A Mental Wellness Moderator in Minority Youth

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ABSTRACT: ***One hundred ninety-seven teenagers (14-19 years of age; 70 percent female; 29 percent sexual minority) completed steps on sexual minority-specific victimization, depressive symptoms, and suicidal ideation at six-month intervals in two phases, six months apart from one another. When compared to heterosexual adolescents, sexual minority adolescents reported greater levels of victimization, depressive symptoms, and suicide ideation related to their sexual orientation. The effect of sexual minority status on depressive symptoms and suicide was shown to be substantially mediated by victimization experienced by members of the LGBT community. Those results provide credence to the notion of minority stress, which asserts that targeted harassment and victimization are responsible for some of the elevated levels of depressive symptoms and suicidal ideation seen in young people who identify as members of sexual minorities. This research supports measures in public policy that reduce bullying and hate crimes since reducing victimization may have a direct impact on the health and well-being of adolescents who identify as sexual minorities, according to the findings.***

KEYWORDS: ***Adolescent, Depression, Heterosexual, Sexual Minority, Suicide Victimization.***

1. INTRODUCTION

The mental health of sexual minority youth (SMY; defined as young people who are attracted to the same sex, participate in same-sex sexual behaviour, or promote a gay, lesbian, or bisexual identity) and heterosexual adolescents differs significantly from one another. One study showed that SMY had greater rates of depression and higher rates of suicidal ideation than heterosexual adolescents, according to a recent meta-analysis of 24 SMY mental health studies (suicide ideation and suicide attempts). Furthermore, the impact size for the relationship between sexual minority status and suicidal ideation grew in direct proportion to the severity of the suicidality scale, which was very significant (e.g., a larger effect size for actual suicide attempts than for having suicidal thoughts).

When compared to heterosexual adolescents, SMY were almost twice as likely to report suicidal thoughts, more than three times as likely to record suicide attempts, and more than four times as likely to report a suicide attempt that required medical care. This finding is especially troubling since it shows that not only is there a significant and widespread discrepancy in SMY's mental health, but that the imbalance is greatest among the most severe outcomes of mental health (e.g., attempted suicide). In addition, according to a recent research, 22 percent of SMY in the 11th grade attempted suicide in the previous 12 months, compared to 4 percent of heterosexual adolescents. According to the research, there are significant disparities in the consequences of depression and suicide among SMY and heterosexual young individuals[1].

The disparities, on the other hand, are not exclusive to depression and suicide. According to a new study by the Centers for Disease Control and Prevention (CDC), SMY have a higher prevalence of health-risk behaviors in seven out of ten health behaviour categories (violence, attempted suicide, tobacco use, alcohol use, other substance use, sexual habits, and weight management) when compared to heterosexual youth. In order to address SMY health inequalities, additional research is urgently needed, as highlighted by the Healthy People 2020 programme and a recent study by the Institute of Medicine (IOM), which was commissioned by the National Institutes of Health. Particularly important is research that finds explanatory mechanisms for these inequalities, which is currently lacking[2].

According to the findings of this research, the concept of minority stress as an explanatory mechanism for explaining the disparities between SMY in depression and suicidal ideation is being investigated. The investigation of the underlying reasons of SMY disparities is still in its early stages. The theory of minority stress asserts that the stigma, racism, and inequality experienced by lesbian, gay, and bisexual people create a hostile social environment that can contribute to chronic stress and mental health issues. Lesbian, gay, and bisexual people are disproportionately represented in the minority population. To this end, most of the research to date has focused on victimization based on sexual minorities' status (i.e., being singled out for bullying and harassment, ranging from verbal insults to physical assault based on one's real or perceived sexual identity), as well as the cause(s) of mental health inequalities among SMY[3].

