005). This pattern of violence has continued to worsen in recent years. For example, according to national crime data, reported hate crimes motivated by sexual orientation increased by 23 percent between 2022 and 2023 (Luneau, 2024). However, the victimization of SMs extends well beyond hate crimes and is pervasive across multiple social contexts. For example, a national survey of SM adolescents found that more than 80 percent reported experiencing physical assault, bullying, sexual victimization, and child maltreatment during their lifetime, with over 40 percent reporting exposure to multiple forms of victimization (Sterzing et al., 2017). In addition to experiencing higher rates of violence, SM youth also report lower levels of parental and peer support and greater social isolation compared to their heterosexual counterparts (Williams et al., 2005).

Black SMs are disproportionately impacted by such violence, with them being overrepresented in reports of hate crime and homicide (López et al., 2022; National Coalition of Anti-Violence Programs [NCAVP], 2018). Compared to their White survivors of hate crime, Black SM survivors were three times more likely to experience sexual violence, twice as likely to experience threats and intimidation, and overall, more likely to experience severe forms of victimization (Dunbar, 2006; NCAVP, 2018). Black SM youth are also more likely than White SM youth or Black heterosexual youth to experience bullying and other forms of school-based victimization, highlighting the

cumulative impact associated with holding multiple marginalized identities (Boyle & McKinzie, 2021; Peguero, 2012; Stilwell et al., 2026). Despite their heightened risk of victimization, Black SMs often face greater barriers to accessing social and institutional support following violence, particularly among low-income communities, which may further exacerbate the adverse consequences of victimization and discrimination (Meyer, 2010).

Beyond interpersonal violence, SMs face increasing systemic hostility at the policy level. The number of anti-LGBTQ+ bills being introduced by state legislatures increased dramatically from 115 in 2015 to 500 in 2023 (Robinson, 2023). Many of these legislative efforts target LGBTQ+ youth by restricting discussions of sexual orientation in schools, limiting access to affirming resources, or mandating disclosure of students' sexual orientation to parents (Robinson, 2023). These patterns of interpersonal and systemic violence coalesce to create a broader climate of stigma and discrimination that impacts the mental health of SM youths.

SMs experience elevated mental health risks compared to their heterosexual peers. Studies consistently demonstrate increased rates of internalizing symptoms, such as depression and anxiety, as well as increased suicidal ideation and attempts among SM youth (Bostwick et al., 2010; Cochran et al., 2003, 2007; Gilman et al., 2001; Hatzenbuehler, 2009; Russell & Fish, 2016). For example, national epidemiological data indicate that while 18 percent of SM youth meet diagnostic criteria for major depression, only 8.2 percent of heterosexual youth meet criteria (Kessler et al., 2012; Nock et al., 2013). Adolescence is a particularly critical developmental period, as longitudinal studies have found that disparities in mood disorders, anxiety disorders, and suicidality

between SM and heterosexual adults tend to emerge during adolescence (Fish & Pasley, 2015; Kessler et al., 2005, 2007; Needham, 2012; Ueno, 2010).

Research suggests that these mental health disparities are not due to sexual orientation itself, but rather chronic exposure to stigma, victimization, and discrimination (Hatzenbuehler, 2009). The Minority Stress Model (MST) claims that SMs experience unique and additive stressors, including enacted discrimination, identity concealment, internalized stigma, and expectations of rejection, that contribute to adverse mental health outcomes (Brooks, 1981; Meyer, 2003; Hatzenbuehler, 2009). However, although MST provides a strong explanatory framework, it does not fully account for intersecting marginalized identities (Calabrese et al., 2015; Meyer, 2003; Hatzenbuehler, 2009; Rivas-Koehl et al., 2023). Intersectionality theory argues that different systems of oppression, such as racism and heterosexism, operate simultaneously to produce a distinct experience for those who occupy multiple marginalized identities (Crenshaw, 1989). Consequently, Black SM youth may experience unique forms of minority stress arising from the intersection of racism and heterosexism, placing them at heightened risk for adverse mental health outcomes (Bowleg, 2013; The Trevor Project, 2020).

Despite extensive research linking discrimination to adverse mental health outcomes among SM youth, relatively few studies center the experiences of Black SM youth or examine within-group differences among SMs across ethnic and racial identities (Fish & Pasley, 2015). Consequently, it remains unclear whether the combined effects of racial and sexual orientation discrimination place Black SM youth at a greater risk for internalizing symptoms and suicidality than youth who experience only

one form of discrimination. This gap is particularly important given Black SM youths' disproportionate exposure to both interpersonal and systemic discrimination and victimization during adolescence, a developmental period characterized by increased vulnerability to the onset of many psychiatric disorders (Fish & Pasley, 2015; Human Rights Campaign, 2026; Kessler et al., 2005, 2007; Needham, 2012; Ueno, 2010). This current study addressed this gap by examining the effect of discrimination on internalizing symptoms and suicidality among three groups: Black SM youth, White SM youth, and Black heterosexual youth.

Chapter 2: Literature Review

The Impact of Discrimination on Internalizing Symptoms and Suicidality Among SM Youth

Discrimination refers to unfair treatment based on one's membership in a socially marginalized group (Meyer, 2003; Priest et al., 2013). Discrimination against SMs occurs across multiple social and institutional contexts, including public settings, schools, families, and systemic institutions. Research identifies three common forms of discrimination experienced by SMs: general discrimination in everyday public interactions, victimization through verbal and physical aggression, and discrimination within healthcare settings (Rice et al., 2021). For SM youth in particular, discrimination also undermines important sources of social support in the form of conflict within their friendship and family of origin. Compared to their heterosexual peers, SM adolescents report lower levels of parental closeness, reduced companionship with close friends, and greater feelings of social isolation (Williams et al., 2005). Qualitative studies have found that many SM youth validly fear rejection or loss of close relationships due to their sexual orientation, with 68 percent of homeless or at risk for being homeless SM youths reporting that the reason they are facing homeless is due to family rejection of their sexual orientation (Durso & Gates, 2012; Hershberger & D'Augelli, 1995; Martin & Hetrick, 1988; Savin-Williams, 1990). The prevalence of these experiences varies across the lifespan, with adolescents (aged 12-18) and young adults experiencing more sexual orientation-based discrimination compared to young children (aged 6-11) and older adults (aged 30+) (Rice et al., 2021; Schuler & Suryavanshi, 2026). The kind of discrimination also varies by age, with adolescents and young adults experiencing more

everyday general discrimination and verbal and physical aggression, while older adults experience more healthcare discrimination (Rice et al., 2019).

A growing body of literature suggests that there is a substantial psychological impact of discrimination on the mental health of SM youths. This impact is seen most clearly in two areas: internalizing symptoms and suicidality. Internalizing symptoms refer to behaviors that arise when a child directs their turmoil inwards and are typically expressed as depressive symptoms (e.g., excessive sadness and anhedonia), anxiety symptoms (e.g., excessive worry), and somatic complaints (e.g., nausea and headaches) (Achenbach, 1978; Liu et al., 2011). Suicidality refers to thoughts, plans, actions, attempts, and completion of ending one's life (Becker & Correll, 2020).

Compared to their heterosexual peers, SM youth experience higher levels of internalizing symptoms and suicidality (Bostwick et al., 2010; Cochran et al., 2003, 2007; Gilman et al., 2001; Hatzenbuehler, 2009; Russell & Fish, 2016). Rather than being attributable to sexual orientation itself, empirical studies consistently demonstrate that disparities in internalizing symptoms and suicidality among SM youth are due to discrimination, with numerous studies identifying discrimination as a reliable predictor of internalizing symptoms such as depressive and anxiety symptoms, somatic complaints, and suicidality (Almeida et al., 2009; Hatzenbuehler et al., 2010; Marshal et al., 2011; Schuler & Suryavanshi, 2026; Takeda et al., 2021). For example, a study by Burton et al. (2013) found that school-based victimization mediated the relationship between SM status and internalizing symptoms and suicidality, such that higher levels of victimization were associated with worse depressive symptoms and suicidality. Similarly, exposure to structural stigma, such as living in a state with more restrictive LGBTQ+ laws, is

associated with suicide attempts among SM populations (Hatzenbuehler et al., 2010; Raifman et al., 2017). The negative impact of discrimination on SM mental health is particularly strong for SM youth, with a study finding that the association between anti-LGB discrimination and suicidal behavior was significant only for those under 30 years old (Fish & Pasley, 2015; Russell & Fish, 2016). Overall, the literature consistently demonstrates that discrimination is pervasive across domains for SM youths and is associated with poorer psychological function.

