The Role of LGBTQ Identity Pride in the Associations among Discrimination, Social Support, and Depression in a Sample of LGBTQ Adolescents

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The current study examined the role of LGBTQ identity pride in the associations among discrimination, social support, and depressive symptoms in a sample of LGBTQ youth. As part of a larger study, 13,440 LGBTQ youth completed a survey assessing depressive symptoms, past-year bullying, family rejection, general and LGBTQ-specific teacher support, general and LGBTQ-specific family support, and LGBTQ identity pride. Findings showed that greater bullying and family rejection were associated with lower LGBTQ identity pride and, in turn, greater depression. Conversely, greater general and LGBTQ-specific teacher support and greater general and LGBTQ-specific family support were associated with greater LGBTQ identity pride and, in turn, lower depression. All of the indirect effects were significant when the predictors were examined in separate models and most remained significant when the predictors were examined simultaneously. LGBTQ identity pride may be a mechanism linking discrimination and social support to depression among LGBTQ youth.

Keywords: LGBT; depression; discrimination; social support; identity pride

Statement of Public Health Significance: Greater social support and lower discrimination may help foster positive LGBTQ identity, which is associated with lower depressive symptoms. Findings highlight the importance of examining positive aspects of LGBTQ youths' experiences. They also provide support for policies and interventions aiming to bolster social support and reduce discrimination among LGBTQ youth.

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http://dx.doi.org/10.1891/LGBTQ-2021-0020

INTRODUCTION

LGBTQ youth consistently report elevated rates of depression compared to cisgender and heterosexual youth.[1–4] In a recent meta-analysis, sexual minority (e.g., lesbian, gay, bisexual, queer) youth were more than three times more likely to report depressive symptoms or a depressive disorder than heterosexual youth.[5] Similarly, results from a national survey demonstrated that 53% of transgender and gender diverse youth reported depressive symptoms compared to only 30% of cisgender youth.[6] Although these disparities are present across the lifespan, disparities in depressive symptoms commonly emerge in adolescence[7,8] and are greatest throughout young adulthood.[9] These figures highlight the importance of identifying risk and protective factors related to depression among LGBTQ youth in order to prevent and/or treat it early in development. In particular, the positive aspects of LGBTQ identity, such as pride in one's LGBTQ identity, have received greater attention in recent years.

The disparities in depression observed among LGBTQ youth compared to cisgender and heterosexual counterparts are often explained by the minority stress model.[10] The minority stress model posits that sexual and gender minority people are at increased risk for negative mental health outcomes due to their exposure to unique stressors related to their sexual and gender minority identities, such as discrimination and victimization. Consistent with this model, a large body of work suggests that experiences of bullying[11,12] and family rejection[13] are associated with greater depression in samples of LGBTQ youth. Minority stress researchers have also aimed to identify factors that are stress-ameliorating (e.g., social support), and more recent work has expanded on the role of social support in LGBTQ mental health (e.g., the minority strengths model).[14] Not only is social support associated with lower depression among LGBTQ young adults,[15] but family support and acceptance have particularly strong influences on well-being in LGBTQ people, including youth and young adults.[15–17] Together, these studies highlight the roles of interpersonal experiences, both negative and positive, in LGBTQ mental health.

While many studies have examined the extent to which rejecting and accepting interpersonal experiences are associated with depression among LGBTQ youth, relatively few studies have examined the mechanisms underlying these associations. Consistent with the psychological mediation framework,[18] studies have demonstrated that experiences of discrimination and victimization may "get under the skin" (i.e., affect mental health) by contributing to general psychological processes (e.g., emotion dysregulation, rumination)[19–21] and sexual minority-specific processes (e.g., internalized stigma, rejection sensitivity).[22] Meanwhile, social support may contribute to lower depression by increasing self-esteem[23] and decreasing hopelessness.[24] These processes have also been studied among LGBTQ youth, finding that the minority stress and psychological mediation framework apply to youth as well,[25–27] though researchers have emphasized the importance of considering social context (e.g., school, family), coping resources, and developmental processes when considering LGBTQ youth.[28] Prior studies generally emphasized the negative stressors of being and growing up as LGBTQ; however, scholars have acknowledged that LGBTQ youth are resilient and have called for greater attention to positive psychosocial experiences (e.g., identity pride) and their role in promoting LGBTQ mental health.[14,29]