Cross-sectional research has been used to test certain elements of the minority stress model, and the results have generally supported the model's predictions. For example, according to a recent meta-analysis, SMY was 1.7 times more likely to report being assaulted at school and 2.4 times more likely to report missing school due to fear than other students. Aside from that, it was discovered that SMY's mental health was significantly impacted by victimization based on her sexual identity. SMY who have experienced higher levels of victimization are 2.6 times more likely to experience depression and 5.6 times more likely to attempt suicide than SMY who have experienced lower levels of victimization; and SMY who have experienced higher levels of victimization are more likely to engage in health risk behaviors than SMY who have experienced lower levels of victimization and heterosexual youth, with the latter two categories not differing.

It should be noted that the negative consequences of victimization based on sexual minority identification are not limited to those young people who are presently defined as being members of a sexual minority. Swearer and colleagues utilized cross-sectional data to discover that, regardless of their true sexual orientation, boys who were bullied because they were branded "gay" were more likely to experience psychosocial stress than boys who were harassed for other reasons. Swearer and colleagues in one longitudinal study, researchers discovered results that were similar to these. Boys who are mistreated because of their real or perceived sexual identity had higher levels of anxiety and depression, even after accounting for the anxiety and sadness that were found a year earlier. Neither research, on the other hand, evaluated the participants' sexual minority status, making it impossible to determine if SMY was disproportionately affected by sexual minority-specific trauma. Taken together, current research indicates that it is not the victimization experienced as a member of a sexual minority that is accountable for these negative consequences, but rather the fact that one is a member of a sexual minority that causes mental health and adjustment problems[4].

There have been a few studies that have tested cross-sectional mediation models of the minority stress hypothesis in young people (aged 14-18 years) using indicators of sexual minority status, victimization and prejudice, and mental health, and the findings of these studies have generally validated the minority stress hypothesis. Almeida et al., for example, utilized cross-sectional data to demonstrate that felt discrimination contributed to the clarification of the relationship between sexual minority status and emotional distress in one study. Williams et al. utilized cross-sectional data to show that victimization contributes to the relationship between sexual minority status and externalizing behaviors (such as aggression, behavioral problems, and delinquency), in addition to longitudinal evidence. Noteworthy is the fact that both of these research utilized cross-sectional data to evaluate the minority stress theory. Our goal is to broaden their findings by testing all of the requisite components of the minority stress hypothesis in SMY, including a longitudinal model, a sexual minority-specific stress variable, and a heterosexual comparison group, in order to more thoroughly evaluate the key tenets of the minority stress hypothesis[5].

1.1 Family Rejection in Adolescence and Young Adulthood:

Studies of sexual minorities are guided by minority stress theory, which helps researchers explain why they have a greater incidence of mental illness and drug abuse than their heterosexual counterparts. When it comes to health outcomes, minorities stress theory places a strong emphasis on how individuals cope with and process social pressures like as stigma, prejudice, and discrimination in the context of their own lives. Despite this, the overwhelming majority of Sexual Minority Women (SMW) do not show signs of disorder or poor health, suggesting that resilience is the norm for the large majority of SMW despite persecution. According to the minority stress paradigm, higher levels of stress are anticipated to be associated with greater discomfort as well as worse physical and mental health consequences. While studying resilience, researchers have discovered that perceptions of greater stress and less resources are linked to reduced rates of disorder.

These results are challenging to explain in terms of the current minority stress paradigm, which has mainly focused on the development of psychopathology as the result of minority stress. The fact that pioneering research on sexual minority stress does not operationalize the function of families throughout development may explain why. Moreover, since interdependent family and community social processes are not addressed within a developmental framework, minority stress theory may fall short of explaining normative sexual minority growth and resilience processes in a satisfactory manner. We think that an emphasis on families among YA SMW is justified because of the importance of families in healthy development, the ability of

families to assist in the prevention of societal risk, and empirical connections between family rejection or support and the health and well-being of young people[6].