The Impact of Discrimination on Internalizing Symptoms and Suicidality Among Black Youth

Similar to discrimination against SM youth, racial discrimination is a pervasive stressor that affects Black youth and occurs at interpersonal, institutional, and systemic levels across multiple contexts (Priest et al., 2013). Common discriminatory experiences include being called racial slurs, experiencing racial bias in healthcare, receiving poorer treatment in public settings, and encountering structural barriers to resources (Benner et al., 2018; Fisher et al., 2000). School-based discrimination is particularly common, with Black youth consistently reporting the highest rates of bullying and racial harassment compared to other racial and ethnic groups (Rhee et al., 2017; Stilwell et al., 2026). Adolescence is a particularly important developmental period for understanding the effects of racial discrimination because youth become increasingly aware of racial stereotypes, develop a stronger sense of racial identity, and gain a greater understanding of how racism shapes their daily experiences (Benner et al., 2018; Umaña-Taylor et al., 2014; Umaña-Taylor, 2016). Additionally, like mental health

disparities among SMs, mental health disparities among Black youth often emerge during early adolescence (Sanders-Phillips et al., 2009).

Research examining the mental health of Black youth reveals a complex pattern. Compared to White youth, Black adolescents often report a lower lifetime prevalence of internalizing symptoms such as depression and anxiety (Breslau et al., 2005, 2006). However, when these disorders occur, they tend to be more persistent and are associated with greater functional impairment (Breslau et al., 2005, 2006). Similarly, although suicide rates among Black adolescents have historically been lower than those of their White peers, Black youth experience disproportionately higher suicide rates at younger ages (Bridge et al., 2015). Studies suggest that there may be protective factors that help buffer the effects of racism on the mental health of Black youth, such as having a strong sense of racial pride and high involvement in the Black community (Herd & Grube, 1996; Sanders-Phillips et al., 2009). Other studies highlight that surveys assessing internalizing symptoms and suicidality may not be culturally attuned to Black populations (Sanders-Phillips et al., 2009). Nevertheless, racial discrimination has consistently been shown to worsen the mental health of Black youth, with chronic exposure to racism being linked to increased internalizing symptoms, including depression, anxiety, somatic complaints, and suicidality (Benner et al., 2018; Coker et al., 2009; Priest et al., 2013; Walker et al., 2017; Williams & Mohammed, 2009). Importantly, much of this research has examined Black youth as a relatively homogeneous group, with comparatively little attention given to variation in mental health outcomes across other marginalized identities, such as sexual orientation.

The Impact of Discrimination on Internalizing Symptoms and Suicidality Among Black SM Youth

Black SM youth face increased and unique barriers stemming from the interaction of their racial and SM identities (Meyer, 2010; Meyer & Frost, 2013). Compared to youth who belong to only one marginalized group, Black SM youth experience higher levels of discrimination, particularly in the form of school-based victimization (Boyle & McKinzie, 2021; Peguero, 2012; Stilwell et al., 2026). These experiences of discrimination often co-occur, as youth who report sexual orientation-based discrimination are also more likely to experience racial discrimination (Schuler & Suryavanshi, 2026). Recent evidence further suggests that youth with both minoritized racial and sexual identities experience greater racial discrimination than their heterosexual racial minority peers (Zhao et al., 2025). These intersecting forms of discrimination shape how SM youth of color navigate their families, communities, and broader society. For example, SM individuals with minoritized racial identities often navigate expectations within both White queer communities and Black heterosexual communities that privilege whiteness and heterosexuality, resulting in pressures to conceal aspects of either their racial or sexual identities to maintain social acceptance (Meyer & Frost, 2013). For Black SM individuals in particular, discrimination and victimization are often accompanied by concerns about negatively representing their racial community (Meyer & Frost, 2013). The cumulative nature of these experiences has important implications for the mental health of Black SM youth. Although research specifically examining Black SM youth remains limited, emerging evidence indicates that adolescents experiencing co-occurring forms of discrimination report substantially

higher rates of internalizing symptoms, particularly depression and anxiety, than their peers (Schuler & Suryavanshi, 2026). Collectively, these findings suggest that Black SM youth experience discrimination that is both more frequent and qualitatively different from that experienced by White SM youth or Black heterosexual youth.

Theoretical Framework

Minority Stress Theory. MST is among the most widely used frameworks for understanding mental health disparities among SMs. Originally developed by Brooks (1981) and popularized by Meyer (2003), the theory proposes that mental health disparities among SM individuals are not attributable to sexual orientation itself but rather to chronic exposure to stigma, prejudice, discrimination, and victimization (Brooks, 1981; Hatzenbuehler, 2009; Meyer, 2003). According to MST, SM individuals experience unique stressors in addition to the general stressors encountered by all individuals, resulting in an excess burden of stress that contributes to poorer mental health outcomes (Meyer, 2003). MST distinguishes between distal and proximal minority stressors. Distal stressors refer to objective external experiences, such as discrimination, harassment, victimization, rejection, and structural stigma (Meyer, 2003; Rivas-Koehl et al., 2023).

In contrast, proximal stressors involve internal psychological processes that develop in response to these experiences, including expectations of rejection, identity concealment, and internalized stigma (Meyer, 2003; Rivas-Koehl et al., 2023). Empirical research has broadly supported MST. Numerous studies have demonstrated that experiences of discrimination are associated with increased internalizing symptoms, including depression, anxiety, and suicidality, among SM youth (Almeida et al., 2009;

Hatzenbuehler et al., 2010; Marshal et al., 2011). Although MST has received considerable empirical support, the model has been criticized for conceptualizing minority stress primarily through a single marginalized identity. While the theory effectively explains how heterosexism contributes to adverse mental health outcomes among SM populations, it provides less guidance for understanding how multiple systems of oppression interact to shape the experiences of individuals who occupy more than one marginalized identity (Calabrese et al., 2015; Hatzenbuehler, 2009; Meyer, 2003).

Intersectionality Theory. Intersectionality theory extends MST by recognizing that individuals simultaneously occupy multiple social identities that cannot be understood in isolation. Originally introduced by Crenshaw (1989) to better understand the experiences of Black women, the theory argues that systems of oppression (e.g., racism, heterosexism, sexism, and other forms of structural inequality) operate simultaneously and interactively to shape individuals' lived experiences. Rather than viewing these systems as separate or additive, intersectionality theory proposes that they mutually reinforce one another, producing unique forms of discrimination and privilege (Crenshaw, 1989). For example, homophobia directed toward Black gay boys is frequently intertwined with racialized stereotypes surrounding Black masculinity, illustrating how racism and heterosexism co-construct unique experiences of victimization (Bowleg, 2013). Thus, Black SM youth may experience forms of discrimination that cannot be fully understood by examining racism or heterosexism independently. Although intersectionality theory provides an important framework for understanding these overlapping systems of oppression, it offers relatively little

guidance regarding the mechanisms through which these intersecting minority stressors influence mental health across development.

Temporal Intersectional Minority Stress Model. The Temporal Intersectional Minority Stress (TIMS) Model integrates MST and intersectionality theory, incorporating developmental timing and historical contexts to understand minority stress (Rivas-Koehl et al., 2023). The model proposes that the effects of minority stress are shaped not only by individuals' intersecting identities but also by the timing of minority stressors across the lifespan (Rivas-Koehl et al., 2023). Rather than viewing minority stress as a static process, the TIMS Model argues that the impact of discrimination is influenced by historical, developmental, and generational contexts, all of which shape individuals' experiences of oppression and mental health over time (Rivas-Koehl et al., 2023). This perspective underscores why it is important to center adolescence, a developmental period characterized by identity exploration, increasing autonomy, heightened sensitivity to peer relationships, and the emergence of many psychiatric disorders (Kessler et al., 2005, 2007; Needham, 2012; Steinberg, 2017; Ueno, 2010). During adolescence, experiences of discrimination may exert particularly strong effects on psychological functioning because youth are simultaneously developing their racial and sexual identities while navigating increasingly complex social environments (Benner et al., 2018; Rivas-Koehl et al., 2023). The TIMS Model further recognizes that racism and heterosexism frequently accumulate across multiple contexts, including schools, families, communities, healthcare settings, and broader institutions, and interact over time to influence mental health (Rivas-Koehl et al., 2023). Consequently, the mental

health consequences of discrimination may differ depending on the timing, frequency, and developmental context in which these experiences occur.