Recent research has shed light on the benefits of feeling pride in one's LGBTQ identity and/or community, focusing on "minority strengths" model that extends the minority stress model by examining how strengths-based variables operate in a causal chain to influence mental and physical health outcomes.[14] Perrin et al. (2020) found that greater social support was

associated with better mental health through identity pride, resilience, and self-esteem among LGBTQ adults.[14] This study provided initial support for the role of LGBTQ identity pride in the association between social support and mental health. A systematic review of studies involving both LGBTQ youth and adults has similarly found that greater social support and acceptance are associated with greater LGBTQ identity pride and sexuality self-acceptance.[30] Previous research has found that family support may be particularly important for identity pride and mental health among LGBTQ youth since youth often spend a substantial amount of time with their family.[31,32] However, other sources of support may also play a role in LGBTQ youths' mental health, such as support from teachers.[33] With ample research demonstrating that experiences of discrimination, such as bullying and family rejection, are associated with negative self-views among LGBTQ youth (e.g., more negative sexual orientation-related identity,[34] greater internalized homophobia[31]), it is reasonable to expect that discrimination may also be associated with low levels of LGBTQ identity pride and, in turn, poor mental health. Additional research is needed to extend the minority strengths model to LGBTQ youth and to understand the extent to which discrimination and support from different sources (e.g., parents, teachers) is associated with LGBTQ identity pride and mental health.

Drawing on the minority stress and minority strengths models,[14] the goal of the current study was to examine the role of LGBTQ identity pride in the associations among discrimination (bullying, family rejection), social support (general and LGBTQ-specific support from teachers and family), and depressive symptoms in a sample of LGBTQ youth. Specifically, we examined the indirect effects of each discrimination and social support variable on depressive symptoms through LGBTQ identity pride (separately and then simultaneously). We hypothesized that higher levels of discrimination (both bullying and family rejection) would be associated with lower levels of LGBTQ identity pride, which in turn would be associated with higher levels of depressive symptoms. In contrast, we hypothesized that higher levels of social support (both general and LGBTQ-specific teacher and family support) would be associated with higher levels of LGBTQ identity pride, which in turn would be associated with lower levels of depressive symptoms.

METHODS

Participants

Data for this study came from the *LGBTQ National Teen Survey*, conducted in partnership with the Human Rights Campaign (HRC) with the goal of increasing scientific research on sexual and gender minority youth health.[35] A total of 17,112 LGBTQ+ youth participated in the study. Youth who did not have data on any of our variables of interest were removed from the dataset, leaving 13,440 in the analytic sample. The mean age of participants was 15.58 years (standard deviation [*SD*] = 1.27 years). The sample included 22.4% cisgender boys (n = 3,011), 43.5% cisgender girls (n = 5,840), 8.5% transgender boys (n = 1,141), 1.1% transgender girls (n = 146), and 23.7% nonbinary/genderqueer youth (n = 4,048). In terms of sexual orientation, 37.1% identified as gay/lesbian (n = 4,985), 34.4% as bisexual (n = 4,618), 1.6% as heterosexual (n = 216), 4.2% as queer (n = 562), 13.5% as pansexual (n = 1,819), 4.6% as asexual (n = 619), 2.5% as questioning (n = 332), and 2.2% as other/not listed (n = 289). A total of 64% of participants identified as White (n = 4,844), 5% as Black/African American (n = 674), 4.1% as Asian (n = 550), 10.8% as Latinx/Hispanic (n = 1,450), 14.7% as youth who chose multiple ethnoracial identities (n = 1,978), and 1.3% as other/not listed (n = 172).