When it comes to support and coping throughout development, families are one of the most significant social resources available. Family support is often shown to be linked with resilience over time, despite the presence of other hazards. It has been discovered that ethnic minority adolescents and young adults may learn to deal with societal prejudice via ethnic socialization techniques in their homes, according to the findings of study (i.e., ethnic identity information, ethnic values and behaviors). Heterosexual parents, on the other hand, raise the vast majority of SMW and do not identify as members of a sexual minority alongside their daughters. SMW must also reveal his or her sexual orientation to family members, which carries with it the distinct danger of familial rejection.

SMW are often between the ages of 17 and 25 when they come out to their families. It has been shown that supportive parental reaction to a child's coming out is associated with better health and well-being. Researchers have shown that having family support may help to decrease sadness and boost self-esteem. However, many YA SMW also suffer familial rejection, and family rejection has been linked to worse health in the past. Suicide, despair, drug addiction, and sexually risky conduct are all linked to feelings of rejection from one's own family. Because of their sexual orientation, a small but significant percentage of SMW have experienced extreme familial rejection, which may include verbal and/or physical assaults from family members. As a result, family rejection may increase the likelihood of social danger. Although perceived discrimination and hate crime victimization were shown to be significant contributors to mental morbidity among sexual minorities, researchers discovered that familial variables explained almost all of the extra risk. As part of the current research, we inquired about participants' experiences of being rejected by their mothers and dads, siblings, or other family members as a result of their lesbian or bisexual self-identification. We also inquired as to whether participants' relatives were unwilling to discuss their sexual orientation or to acknowledge their same-sex relationships[7].

1.2 Hypotheses and A High-Level Overview:

We used a six-month longitudinal design to explicitly test the minority stress hypothesis, which states that SMY experience greater sexual minority-specific victimization than heterosexual youth, and that this victimization is at least partially responsible for elevated levels of depression and suicidal ideation in SMY. The researchers predicted that, as compared to heterosexual adolescents, SMY would exhibit higher levels of sexual minority-specific victimization, depressive symptomatology, and suicidal ideation, and that these variables would be positively related. We also anticipated that increased sexual minority-specific victimization would help to clarify the relationship between sexual minority status and mental health outcomes. In order to assess this prediction, we utilized a mediation model, which is a statistical technique that is used to identify causal pathways for the effect of a predictor (for example, sexual minority status) on an outcome (e.g., sexual minority specific victimization).

2. DISCUSSION

Studies and government reports have identified SMY as a group that is at risk for mental health problems, and there have been reports of mental health disparities in this community. For the purpose of expanding on this research, the present project is being planned to utilize a longitudinal approach to identify one factor that is at least partially responsible for SMY mental health disparities in order to further the investigation. Furthermore, the current study investigated the concept of minority stress as an explanatory mechanism for better understanding the potential reasons of SMY disparities. In specifically, according to the concept of minority stress, persecution and abuse experienced by sexual minorities, among other things, lead to poor health consequences in the long run. When compared to heterosexual peers, the results of this study were similar with prior research in that SMY reported greater rates of sexual minority-specific victimization as well as a higher frequency of depressive symptoms and suicide ideation. A validation study using experimental mediation models discovered that the greater prevalence of depressive symptoms and suicidal ideation in SMY was partly responsible for the increased levels of sexual minority-specific victimization in this population[8].

Clearly, the mediation paradigm for depressed symptomatology had been established. Taking into account the connection between sexual minority status and depressed symptoms six months later, it was discovered that

sexual minority-specific victimization moderated the relationship between sexual minority status and depressive symptoms six months later. For suicidal behaviour, the model of mediation seemed to be less clear. Because of a restriction in the baseline computation, the model was unable to track the recent history of suicidal ideation in the population. So two models of mediation were tested: one controlling depressed symptoms for recent history and the other controlling suicidal ideation for life history. The former model was shown to be significant, while the latter was found to be insignificant. In small samples, suicidal ideation is a challenging concept to investigate since the base rate is so low. As a result, statistical modelling is difficult. It is also possible that only little changes in suicidality rates or severity over a six-month period occur, which would be difficult to detect without doing a more in-depth clinical interview with participants, which was outside the scope of this study. Suicidal ideation is a significant concept to investigate, however, due to the severity of the consequences of engaging in it; any level of suicidal ideation is damaging and may result in death if left undiagnosed or untreated. However, it is possible that the strength of the impact is smaller than that found for depressive symptoms because the connection between sexual minority status and suicidality is partially explained by sexual minority-specific victimization, as shown by the results of this study[9].