All three theoretical frameworks guide the present study. MST provides the foundation for understanding how discrimination contributes to mental health disparities among SM youth (Meyer, 2003; see Figure 1). Intersectionality theory extends this framework by recognizing that Black SM youth experience unique forms of discrimination arising from the intersection of racism and heterosexism (Crenshaw, 1989). Finally, the TIMS Model integrates these perspectives by emphasizing that intersecting forms of discrimination are dynamic, accumulate across developmental contexts, and may have particularly profound implications during adolescence (Rivas-Koehl et al., 2023). Compared with MST alone, the TIMS Model offers a more comprehensive framework by simultaneously accounting for intersecting identities and developmental timing. Together, these frameworks provide the conceptual foundation for examining whether discrimination is differentially associated with internalizing symptoms and suicidality among Black SM youth, White SM youth, and Black heterosexual youth (see Figure 1).

Present Study

Although a substantial body of research demonstrates that discrimination is associated with poorer mental health among SM youth and Black youth, important gaps remain in the literature. Much of the existing research has examined either sexual orientation discrimination among predominantly White SM samples or racial discrimination among Black youth, with comparatively few studies investigating how intersecting forms of discrimination affect Black SM youth (Fish & Pasley, 2015).

Emerging evidence suggests that racial and sexual orientation-based discrimination frequently co-occur and are associated with elevated rates of internalizing symptoms and suicidality (Rice et al., 2021; Schuler & Suryavanshi, 2026). However, relatively little research has directly compared Black SM youth with White SM youth and Black heterosexual youth to determine whether discrimination differentially contributes to mental health outcomes across these groups.

Addressing this gap is particularly important because adolescence represents a critical developmental period during which identity development, exposure to discrimination, and the onset of many psychiatric disorders converge (Kessler et al., 2005, 2007; Needham, 2012; Ueno, 2010). Guided by MST, intersectionality theory, and the TIMS Model, the present study examines whether experiences of discrimination are differentially associated with internalizing symptoms and suicidality among Black SM youth, White SM youth, and Black heterosexual youth. Specifically, this study addresses the following research questions: 1) Do Black SM youth report higher levels of internalizing symptoms and suicidality than White SM youth and Black heterosexual youth? 2) Among Black SM youth, do internalizing symptoms and suicidality differ based on the type of discrimination? Based on the existing literature and theoretical frameworks, the following hypotheses were proposed: 1) Black SM youth will report significantly higher levels of internalizing symptoms and suicidality than White SM youth and Black heterosexual youth, 2) Black SM youth who report both racial and sexual orientation discrimination will have significantly higher internalizing symptoms and greater odds of suicidality than youth who report no discrimination or only one form of discrimination (see Table 1).

Chapter 3: Methods

Participants

The current study used cross-sectional data from the two-year follow-up assessment of the Adolescent Brain Cognitive Development (ABCD) Study (data release 3.0; https://doi.org/10.15154/1520591). The ABCD Study is an ongoing longitudinal cohort study that seeks to improve our understanding of genetic, environmental, neurobiological, and behavioral factors that impact the mental and physical health of youth (Barch et al., 2017; Saragosa-Harris et al., 2022). Although the ABCD Study is an ongoing longitudinal cohort study, the present analyses were limited to data collected at a single time point at the two-year follow-up to baseline.

Originally, the data included 11,875 participants aged 9-10 years at baseline (collected in 2016-2018) from 21 recruitment sites across the United States (Barch et al., 2017; Saragosa-Harris et al., 2022). The analytic sample was derived by applying the study's inclusion criteria to the ABCD dataset. Participants were included if they (1) identified as Black, regardless of sexual orientation, or (2) identified as White and as an SM. All participants included in the analytic sample had complete data on the study variables of interest. Applying these criteria resulted in a final analytic sample of 1,393 participants, including 73 Black SM youth, 312 White SM youth, and 1,008 Black heterosexual youth.

Participants had a mean age of 11.94 years (*SD* = 0.62). The sample included 56.93% of youth assigned female at birth (AFAB) and 43.07% of youth assigned male at birth (AMAB). Approximately 9.76% of participants were classified as gender minority youth, whereas 90.24% were classified as cisgender. Based on parent-reported annual

household income, 44.76% of participants lived at or near the poverty line, 16.20% were lower middle class, and 39.03% were middle class or above. See Table 2 for demographic characteristics.

Procedures

ABCD Study staff obtained institutional review board approval at the University of California, San Diego. Analysis of secondary data was determined to be non-human subjects research by the Auburn University Institutional Review Board. Data collection was done in person at various sites. After parents provided informed consent and adolescents provided their assent, families were asked to complete questionnaires on demographics, discrimination, and some mental health outcomes (i.e., Child Behavioral Checklist) on tablets; remaining mental health questions (i.e., KSADS-5) were administered verbally by trained research assistants.

Measures

Sexual Orientation: To assess sexual orientation, we used child-reported responses to "*Are you gay or bisexual?*" Participants could respond *Yes*, *Maybe*, *No*, *I do not understand this question*, or *Refuse/Decline to answer*. Youth who responded *Yes* or *Maybe* were classified as SM, whereas youth who responded *No* were classified as heterosexual. Participants who responded *Maybe* were classified as SM because sexual orientation uncertainty is common during early adolescence, when youth may recognize same-sex attraction but have not yet adopted a specific sexual identity label (Raney et al., 2026). This classification is consistent with prior ABCD studies that operationalized both *Yes* and *Maybe* responses as indicating probable SM status (Raney et al., 2026).

Race: To assess race, we used parent-reported responses to "*What race do you consider the child to be? Please check all that apply*." Participants were classified as Black if caregivers selected *Black/African American,* regardless of whether additional racial categories were also selected, whereas participants were classified as White if caregivers selected *White*. Participants identifying as both Black and another race were included in the Black group because the present study focused on exposure to racialized discrimination rather than mutually exclusive racial categories. This approach is consistent with research indicating that multiracial individuals with Black identities continue to experience anti-Black racism and racialized discrimination (Snyder, 2016).

Discrimination. To assess discrimination, we used youth responses to two items from the ABCD Youth Discrimination Measure, a measure developed for the ABCD Study that incorporates items from the 2006 Boston Youth Survey and the Measure of Perceived Discrimination (Gonzalez et al., 2021): "In the past 12 months, have you felt discriminated against: because someone thought you were gay, lesbian, or bisexual?" and "In the past 12 months, have you felt discriminated against: because of your race, ethnicity, or color?" Each participant responded either yes or no. Among Black SM youth, responses were used to classify participants into one of four discrimination groups: no reported discrimination, racial discrimination only, sexual minority discrimination only, or both racial and sexual minority discrimination. See the analysis plan for more information.

Mental Health Outcomes. Internalizing symptoms were measured using parent-reported responses to the internalizing problem composite of the Child Behavior Checklist (CBCL) for children aged 6-18 (Achenbach & Rescorla, 2001) (see Appendix

A). The revised 2001 CBCL internalizing problems composite combines scores from three syndrome subscales (a total of 25 items): Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints, and yields a standardized T-score normed for age and assigned sex at birth (ASAB) (Achenbach & Rescorla, 2001). For this study, only the internalizing problems composite was used to capture both clinical and subclinical levels of youth mental health. Caregivers rate each item (e.g., “Cries a lot”) on how true it is for their children within the past 6 months on a 3-point Likert scale: 0 = *Not True*, 1 = *Somewhat True*, and 2 = *Very True*. The CBCL has demonstrated strong reliability, with an overall α = .97 and an α = .90 for the internalizing problems composite (Albores-Gallo et al., 2007).

Suicidality was assessed using youth-reported responses from the Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS-5), specifically the suicide subsection (Kaufman et al., 1997) (see Appendix B). The KSADS-5 suicide items assess recurrent thoughts of death, suicidal ideation, suicidal attempts, lethality of suicidal attempts, and non-suicidal self-injurious behaviors (Kaufman et al., 1997). The interviewer assessed youth suicidality via a semi-structured interview process and, for each item (e.g., “Sometimes children who get upset or feel bad, wish they were dead or feel they'd be better off dead. Have you ever had these thoughts? When? Do you feel that way now? Was there ever another time you felt that way?) Furthermore, each item was rated as absent, subthreshold, or threshold. For this study, any endorsement of suicidality at either the subthreshold or threshold level was coded as 1, and no endorsement was coded as 0, creating a dichotomous indicator of suicidality.