Procedures

Recruitment was conducted through social media advertisements (i.e., Facebook, Instagram, Twitter, Reddit, and Snapchat) and through HRC partner organizations (i.e., Youth Link, The Trevor Project, Advocates for Youth, Planned Parenthood, and Big Brother/Big Sister). Interested youth clicked on a link and were invited to complete a web-based survey. Participants were entered into a drawing for one of 100 Amazon gift cards valued at $50 and a six-pack of HRC wristbands. Participants were required to be English-speaking, LGBTQ+, 13–17 years old, and living within the United States. All youth participants provided assent, but the University of Connecticut ethics board granted a waiver of parental consent given that it was a minimal risk study and that requiring parental consent could have put youth at risk if they were not out to their parents and/or if their parents were not accepting of their LGBTQ identity.

Measures

Depression. Depression symptoms were measured using 10 items from the 11-item Kutcher Adolescent Depression Scale[36]; the suicide/self-harm item was not administered. Participants were asked to rate how often they experienced each symptom over the past week. Example items included "Low mood, sadness, feeling blah or down, depressed, just can't be bothered" and "Feeling that life is not very much fun, not feeling good when usually would feel good, not getting as much pleasure from fun things as usual." Items were rated on a 4-point scale (0 = *hardly ever,* 3 = *all of the time*) and responses were averaged across items. In this sample, the measure showed good internal consistency (Cronbach's α = .90).

Past-Year Bullying. Past-year bullying was first assessed by asking participants whether they had been teased or bullied because of their actual or perceived LGBTQ identities at school. Specifically, youth were first asked, "Have you ever been teased or bullied because of your actual or perceived LGBTQ identities at school?" Response options included "No," "Yes, because I am LGBTQ and I have told others," and "Yes, because someone thought I was LGBTQ." Those who endorsed any bullying were then asked, "Has this happened to you within the past year?" (response options: 0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = very often). Those who did not endorse any bullying in their lifetime were assigned a score of 0 for past-year bullying.

Family Rejection. Family rejection was assessed using four items adapted from prior research on family acceptance and rejection among LGBTQ adolescents and young adults.[37] Participants were asked how much their family taunts or mocks them because they are an LGBTQ person, says negative comments about them being an LGBTQ person, says bad things about LGBTQ people in general, and makes them feel like they are bad because they are an LGBTQ person. Participants rated each item on a 4-point scale (0 = never, 3 = often). Responses were averaged across items. The measure demonstrated good reliability in our sample (Cronbach's α = .89).

General and LGBTQ-Specific Teacher Support. General teacher support was assessed using one item asking, "Do you agree or disagree that your teachers really care about you and give you encouragement and support?" Response options ranged from 0 (strongly disagree) to 3 (strongly agree). Participants could also respond with "not sure," which was coded as missing.

LGBTQ-specific teacher support was assessed by asking participants, "How many of the teachers and staff at your school do you think are supportive of LGBTQ people?" Response options ranged from 0 (none of them) to 3 (all of them).

General and LGBTQ-Specific Family Support. General family support was measured using three items adapted from prior research on perceived social support.[38] Participants were asked to rate their agreement or disagreement with three statements: "your family cares about you," "your family has lots of fun together," and "your family pays attention to you." Items were rated on a 5-point scale (0 = strongly disagree, 4 = strongly agree) and responses were averaged across items. LGBTQ-specific family support was measured using four items adapted from the Family Acceptance Project,[37] asking how much the youth feels their family says they like the youth as they are in regards to being an LGBTQ person, says they are proud of the youth for being an LGBTQ person, gets involved in the larger LGBTQ community, and tells the youth that they are a role model as an LGBTQ person. Response options ranged from 0 (never) to 3 (often) and responses were averaged across items. Both scales demonstrated good reliability in our sample (Cronbach's α = .84 for general family support and .81 for LGBTQ-specific family support).

LGBTQ Identity Pride. LGBTQ identity pride was measured using two items: "I am proud to be a part of the LGBTQ community" (0 = strongly disagree, 3 = strongly agree) and "Do you feel pride in being an LGBTQ person?" (0 = definitely no, 3 = definitely yes). Responses were averaged across items. This measure demonstrated good internal consistency in our sample (Cronbach's α = .83).