Recent years, the victimization of children, especially bullying, has emerged as a major concern for public health authorities in the United States, who have made it a top priority. In addition to higher school absenteeism and poorer grades, bullying is linked to a reduction in school ownership (a feature related with suicide safety) and an increased risk of sexually transmitted infections (STIs), including HIV. According to media surveys, bullying, particularly in its most extreme form, is often mentioned as a contributing factor to adolescent suicide. Our results indicate the existence of a link between bullying and suicide, at least among young people who are contemplating suicide or who have survived a suicide attempt, according to the authors. There has been no study on suicide finishers that has looked at the issue of victimization.

The Youth Risk Behavior Survey (YRBS), on the other hand, has shown that victimization is a significant predictor of suicide attempts among adolescents. Furthermore, meta-analytic investigations have shown that when the prevalence of suicidality rises, the gap between SMY and heterosexual adolescents in terms of suicidal ideation grows. For example, although SMY is about twice as likely as the general population to have suicidal thoughts, they are more than four times as likely as the general population to report a suicide attempt that required medical care. Possibly, the emotions of despair that have been created or exacerbated by discrimination against sexual minorities are the driving force behind these severe attempts.

The fundamental mechanism(s) through which sexual minority-specific victimization leads to higher depressive symptoms and suicidal ideation is outside the scope of this research. Recent study, on the other hand, has dug further into the nature of these connections. One study of adults who identify as sexual minorities discovered that internalized homo-negativity (the internalization of derogatory social beliefs about homosexuality) and rejection sensitivity mediate the relationship between victimization and depressive symptoms that are specific to sexual minorities. Taken together, previous research and the current study suggest that through experiencing sexual minority-specific victimization, SMY develops negative emotions about themselves as individuals and learns to expect intolerance and rejection, which may lead to greater depression and suicide ideation[10].

3. CONCLUSION

This investigation is not without its limitations. It was decided to utilize a sub-sample of young people who were recruited as part of a larger NIH-funded continuing research with an open enrollment design, which would eventually engage 400 young people over the course of four to five years. We are still able to get statistically significant findings even after controlling for demographic variables because, despite the fact that the current subsample represents just half of the entire planned enrolment, we have less statistical power than we would have at the conclusion of the enrollment. For the time being, the sample size of the current research is insufficient to investigate SMY subgroups in depth. Not all subgroups of the sexual minority are exposed to the same degree of danger. According to research, SMYs who identify as bisexual and "mainly heterosexual" are more likely to engage in drug use and suffer from depression than young people who identify as "100 percent heterosexual" or "100 percent gay."

Discrepancies between SMY subgroups may be investigated, however dividing any minority group into subgroups requires very large sample numbers, which is not feasible in practice. Furthermore, SMY may be exposed to distinct risk factors for racial/ethnic minorities than SMY for non-racial/ethnic minorities, depending on the situation. The present study's sample was mostly African American (63 percent), however it is unclear if African American SMY differs significantly from other racial/ethnic SMY groups on the factors under investigation. The collection of longitudinal data, which distinguishes this study from previous similar studies, is a significant advantage. While the longitudinal design has obvious advantages, the interval between measurement points was just 6 months, which is a significant limitation. It is possible that future studies will examine SMY victimization and mental well-being over longer periods of time, and they may employ the technique of person trend modelling (for example, latent growth curve modelling) to determine whether victimization continues to increase or decrease, and whether the effects over time persist or dissipate over time.

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