Covariates. Covariates included socioeconomic status (SES), ASAB, and gender minority status. SES was measured by parent-reported responses to “What is your total combined family income for the past 12 months?” Based on this response, participants were split into three groups: (1) at or near the poverty line, (2) lower middle class, and (3) middle class and above. ASAB was measured using the parent-reported response to the question of their child's sex at birth. Gender minority status was measured by whether youth (1) answered “*Yes*” or “*Maybe*” to the question, “Are you transgender?”; (2) reporting “*Not at all*,” “*A little*,” or “*Somewhat*” to the question, “How much do you feel like your [ASAB]?”; or (3) reporting “*Totally*,” “*Mostly*,” or “*Somewhat*” to the question, “How much do you feel like the sex opposite to your [ASAB]. If they met any of these criteria, they were coded as 1. If not, they were coded as 0, creating a dichotomous variable for gender-minority status.

Analysis Plan

All analyses were conducted using SPSS. Prior to hypothesis testing, the data were screened for missing values, outliers, and violations of normality assumptions. Descriptive statistics, including means, standard deviations, and frequencies, were computed for all study variables, and histograms were examined to assess variable distributions. To test hypothesis 1, participants were categorized into three identity-based groups: (1) Black SM youth, (2) White SM youth, and (3) Black heterosexual youth. An analysis of covariance (ANCOVA) alongside Levene’s test of homogeneity of variances was conducted to examine differences in internalizing symptoms among Black SM youth, White SM youth, and Black heterosexual youth while controlling for SES, ASAB, and gender minority status. Because Levene's test of homogeneity of

variances was significant, indicating that the assumption of equal variances was violated, Games–Howell post hoc comparisons were used to determine which identity groups differed significantly in internalizing symptoms. For suicidality, a chi-square test was conducted to examine the relationship between identity group (Black SM youth, White SM youth, and Black heterosexual youth) and suicidality (presence vs. absence of suicidality).

To test hypothesis 2, the subsample of Black SM youth was categorized into four groups based on reported experiences of discrimination: (1) no discrimination reported, (2) SM discrimination only, (3) racial discrimination only, and (4) both SM and racial discrimination. An ANCOVA was conducted to examine differences in internalizing symptoms across the four discrimination groups, controlling for covariates. Regarding suicidality, a chi-square test was conducted to examine the relationship between discrimination groups (no discrimination, SM discrimination only, racial discrimination only, and both SM and racial discrimination) and suicidality (presence vs. absence).

Chapter 4: Results

Group Differences by Sexual Minority and Racial Identity

Internalizing Symptoms. To examine differences in internalizing symptoms among Black SM youth, White SM youth, and Black heterosexual youth, an ANCOVA was conducted, controlling for SES, ASAB, and gender minority status. Before conducting the analysis, Levene's test indicated that the assumption of homogeneity of variances was violated, $F(2, 1389) = 4.40$, $p = .01$. Consequently, Games–Howell post hoc comparisons were used to examine pairwise group differences.

The ANCOVA revealed a significant effect of identity group on internalizing symptoms, $F(2, 1389) = 40.83$, $p < .001$, $\eta^2 = .056$. White SM youth reported the highest mean internalizing scores ($M = 52.36$, $SD = 11.34$), followed by Black SM youth ($M = 49.43$, $SD = 12.52$), and Black heterosexual youth ($M = 46.04$, $SD = 10.69$). The effect size was moderate, indicating that identity group accounted for approximately 5.6% of the variance in internalizing symptoms. Games–Howell post hoc comparisons indicated that White SM youth reported significantly higher internalizing symptoms than Black heterosexual youth (mean difference = 6.32, $p < .001$). Although the difference between Black SM youth and White SM youth was not statistically significant ($p = .17$), the comparison between Black SM youth and Black heterosexual youth was marginally significant (mean difference = 3.39, $p = .07$), suggesting a trend toward higher internalizing symptoms among Black SM youth (see Table 5 and Figure 2).

Suicidality. A chi-square test was conducted to examine the association between identity group and suicidality. The assumptions for the analysis were met, with no expected cell counts below five. The association between identity group and suicidality

was statistically significant, $\chi^2(2, N = 1{,}393) = 85.83$, $p < .001$, Cramér's $V = .25$. The effect size indicated a moderate association between identity group and suicidality. Black SM youth (19.20%) and White SM youth (18.90%) reported substantially higher rates of suicidality than Black heterosexual youth (3.90%) (see Table 6 and Figure 3).

Mental Health Outcomes by Discrimination Experiences Among Black SM Youth

Internalizing Symptoms. To examine whether internalizing symptoms differed according to reported experiences of discrimination among Black SM youth, participants were categorized into four groups: (1) no discrimination, (2) SM discrimination only, (3) racial discrimination only, and (4) both SM and racial discrimination. An ANCOVA was conducted to compare internalizing symptoms across the four discrimination groups while controlling for the covariates. Levene's test indicated that the assumption of homogeneity of variances was satisfied, $F(3, 68) = 0.61$, $p = .61$. Therefore, Tukey's Honestly Significant Difference (HSD) test was used for post hoc comparisons.

The ANCOVA revealed no significant differences in internalizing symptoms among the four discrimination groups, $F(3, 68) = 1.17$, $p = .33$, $\eta^2 = .049$. Although youth reporting both SM and racial discrimination had the highest mean internalizing score ($M = 57.29$, $SD = 12.85$), followed by youth reporting SM discrimination only ($M = 50.60$, $SD = 10.29$), racial discrimination only ($M = 49.83$, $SD = 14.76$), and no discrimination ($M = 48.02$, $SD = 12.54$) (see Table 7 and Figure 4), Tukey HSD post hoc comparisons indicated that none of the pairwise differences reached statistical significance (all $ps > .05$).

Suicidality. A chi-square test was conducted to examine the association between discrimination group and suicidality among Black SM youth. The association was

marginally significant, but did not reach statistical significance, $\chi^2(3, N = 73) = 6.84$, $p = .08$, Cramér's $V = .31$. However, 50% of the expected cell counts were less than five, indicating that the assumptions of the chi-square test were not fully satisfied. Therefore, these findings should be interpreted with caution. Descriptively, suicidality was reported by 16.3% of youth who reported no discrimination, 45.5% of youth who reported SM discrimination only, 16.7% of youth who reported racial discrimination only, and none of the youth who reported both SM and racial discrimination (see Table 9 and Figure 5). Although these descriptive differences were notable, they did not reach statistical significance.

Chapter 5: Discussion

Summary of Findings

The purpose of the present study was to examine differences in internalizing symptoms and suicidality among Black SM youth, White SM youth, and Black heterosexual youth. Additionally, this study examined whether experiences of racial discrimination, SM discrimination, or both were associated with internalizing symptoms and suicidality among Black SM youth. Overall, the findings provided partial support for the proposed hypotheses.

Consistent with the first hypothesis, significant differences in internalizing symptoms were observed across identity groups. White SM youth reported significantly higher levels of internalizing symptoms than Black heterosexual youth, whereas Black SM youth demonstrated marginally higher levels of internalizing symptoms than Black heterosexual youth. However, contrary to the hypothesis, Black SM youth did not significantly differ from White SM youth in internalizing symptoms. Regarding suicidality, both Black SM youth and White SM youth reported substantially higher rates of suicidality than Black heterosexual youth, supporting the hypothesis that sexual minority youth would experience greater suicide risk than their heterosexual peers. However, like with internalizing symptoms, Black SM youth and White SM youth reported similar levels of suicidality.

The second hypothesis was not supported. Although Black SM youth who reported experiencing both racial and SM discrimination demonstrated the highest levels of internalizing symptoms, differences in internalizing symptoms across discrimination groups were not statistically significant. Similarly, the association

between discrimination experiences and suicidality among Black SM youth only approached statistical significance. Descriptively, youth who reported only experiencing SM discrimination had the highest proportion of suicidality. However, these findings should be interpreted with caution due to the small sample size and a violation of the chi-square assumption regarding expected cell counts.

Interpretation of Findings in Relation to the Literature

Internalizing Symptoms and Suicidality Across Group Identity. While both SM groups had higher levels of internalizing symptoms and suicidality compared to Black heterosexual youth, they did not differ from each other. These results partially support MST, which claims that SMs experience group-specific stressors in addition to general distress that contribute to poorer mental health outcomes (Meyer, 2003; Hatzenbuehler et al., 2010). Both Black and White SM youth may experience elevated internalizing symptoms and suicidality because of exposure to victimization, structural stigma, identity concealment, and expectations of rejection (Almeida et al., 2009; Hatzenbuehler et al., 2010; Marshal et al., 2011). Furthermore, the finding that Black heterosexual youth report lower internalizing symptoms and suicidality than both SM groups is also consistent with previous research that found Black youth report lower lifetime prevalence of internalizing symptoms and lower rates of suicidality compared to their White counterparts despite greater exposure to adversity (Breslau et al., 2005, 2006; Bridge et al., 2015).