Demographics. Participants were asked to report their age, sex assigned at birth, gender identity, sexual orientation, race, and ethnicity. For sex assigned at birth, participants were asked "What sex were you assigned at birth?" (response options: "male" and "female"). For gender identity, participants were asked "What is your current gender identity?" and they were allowed to select multiple response options (response options: "male," "female," "trans male/-trans boy," "trans female/ trans girl," "nonbinary," "genderqueer/gender nonconforming," and "different identity"). For sexual orientation, participants were asked "How do you describe your sexual orientation?" (response options: "gay or lesbian," "bisexual," "straight, that is not gay," and "something else"). Those who selected "something else" were provided additional response options ("queer," "pansexual," "asexual," "questioning," and "other"). For race/ethnicity, participants were asked a single question—"How would you describe yourself?"—and they could select multiple response options from the following list: "White, non-Hispanic, non-Latino," "Black or African American," "American Indian or Alaskan Native," "Asian or Pacific Islander," "Latino, Hispanic, or Mexican-American" (referred to as Latinx/Hispanic hereafter), or "Other." Individuals who selected multiple response options were categorized as "youth with multiple ethnoracial identities." To reduce the number of variables in our models, sex assigned at birth and gender identity were used to create five categories (cisgender boy, cisgender girl, transgender boy, transgender girl, nonbinary/genderqueer youth). In addition, sexual orientation was recoded into eight categories (gay/lesbian, bisexual, heterosexual, queer, pansexual, asexual, questioning, other), and race/ethnicity was recoded into six categories (White, Black, Asian, Latinx/Hispanic, multiple ethnoracial identities, other).

Analytic Strategy

We used path analysis conducted in MPlus version 8.[39] First, in separate models, we examined the indirect effect of each discrimination variable (past-year bullying and family rejection) and each social support variable (general and LGBTQ-specific teacher and family support) on depressive symptoms via LGBTQ identity pride. Then, we examined them as simultaneous predictors in the same model. Missing data ranged from 13% to 30% for the predictors, and it was 17% for the outcome (depressive symptoms). There were no missing data on demographic variables. There is no empirical method to test whether data are missing at random, so we addressed the assumptions of missing at random by including covariates (age, sex/gender, sexual orientation, and race/ethnicity), as recommended by Widaman.[40] We also used full-information maximum likelihood to account for missing data[41] and computed unstandardized indirect effects for each of 10,000 bootstrapped samples, as well as 95% confidence interval. All analyses controlled for age, sex/gender, sexual orientation, and race/ethnicity.

RESULTS

Preliminary Results

Means, *SD*s, and zero-order correlations are presented in Table 2. Higher levels of past-year bullying were significantly associated with higher levels of family rejection and depressive symptoms as well as lower levels of general teacher support, LGBTQ-specific teacher support, general family support, and LGBTQ identity pride. Higher levels of family rejection were significantly associated with higher levels of depressive symptoms and lower levels of general teacher support, LGBTQ-specific teacher support, general family support, LGBTQ-specific family support, and LGBTQ identity pride. Finally, all four social support variables (general teacher support, LGBTQ-specific teacher support, general family support, and LGBTQ-specific family support) were significantly associated with higher levels of LGBTQ identity pride and lower levels of depressive symptoms.