Although MST explains why Black and White SM youth experienced poorer mental health outcomes compared to Black heterosexual youth, it does not explain why Black SM youth did not report higher rates of internalizing symptoms and suicidality

compared to White SM youth. Drawing from intersectionality theory and the TIMS Model, it was hypothesized that Black SM would report the highest internalizing symptoms and suicidality based on the combined effects of heterosexism and racism (Crenshaw, 1989; Rivas-Koehl et al., 2023).

One possible explanation is that although Black SM youth experience the intersecting stressors of heterosexism and racism, they may also benefit from the resilience factor associated with a strong racial and ethnic identity (Meyer et al., 2008; Ghabrial, 2017). Research has found that a stronger ethnic/racial identity, a greater connection to Black social networks, and living in a majority Black neighborhood are associated with better psychological well-being and decreased suicidality (Gibbs, 1997; Herd & Grube, 1996). Likewise, interventions aimed at strengthening racial/identity exploration have been shown to improve psychological well-being in youth of color (Marks, 2020; Umaña-Taylor et al., 2018). Consequently, a strong racial and ethnic identity may partially buffer the psychological effects of minority stress, resulting in internalizing symptoms and suicidality levels comparable to those observed among White SM youth. Another explanation is that the lack of significant differences between Black SM and White SM youth may reflect limited statistical power. Black SM youth comprised only 5.20% of the analytic sample (n = 73), reducing the ability to detect small- to moderate-sized group differences between the two SM groups. Therefore, meaningful differences may have gone undetected because of the relatively small sample size.

The Impact of Discrimination on Internalizing Symptoms and Suicidality. Contrary to the study hypotheses, discrimination experiences were not significantly associated

with internalizing symptoms or suicidality among Black SM youth. These findings contrast with MST theory and the TIMS Model, both of which propose that the accumulation of minority stress would increase psychological risk (Meyer, 2003; Rivas-Koehl et al., 2023). Several explanations may account for these unexpected results. Firstly, the discrimination measure used may not have fully captured the complexity of minority stress experiences. In this study, discrimination was assessed using two dichotomous items that measured whether participants had experienced racial or SM discrimination within the past 12 months. These items did not assess the frequency, severity, chronicity, or context of discriminatory experience, nor did they capture discrimination specifically targeting the intersection of participants' racial and SM identities. As a result, these measures may have underestimated the cumulative burden of minority stress and the ability to detect associations with mental health outcomes.

Secondly, similar to the group comparison analyses, the relatively small Black SM subsample likely limited the statistical power to detect meaningful associations between discrimination and mental health outcomes. This limitation was particularly evident in the suicidality analyses, where the chi-square assumptions were not fully met, with 50% of the expected cell counts being fewer than five. Finally, also similar to the group comparison findings, it is possible that protective factors buffered the psychological effects of discrimination among Black SM youth. Prior research suggests that a strong racial and ethnic identity, connection to Black communities, religiosity, and supportive family relationships can promote resilience and mitigate the adverse psychological effects of discrimination (Ghabrial, 2017; Herd & Grube, 1996; Marks, 2020; Umaña-Taylor et al., 2018).

Clinical Implications

The present study has several implications for mental health professionals working with Black SM youth. Although Black SM youth did not report significantly poorer mental health outcomes than White SM youth, both SM groups demonstrated higher levels of internalizing symptoms and suicidality than Black heterosexual youth. These results underscore the importance of routinely screening SM adolescents for depression, anxiety, somatic complaints, and suicidality regardless of racial identity (Russell & Fish, 2016). Clinicians should also adopt an intersectional, culturally responsive approach to assessment by exploring how race, sexual orientation, and other social identities shape each youth's experiences of discrimination, minority stress, and support rather than assuming these experiences are uniform across individuals (Crenshaw, 1989; Rivas-Koehl et al., 2023). In addition to assessing minority stressors, clinicians should assess and strengthen protective factors that may promote resilience, such as supportive family relationships, affirming peer and community connections, and positive racial and ethnic identity development (Ghabrial, 2017; Herd & Grube, 1996; Marks, 2020; Umaña-Taylor et al., 2018). Within marriage and family therapy, interventions that promote family acceptance, strengthen cultural connection, and enhance supportive relationships may help reduce the psychological impact of minority stress while fostering resilience among Black SM youth (Meyer, 2003; Rivas-Koehl et al., 2023).

Strengths and Limitations

The present study has several strengths. Firstly, it addresses a notable gap by examining Black SM youth, a population historically underrepresented in research (Fish

& Pasley, 2015), with much of the existing literature either focusing on SM youth without considering racial differences or on Black youth without accounting for SM status. Secondly, the study utilized data from the ABCD study, one of the largest and most diverse longitudinal studies of adolescent development in the United States (Dowling et al., 2024). The large, geographically diverse sample enhances the generalizability of the findings and reduces concerns associated with single-site or convenience samples that are common in SM research (Delgado-Ron et al., 2023). Finally, the study employed well-validated measures of internalizing symptoms and suicidality, including the CBCL and the K-SADS-5, increasing confidence in the reliability and validity of the mental health outcomes.

Despite these strengths, several limitations should be considered when interpreting the results. First, while the overall sample was large, statistical power was limited among the Black SM subgroup, particularly for analyses examining the impact of the type of discrimination reported on suicidality. Additionally, as previously stated, the discrimination measure did not capture the frequency, severity, chronicity, or intersectional nature of discrimination. Finally, the present study did not examine potentially important protective factors, such as racial and ethnic identity, family acceptance, social support, religiosity, or community connectedness.

Future Directions

The present study highlights several important directions for future research. First, future studies should recruit larger samples of Black SM youth to increase statistical power and permit more robust examinations of mental health disparities within this population. Larger samples would also allow researchers to examine differences

across specific sexual minority identities (e.g., gay, lesbian, bisexual, questioning). Secondly, future research should employ more comprehensive measures of minority stress and discrimination. Rather than relying on dichotomous indicators, researchers should assess the frequency, severity, chronicity, context, and developmental timing of discriminatory experiences. Additionally, measures should capture intersectional discrimination, experiences in which racism and heterosexism occur simultaneously, rather than assessing racial and sexual minority discrimination independently.

Thirdly, future research should evaluate the TIMS Model by examining how intersecting minority stressors and resilience processes change across developmental stages and cohorts. Longitudinal and cross-sequential designs are particularly well suited to test the model's proposition that the impact of minority stress varies over time and across developmental and historical contexts. Such designs would enable researchers to distinguish age-related changes in minority stress and mental health from changes driven by shifting sociopolitical contexts, thereby providing a more nuanced understanding of the experiences of Black SM youth. Finally, future research should move beyond identifying risk factors to examining protective processes that promote resilience among Black SM youth. Identifying these protective mechanisms would not only advance theoretical understanding of resilience among Black SM youth but also inform the development of culturally responsive, strength-based interventions to reduce mental health disparities.

Conclusion

Black SM youth occupy a unique intersection of identities that cannot be fully understood by examining race or sexual orientation in isolation. The present study

highlights the importance of moving beyond treating sexual minority youth as a homogeneous population and instead recognizing the diversity of experiences that exist within these communities. Centering Black SM youth in research not only advances a more nuanced understanding of mental health disparities but also lays the foundation for culturally responsive theory, research, and clinical practice that reflects their lived experiences. Ultimately, achieving equity in mental health requires ensuring that those at the intersections of multiple marginalized identities are intentionally centered in research.

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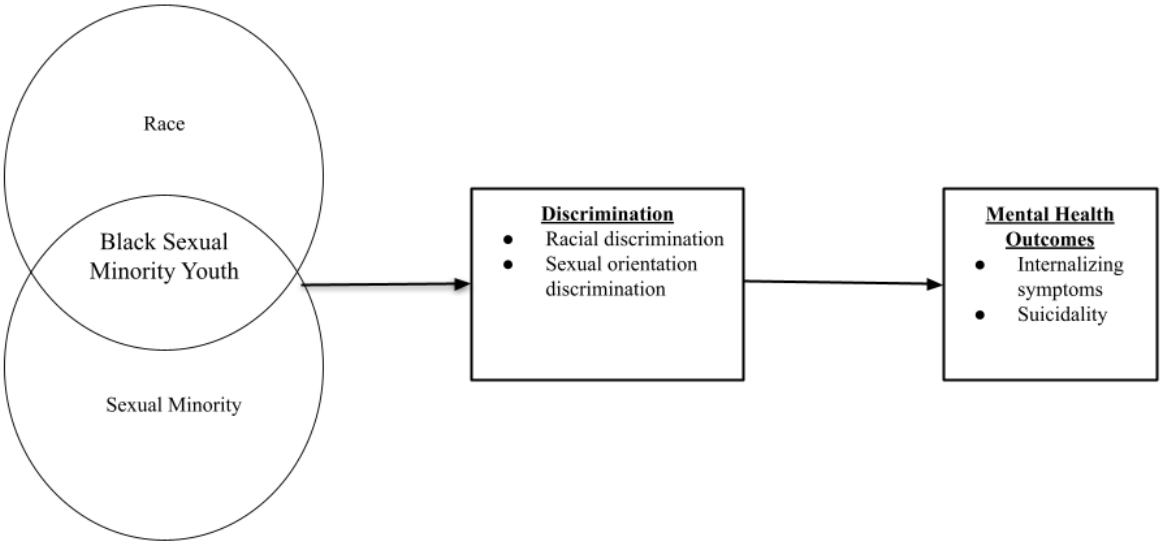
Figure 1

Conceptual Model Guiding the Present Study



Note. Guided by Minority Stress Theory, Intersectionality Theory, and the Temporal Intersectional Minority Stress Model, the conceptual model illustrates the hypothesized relationships among Black sexual minority identity, experiences of racial and sexual orientation discrimination, and mental health outcomes (internalizing symptoms and suicidality).

Table 1

Summary of Research Questions, Hypotheses, Statistical Analyses, and Key Findings

Research Questions	Hypothesis	Statistical Analyses	Key Findings
Do Black SM youth report higher levels of internalizing symptoms and suicidality than White SM youth and Black heterosexual youth?	Black SM youth will report significantly higher levels of internalizing symptoms and suicidality than White SM youth and Black heterosexual youth.	**Internalizing Symptoms:** ANCOVA with Games-Howell post hoc controlling for SES, ASAB, and gender minority status. **Suicidality:** Chi-square test.	**Internalizing Symptoms:** Black SM youth reported marginally higher internalizing symptoms than Black heterosexual youth but did not differ significantly from White SM youth. **Suicidality:** Black SM youth reported significantly higher rates of suicidality than Black heterosexual youth but did not differ significantly from White SM youth.

Research Questions	Hypothesis	Statistical Analyses	Key Findings
Among Black SM youth, do internalizing symptoms and suicidality differ based on experiences of racial and sexual orientation discrimination?	Black SM youth who report both racial and sexual orientation discrimination will have significantly higher internalizing symptoms and greater odds of suicidality than youth who report no discrimination or only one form of discrimination.	**Internalizing Symptoms:** ANCOVA with Tukey HSD controlling for SES, ASAB, and gender minority status. **Suicidality:** Chi-square test.	**Internalizing Symptoms:** Internalizing symptoms were highest among youth reporting both racial and sexual orientation discrimination. However, differences across discrimination groups were not statistically significant. **Suicidality:** Youth reporting sexual orientation discrimination only had the highest prevalence of suicidality, although differences across discrimination groups were only marginally significant.

Note. SM = sexual minority; SES = socioeconomic status; ASAB = assigned sex at birth; ANCOVA = analysis of covariance

Table 2

Demographic Characteristics of the Study Sample

	M (*SD*) or %
Age	11.94 (.62) years
Assigned Sex at Birth	
AFAB	56.93%
AMAB	43.07%
Gender Minority Status	
Gender Minority	9.76%
Cisgender	90.24%
Socioeconomic status	
At or near poverty line	44.76%
Lower middle class	16.20%
Middle class and above	39.03%
Race	
Black/African American	77.60%
White	22.40%
Sexual Orientation	
Sexual Minority	27.64%
Heterosexual	72.36%
Race x Sexual Orientation	
Black SM	5.20%
White SM	22.40%

	M (*SD*) or %
Black Heterosexual	72.40%

Note. M = mean; *SD* = standard deviation; AFAB = assigned female at birth; AMAB = assigned male at birth; SM = sexual minority. Percentages may not total exactly 100% due to rounding.

Table 3

Descriptive Statistics for Primary Study Variables Examined in Hypothesis 1

	M	*SD*	Min	Max
Internalizing Symptoms	47.63	11.25	33.00	86.00
Black SM	49.43	12.52	33.00	75.00
White SM	52.36	11.34	33.00	83.00
Black Heterosexual	46.04	10.69	33.00	86.00
	n		%	
Suicidality				
Suicidality Present	112		8.00%	
Suicidality Absent	1281		92.00%	

Note. M = mean; *SD* = standard deviation; Min = minimum; Max = maximum. Descriptive statistics for internalizing symptoms are presented for the total sample and separately for Black SM, White SM, and Black heterosexual youth. Suicidality frequencies and percentages are based on the total sample (*N* = 1,393).

Table 4

Descriptive Statistics for ANCOVA Covariates by Identity Group

	M	*SD*	Min	Max
SES	2.86	2.34	0.05	12.11
Black SM	2.19	1.55	0.07	7.38
White SM	4.56	2.45	0.08	12.11
Black Heterosexual	2.33	2.06	0.05	9.84
ASAB	0.57	0.50	0.00	1.00
Black SM	0.88	0.33	0.00	1.00
White SM	0.83	0.37	0.00	1.00
Black Heterosexual	0.47	0.50	0.00	1.00
Gender Minority Status	0.10	0.30	0.00	1.00
Black SM	0.26	0.44	0.00	1.00
White SM	0.24	0.43	0.00	1.00
Black Heterosexual	0.04	0.20	0.00	1.00

Note. SES = socioeconomic status; ASAB = assigned sex at birth. SES was measured using the income-to-needs ratio, with higher scores indicating greater socioeconomic status. ASAB was coded as 0 = Male and 1 = Female. Gender minority status was coded as 0 = cisgender and 1 = gender minority. Means and standard deviations are presented for the overall sample and each identity group.

Table 5

Pairwise Comparisons of Internalizing Symptoms by Identity Group

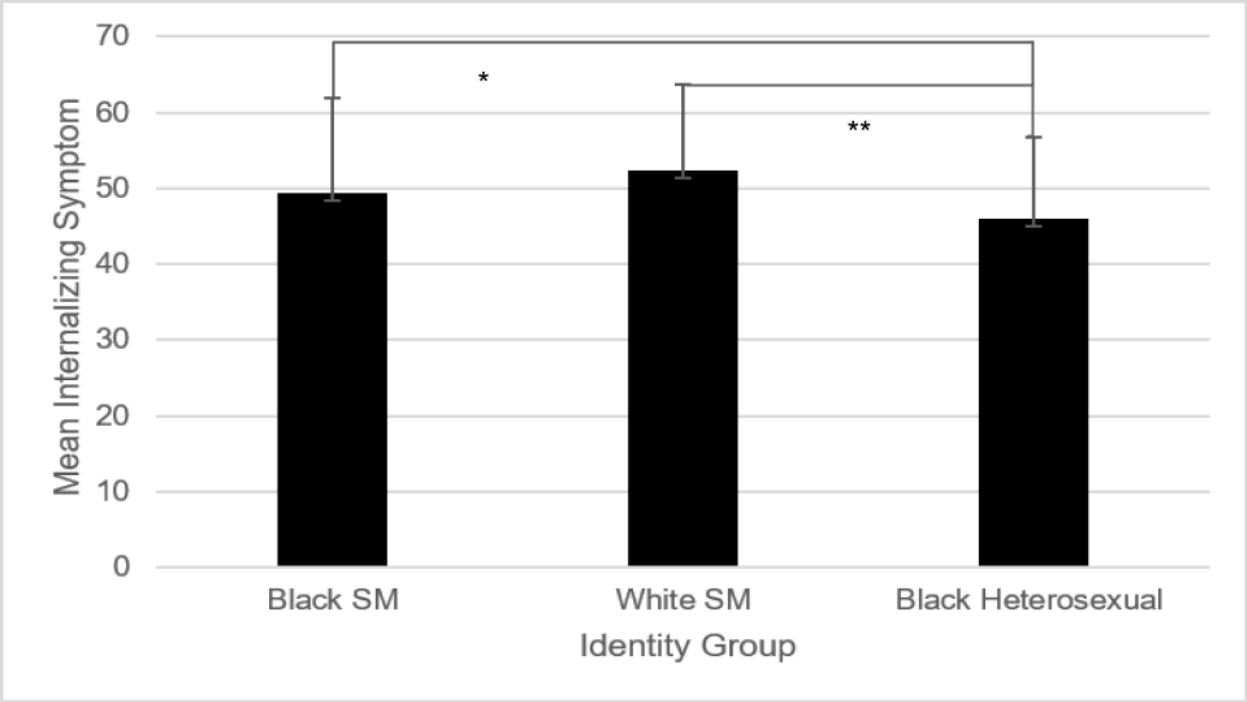
		Mean Difference	SE	*p*
Black SM	White SM	-2.93	1.61	0.17
	Black Heterosexual	3.39	1.51	0.07*
White SM	Black SM	2.93	1.61	0.17
	Black Heterosexual	6.32	0.73	< 0.001**
Black Heterosexual	Black SM	-3.39	1.51	0.07*
	White SM	-6.32	0.73	< 0.001**