In addition, given our primary focus on LGBTQ identity pride, we examined demographic differences in pride. Greater age was associated with lower pride ($r = -.06$, $p < .001$). There was a significant association between sex/gender and LGBTQ identity pride, $F(11,347) = 55.41$, $p < .001$. Nonbinary youth ($M = 2.59$, $SD = .59$) reported the greatest levels of pride, followed by cisgender girls ($M = 2.54$, $SD = .60$), transgender boys ($M = 2.45$, $SD = .70$), cisgender boys ($M = 2.35$, $SD = .75$), and transgender girls ($M = 2.33$, $SD = .81$). There were significant differences between most of these groups (p's ranged from < .001 to .007), except transgender girls did not differ from cisgender boys ($p = .99$) or transgender boys ($p = .26$). There was also a significant association between sexual orientation and LGBTQ identity pride, $F(11,156) = 35.42$, $p < .001$. Youth who identified as pansexual ($M = 2.66$, $SD = .52$) reported the greatest levels of LGBTQ pride, followed by other ($M = 2.64$, $SD = .54$), queer ($M = 2.61$, $SD = .54$), gay/lesbian ($M = 2.51$, $SD = .64$), asexual ($M = 2.44$, $SD = .66$), bisexual ($M = 2.43$, $SD = .67$), and questioning ($M = 2.30$, $SD = .72$). There were significant differences between most of these groups (p's ranged from < .001 to .04) with the following exceptions: gay/lesbian youth did not differ from asexual youth ($p = .13$), bisexual youth did not differ from asexual youth($p = 1.0$), queer youth did not differ from pansexual ($p = .78$) or other youth ($p = .997$), pansexual youth t differ from other youth (p = 1.0), and asexual youth did not differ from questioning youth ($p = .06$). Finally, there was a significant association between ethnoracial identity and LGBTQ

TABLE 1. Description of Sample Demographics (*N* = 17,112)

Variable	%	*n*
Gender identity		
Cisgender boy	23.8	4,079
Cisgender girl	43.2	7,396
Transgender boy	8.2	1,404
Transgender girl	1.1	185
Nonbinary/genderqueer	23.7	4,048
Sexual identity		
Gay/lesbian	37.4	6,401
Bisexual	34.9	5,970
Heterosexual	1.6	279
Queer	4.1	699
Pansexual	13.2	2,256
Asexual	4.2	725
Questioning	2.5	424
Other/not listed	2.1	358
Race/ethnicity		
White	62	10,245
Black/African-American	5.8	959
Asian	4.2	696
Latinx/Hispanic	11.4	1.877
Multiple ethnoracial identities	15.2	2,508
Other/not listed	1.4	236

identity pride, F(11330) = 3.01, p = .01. The only significant group comparison was that individuals with multiple ethnoracial identities reported significantly lower pride (M = 2.47, SD = .67) than Hispanic/Latinx youth (M = 2.55, SD = .62; p = .02). Because these demographic variables were associated with LGBTQ+ identity pride, we included them as covariates in the indirect effect analyses.

Indirect Effect Analyses

Results are presented in Table 3. Higher levels of each of the discrimination variables (past-year bullying and family rejection) were significantly associated with lower levels of LGBTQ identity pride, which in turn was significantly associated with higher levels of depressive symptoms. In contrast, higher levels of each of the social support variables (general teacher support, LGBTQ-specific teacher support, general family support, and LGBTQ-specific family support) were significantly associated with higher levels of LGBTQ identity pride, which in turn was significantly associated with lower levels of depressive symptoms. All of the indirect effects were significant. The pattern of results was largely the same when all of the discrimination and social support variables were included in the same model (see Table 7 and Figure 1) with two

exceptions: the indirect effects of past-year bullying and LGBTQ-specific teacher support on depressive symptoms via LGBTQ identity pride were no longer significant.

DISCUSSION

Informed by the minority stress and minority strengths models, we sought to examine the roles of discrimination and social support in shaping pride in one's LGBTQ identity as well as depressive symptoms among LGBTQ youth. Youth are continuing to express their LGBTQ identities at younger ages compared to older generations of LGBTQ people.[42] Though this reflects progress in the fight for LGBTQ equality, public and adolescent health experts must ensure that there are adequate resources within social institutions to mitigate exposure and consequences of minority stress, and support LGBTQ identity development, pride, and expression.[43–45] Our study's findings underscore the importance of this concern; specifically, we observed that participants who experienced more LGBTQ-related bullying and family rejection reported less pride in their LGBTQ identities and more depression. These findings aligned with prior studies of LGBTQ adults[14,46] that also found an inverse association between levels of LGBTQ identity pride and depression. Additionally, we found that participants who had higher levels of social support reported higher levels of LGBTQ identity pride and less depression compared to those with lower levels of social support. These findings point to the importance of social support as a resilience factor for LGBTQ adolescents.[47]