Note. SM = sexual minority; SE = standard error. Mean differences are based on Games–Howell post hoc comparisons following the omnibus analysis. Positive mean differences indicate that the first group had higher adjusted mean internalizing symptom scores than the comparison group.

*$p < .10$. ** $p < .001$

Figure 2

Mean Internalizing Symptoms by Identity Group



Note. Error bars represent 95% confidence intervals. Higher scores indicate greater internalizing symptoms.

*$p < .10$. ** $p < .001$

Table 6

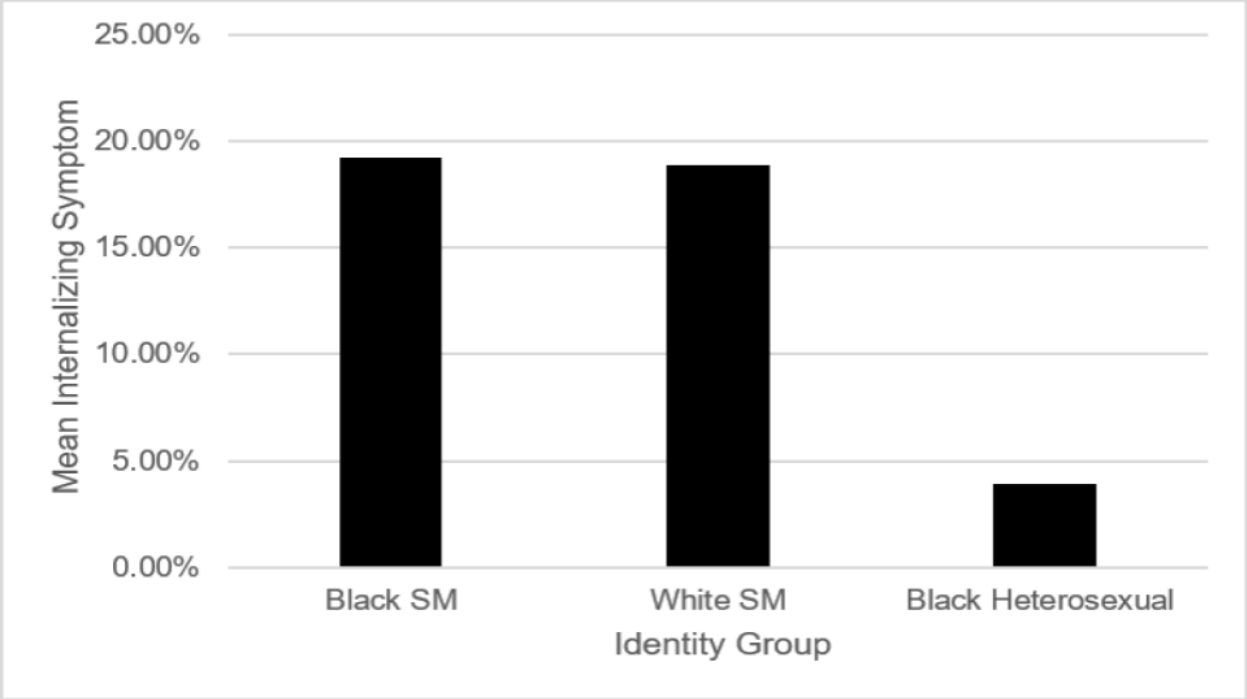
Frequencies of Suicidality by Identity Group

	Suicidality Present		Suicidality Absent	
	n	%	*n*	%
Black SM	14	19.20%	59	80.80%
White SM	59	18.90%	253	81.10%
Black Heterosexual	39	3.90%	969	96.10%

Note. SM = sexual minority. Percentages represent the proportion of participants within each cell. Overall group differences were examined using a chi-square test of independence, $\chi^2(2, N = 1{,}393) = 85.83$, $p < .001$, Cramér's $V = .25$.

Figure 3

Prevalence of Suicidality by Identity Group



Note. Percentages represent the proportion of youth within each identity group reporting suicidality.

Table 7

Descriptive Statistics for Internalizing Symptoms by Discrimination Type Among Black Sexual Minority Youth

	M	*SD*	Min	Max
Internalizing Symptoms	49.43	12.52	33.00	75.00
No Discrimination	48.02	12.54	33.00	75.00
SM Discrimination	50.60	10.29	33.00	63.00
Racial Discrimination	49.83	14.76	33.00	64.00
SM + Racial Discrimination	57.29	12.85	33.00	70.00

Note. M = mean; *SD* = standard deviation; Min = minimum; Max = maximum; SM = sexual minority. Descriptive statistics are presented for Black sexual minority youth overall and by discrimination type.

Table 8

Descriptive Statistics for ANCOVA Covariates by Discrimination Type Among Black Sexual Minority Youth

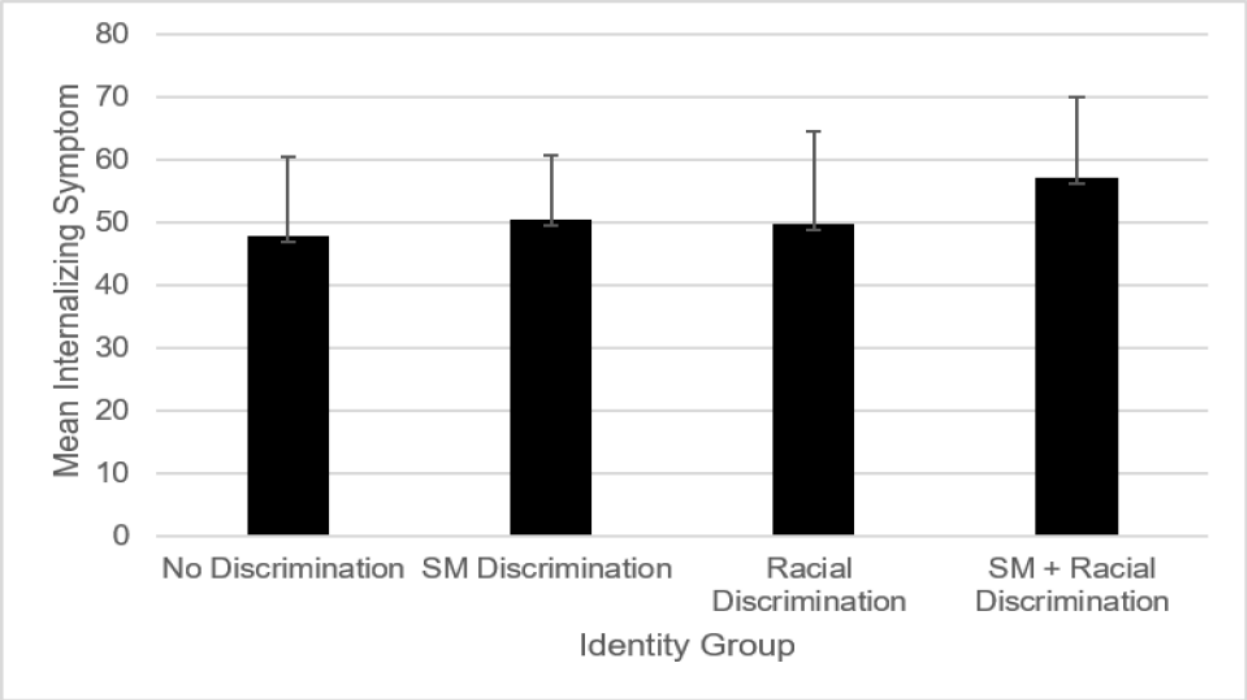
	M	*SD*	Min	Max
SES	2.19	1.55	0.07	7.38
No Discrimination	2.23	1.71	0.07	7.38
SM Discrimination	2.13	1.07	0.80	3.78
Racial Discrimination	2.21	0.81	1.37	3.34
SM + Racial Discrimination	2.03	2.11	0.69	5.73
ASAB	0.88	0.33	0.00	1.00
No Discrimination	0.90	0.31	0.00	1.00
SM Discrimination	0.73	0.47	0.00	1.00
Racial Discrimination	1.00	0.00	1.00	1.00
SM + Racial Discrimination	0.86	0.38	0.00	1.00
Gender Minority Status	0.26	0.45	0.00	1.00
No Discrimination	0.27	0.45	0.00	1.00
SM Discrimination	0.09	0.30	0.00	1.00
Racial Discrimination	0.17	0.41	0.00	1.00
SM + Racial Discrimination	0.57	0.53	0.00	1.00