Our most noteworthy findings were that all indirect pathways in our hypothesized model were statistically significant, suggesting that bullying and family rejection may contribute to depression by reducing pride in one's LGBTQ identity, whereas social support may protect against depression by increasing pride in one's LGBTQ identity. We found the same pattern of results for both types of discrimination (bullying and family rejection) and for all four types of social support (general teacher support, LGBTQ-specific teacher support, general family support, and LGBTQ-specific family support). These findings are consistent with prior research suggesting that discrimination from peers as well as family members can have negative consequences for LGBTQ identity development and mental health.[31,32] Conversely, our findings suggest that social support from teachers and family members may be related to positive outcomes. Furthermore, our findings suggest that support may not have to be specific to one's LGBTQ identity to be associated with greater LGBTQ pride. Rather, by feeling cared for and supported, youth are able to be themselves and flourish. Since general- and LGBTQ-specific family support were correlated, it is possible that general support allows for youth to seek out affirmative experiences. Of note, when all of the discrimination and social support variables were included in the same model, two of the indirect effects were no longer significant (the indirect effects of past-year bullying and LGBTQ-specific teacher support on depression via LGBTQ identity pride). This is likely the result of family rejection and the other types of social support being more strongly associated with LGBTQ identity pride than were past-year bullying and LGBTQ-specific teacher support.

The interpretations of our findings should be considered in light of several limitations. First, given that our data were cross-sectional, we cannot draw causal conclusions from our results. Second, our data were from a non-probability sample of LGBTQ youth and, as such, our findings may not be generalizable to the broader population of LGBTQ youth. Third, several of our measures referred to "LGBTQ" identities even though some of our participants identified as both sexual and gender minorities. As such, in some cases, it is unclear which of these identities youth were considering when responding to these measures. Fourth, although we

TABLE 2. Pearson's Correlations, Means, Standard Deviations, and Ranges for Study Variables

Variable	1	2	3	4	5	6	7	8
1. Bullying	-							
2. Family rejection	.24[c]	-						
3. General teacher support	−.22[c]	−.14[c]	-					
4. LGBT-specific teacher support	−.23[c]	−.21[c]	.41[c]	-				
5. General family support	−.24[c]	−.47[c]	.25[c]	.18[c]	-			
6. LGBT-specific teacher support	.02	−.39[c]	.10[c]	.14[c]	.39[c]	-		
7. LGBT pride	−.02[a]	−.11[c]	.09[c]	.05[c]	.11[c]	.16[c]	-	
8. Depressive symptoms	.31[c]	.31[c]	-.27[c]	−.17[c]	−.45[c]	−.15[c]	−.08[c]	-
M (*SD*)	1.25 (1.28)	1.07(.96)	2.65(1.23)	1.53(.65)	3.44(1.00)	1.75(.83)	2.50(.65)	13.32(7.53)
Range	0–4	0–3	0–4	0–3	1–5	1–4	0–3	0–30

[a]Significant at the 0.05 level two-tailed).
[b]Significant at the 0.01 level (two-tailed).
[c]Significant at the 0.001 level (two-tailed).

TABLE 3. Individual Indirect Effect Analyses

Independent Variable	a path			b path			Direct effect			Indirect effect			
	B	*SE*	*P*	b	*SE*	*p*	B	*SE*	*p*	b	*SE*	*p*	95% CI
Bullying	−.02	.01	<.01	−1.17	.11	<.001	1.69	.06	<.001	.02	.01	<.01	[.01, .03]
Family rejection	−.07	.01	<.001	−.91	.11	<.001	1.98	.07	<.001	.07	.01	<.001	[.05, .09]
General teacher support	.05	.01	<.001	−1.03	.11	<.001	−1.26	.06	<.001	−.05	.01	<.001	[−.07, −.04]
LGBT teacher support	.04	.01	<.001	−1.22	.11	<.001	−1.07	.10	<.001	−.05	.01	<.001	[−.08, −.03]
General family supp	.07	.01	<.001	−.78	.11	<.001	−2.64	.07	<.001	−.06	.01	<.001	[−.08, −.04]
LGBT family support	.11	.01	<.001	−1.10	.12	<.001	−.96	.09	<.001	−.12	.02	<.001	[−.15, -.09]

Note. Each discrimination and social support variable was examined in a separate model; the "a path" refers to the association between the independent variable and LGBT pride; the "b path" refers to the association between LGBT pride and depression.

TABLE 4. Simultaneous Indirect Effect Analyses

Independent Variable	a path			b path			Direct effect			Indirect effect			
	b	SE	*P*	b	SE	*p*	b	SE	*p*	b	SE	*p*	95% CI
Bullying	0.01	0.01	0.27	−0.55	0.1	<.001	.99	0.06	<.001	<−.01	<.01	0.29	[−.01, .002]
Family rejection	−0.04	0.01	<.001				0.77	0.08	<.001	0.02	0.01	<.001	[.01, .04]
General teacher support	0.04	0.01	<.001				−0.76	0.07	<.001	−0.02	0.01	<.001	[−.04, −.01]
LGBT teacher support	<.001	0.01	0.97				0.01	0.12	0.93	<.001	0.01	0.97	[−.01, .01]
General family support	0.03	0.01	<.01				−2.39	0.08	<.001	−0.02	0.01	.01	[−.03, −.01]
LGBT family support	0.08	0.01	<.001				0.44	0.09	<.001	−0.04	0.01	<.001	[−.06, −.03]

Note. All of the discrimination and social support variables were examined in a single model; the "a path" refers to the association between the independent variable and LGBT pride; the "b path" refers to the association between LGBT pride and depression (and, as such, there was only one "b path" in the simultaneous indirect effects model).

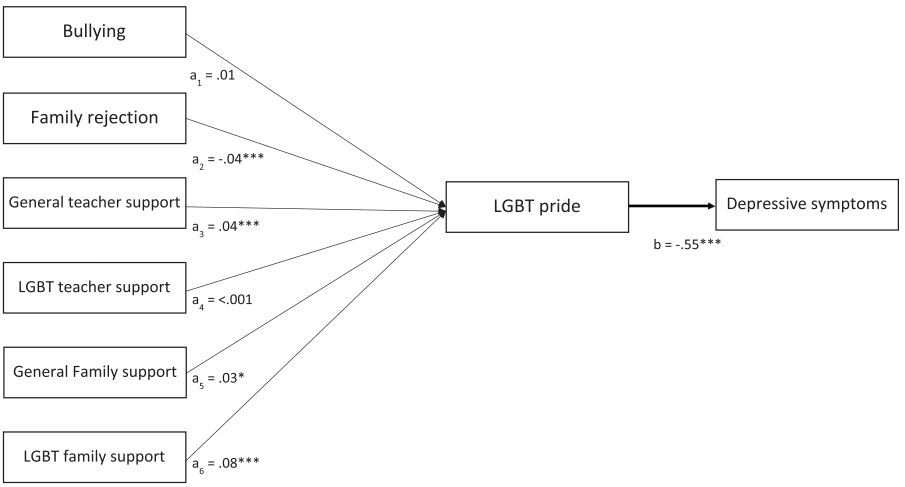

Figure 1. The indirect effect of each risk/protective factor on depressive symptoms through LGBT pride was significant, except for past-year bullying and LGBT-specific teacher support. Unstandardized regression coefficients are presented. Direct effects of the risk/protect factors on depressive symptoms as well as indirect effects can be found in Table 4. $^{**}p < .01$. $^{***}p < .001$

assessed multiple types of discrimination and social support, our measures were not exhaustive (e.g., our measures of discrimination did not include microaggressions, our measures did not differentiate between experiences with parents versus siblings) and some of them had different timeframes (e.g., past-year bullying versus past-week depressive symptoms). As such, it will be important to replicate these findings in a longitudinal study with a nationally representative sample, and for future studies to assess different types of discrimination from different sources (and their salience) using measures with timeframes that are more closely aligned, as well as focusing on intersectionality between different identities. Additionally, future research should examine other protective factors that were not captured in our study (e.g., peer networks, LGBTQ role models, having LGBTQ staff and teachers, access to LGBTQ clubs), given that these factors have been identified as protective factors in past studies.[3,48]