Note. SES = socioeconomic status; ASAB = assigned sex at birth; SM = sexual minority. SES was measured using the income-to-needs ratio, with higher values indicating greater socioeconomic status relative to the federal poverty threshold. ASAB was coded as 0 = male and 1 = female. Gender minority status was coded as 0 =

cisgender and 1 = gender minority. Means and standard deviations are presented for the overall sample of Black sexual minority youth and for each discrimination type.

Figure 4

Mean Internalizing Symptoms by Discrimination Type



Note. Error bars represent 95% confidence intervals. Higher scores indicate greater internalizing symptoms.

Table 9

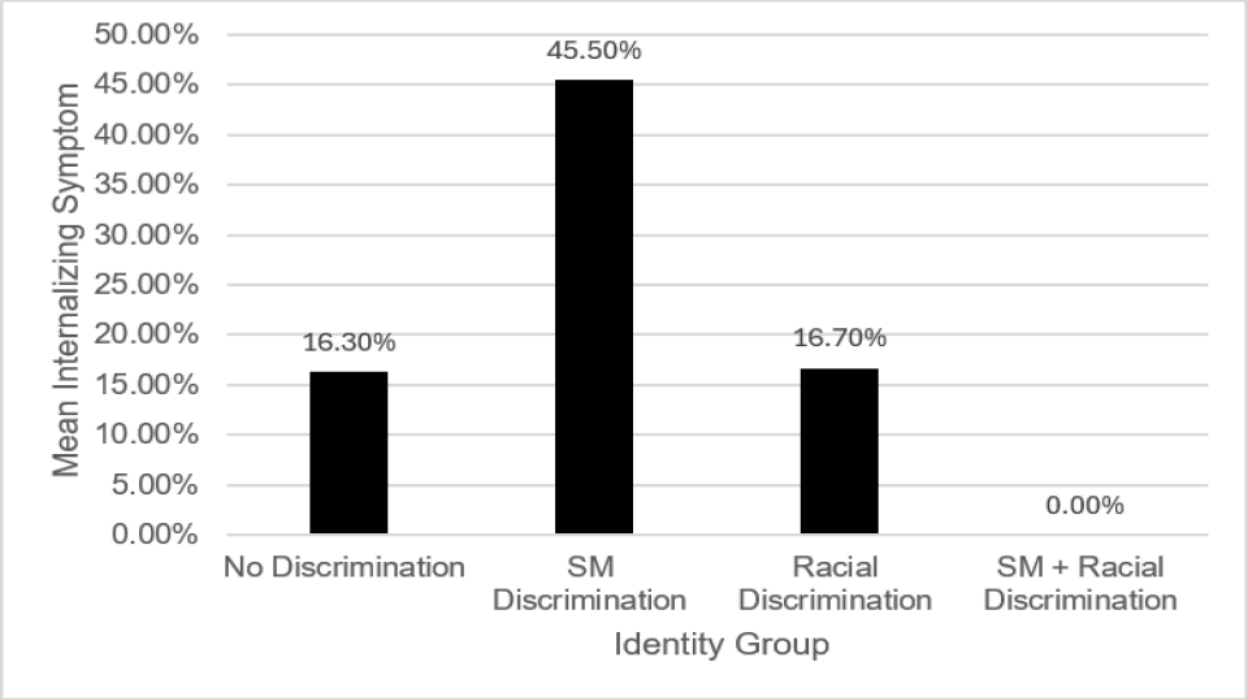
Frequencies of Suicidality by Discrimination Type Among Black Sexual Minority Youth

	Suicidality Present		Suicidality Absent	
	n	%	*n*	%
No Discrimination	8	16.30%	41	83.70%
SM Discrimination	5	45.50%	6	56.50%
Racial Discrimination	1	16.70%	5	83.30%
SM + Racial Discrimination	0	0.00%	7	100.00%

Note. SM = sexual minority. Percentages represent the proportion of participants within each cell. Group differences were examined using a chi-square test of independence, $\chi^2(3, N = 73) = 6.84$, $p = .08$, Cramér's $V = .31$.

Figure 5

Prevalence of Suicidality by Discrimination Type Among Black Sexual Minority Youth



Note. Percentages represent the proportion of Black sexual minority youth within each discrimination group reporting suicidality.

Appendix A

Internalizing Problems Composite of the Child Behavior Checklist

Below is a list of items that describe children and youths. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know), 1 = Somewhat/ Sometimes True, 2 = Very True/Often True

1. There is very little he/she enjoys
2. Cries a lot
3. Fears certain animals, situations, or places, other than school (describe):
4. Fears going to school
5. Fears he/she might think or do something bad
6. Feels he/she has to be perfect
7. Feels or complains that no one loves him/her
8. Feels worthless or inferior
9. Would rather be alone than with others
10. Nervous, highstrung, or tense
11. Nightmares
12. Too fearful or anxious

13. Feels dizzy or lightheaded
14. Feels too guilty
15. Overtired without good reason
16. Physical problems without know medical cause:

a. Aches or pains (not stomach or headaches)
b. Headaches
c. Nausea, feels sick
d. Problems with eyes (not if corrected by glasses) (describe):
e. Rashes or other skin problems
f. Stomachaches
g. Vomiting, throwing up
h. Other (describe):

17. Refuses to talk
18. Secretive, keeps things to self
19. Self-conscious or easily embarrassed
20. Too shy or timid
21. Talks about killing self
22. Underactive, slow moving, or lacks energy
23. Unhappy, sad, or depressed
24. Withdrawn, doesn't get involved with others
25. Worries

Appendix B

Suicide subsection of the Kiddie Schedule for Affective Disorders and Schizophrenia

0 = No information, 1 = Not Present, 2 = Subthreshold, 3 = Threshold

Recurrent Thoughts of Death

Sometimes children who get upset or feel bad, wish they were dead or feel they'd be better off dead. Have you ever had these type of thoughts? When? Do you feel that way now? Was there ever another time you felt that way?

Suicidal Ideation

Sometimes children who get upset or feel bad think about dying or even killing themselves. Have you ever had such thoughts? How would you do it? Did you have a plan?

Suicidal Acts – Intent

Have you actually tried to kill yourself? When? What did you do? Any other things? How close did you come to doing it? Was anybody in the room? In the apartment? Did you tell them in advance? How were you found? Did you really want to die? Did you ask for any help after you did it?

Suicidal Acts - Medical Lethality

Actual medical threat to life or physical condition following the most serious suicidal act. Take into account the method, impaired consciousness at time of being rescued,

seriousness of physical injury, toxicity of ingested material, reversibility, amount of time needed for complete recovery and how much medical treatment needed. How close were you to dying after your (most serious suicidal act)? What did you do when you tried to kill yourself? What happened to you after you tried to kill yourself?

Non-suicidal, Self-Injurious Behavior

Refers to intentional self-inflicted damage to the surface of the body, of a sort likely to induce bleeding or pain for purposes that are not socially sanctioned AND done without intent of killing himself, with the expectation that the injury will lead to only minor or moderate physical harm. Did you ever try to hurt yourself? Have you ever burned yourself with matches/ candles? Or scratched yourself with needles/ a knife? Your nails? Or put hot pennies on your skin? Anything else? Why did you do it? How often? Do you have many accidents? What kind? How often? Some kids do these types of things because they want to kill themselves and other kids do them because it makes them feel a little better afterwards. Why do you do these things?