Despite our study's limitations, our findings provide insight for public health policy and practice. Narrowing the mental health disparities that burden LGBTQ adolescents compared to their cisgender, heterosexual counterparts warrants attention from implementation researchers and health practitioners to attend to the social and cultural environments that shape LGBTQ identity pride and development.[49,50] This is especially critical as adverse experiences in formative years have implications for mental health into early adulthood and across the life course.[51,52] Given that school experiences (e.g., bullying, teacher support) and family experiences (e.g., family rejection, family support) were both associated with LGBTQ identity pride and depression, our findings underscore the need to intervene in multiple interpersonal contexts concurrently. In prior studies, researchers have found that implementing protective school programs (e.g., inclusive anti-bullying policies, gender and sexuality alliances) is associated better mental health among LGBTQ youth.[48,53,54] As such, by providing LGBTQ youth with a safe environment for learning and socializing, schools have the potential to promote pride in one's LGBTQ identity and to improve mental health as well.

Given our findings, we also advocate the importance of supporting families of LGBTQ youth and intervening when family members are rejecting of LGBTQ youth's identities. Recent research has begun to focus on interventions that improve attitudes and behaviors toward LGBTQ youth in family members with LGBTQ-stigmatizing beliefs. For instance, Huebner et al. (2013) developed a film-based intervention to improve parents' responses to their LGB children, which was perceived as helpful by parents and led to increases in parents' self-efficacy

for parenting an LGB child.[55] In addition, the Family Acceptance Project has developed a number of evidence-based resources (e.g., infographics, videos) that can be used to help reduce parents' rejecting behaviors toward their LGBTQ children.[56] More specific to transgender and gender nonconforming youth, the Parent Support Program has shown promise for increasing parents' transgender affirming behaviors.[57] Future work might consider ways to adapt these findings to be delivered to teachers as well. In sum, efforts to reduce negative experiences related to one's LGBTQ identity (e.g., bullying, rejection) and efforts to provide LGBTQ youth with more support both have the potential to increase LGBTQ identity pride and, in turn, to improve mental health among LGBTQ youth.

Our findings also provide support for the need to enact curricular standards that affirm the visibility of LGBTQ youth in school settings. Implementing these standards may concomitantly work to minimize negative attitudes toward LGBTQ peers among cisgender, heterosexual students while supporting identity affirmation among LGBTQ students. As of this writing, only five states (California, Colorado, Illinois, New Jersey, and Oregon) allow inclusive portrayals of LGBTQ communities in schools while five other states (Alabama, Louisiana, Mississippi, Oklahoma, and Kentucky) have codified *no promo homo* laws that expressly forbid positive and affirming representation of LGBTQ identities in K-12 education.[58] These laws have also been used to disallow the formation of GSAs and sensitivity training to school staff. Similarly, only 24 states and Washington, DC, have passed legislation that prohibit bullying and harassment based on sexual orientation and gender identity. This leaves LGBTQ youth in the remainder of the country without any enumerated protections.

CONCLUSIONS

Affirming social experiences in adolescence are critical to LGBTQ people's psychosocial development across the life course. LGBTQ identity pride is an important facet of psychological well-being among LGBTQ youth and has important implications for reducing the mental health disparities that negatively impact these communities. In our study, we highlighted how LGBTQ pride may serve as a mechanism linking discrimination and social support to mental health among LGBTQ youth. We provide support for the importance of examining positive aspects of LGBTQ youths' experiences, which have received relatively little attention in the literature. Public health experts must continue to enact policies and programming the minimize exposure to minority stressors like bullying and rejection in adolescence while supporting LGBTQ identity pride and development.

Compliance with Ethical Standards

The authors declare that they have no conflict of interest. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

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Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Funding. The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the National Institute on Drug Abuse K08DA045575; K01DA047918. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding agencies.

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