

Disclosure of Self-Injurious Thoughts and Behaviors Across Sexual and Gender Identities

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abstract

OBJECTIVES: Evidence suggests that sexual minority (SM) and gender minority (GM) youth are more likely to experience self-injurious thoughts and behaviors (SITBs) than heterosexual and cisgender youth. A major barrier to identifying and treating SITBs is nondisclosure. In this study, we explored differences in SITB disclosure patterns between SM and GM youth and their heterosexual and cisgender peers. In this study, we further examined the association between discrimination experiences and SITB disclosure.

METHODS: Adolescents ($N = 931$) completed questionnaires assessing demographics, SITBs, disclosure history, disclosure barriers, future intentions to disclose SITBs, and discrimination history.

RESULTS: Few differences in SITB disclosure patterns emerged between SM and GM youth and heterosexual and cisgender youth ($P > .05$). SM and GM youth endorsed greater rates of fear of disclosure to and worrying parents, two parent-related barriers ($\chi^2_2 = 8.11, P = .017$; $\chi^2_2 = 7.25, P = .027$). GM youth reported greater discrimination experiences than SM youth ($F = 6.17, P = .002$); discrimination experiences impacted their willingness to disclose future SITBs more so than their SM and heterosexual and cisgender peers ($F = 11.58, P < .001$). Among the full sample, more discrimination experiences were associated with lower previous disclosure honesty to therapists and pediatricians ($r = -0.09$ to $-0.10, P < .05$). Among SM and GM youth, discrimination experiences were associated with lesser odds of disclosing suicide attempts in the future ($r = -0.12, P < .05$).

CONCLUSIONS: Minority stress experiences may interfere with SITB disclosure, particularly among GM youth. Targeted interventions should be considered to reduce minority stress and support disclosure.



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Drs Burke and Bettis conceptualized and designed the study, drafted parts of the initial manuscript, and reviewed and revised the manuscript; Dr Fox conceptualized and designed the study, conducted the data analysis, coordinated and supervised data collection, drafted the Results section of the initial manuscript, and reviewed and revised the manuscript; Ms Barnicle and Ms Wang drafted parts of the initial manuscript and reviewed and revised the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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WHAT'S KNOWN ON THIS SUBJECT: Evidence suggests that sexual minority and gender minority (GM) youth experience higher rates of self-injurious thoughts and behaviors (SITBs) than their heterosexual and cisgender counterparts. However, research has yet to explore whether these differences are observed in SITB disclosure.

WHAT THIS STUDY ADDS: Results suggest few differences in SITB disclosure patterns between sexual minority and GM youth seeking treatment and their heterosexual and cisgender counterparts. However, our findings suggest that minority stress experiences may interfere with SITB disclosure, particularly among GM youth.

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Lesbian, gay, bisexual, transgender, gender nonconforming, queer, and questioning (LGBTQ+) youth are at significantly elevated risk for self-injurious thoughts and behaviors (SITBs). Evidence suggests that LGBTQ+ youth are at least 2 to 3 times more likely to experience suicidal thoughts and 3 to 5 times more likely to attempt suicide than their cisgender heterosexual counterparts.¹⁻³ LGBTQ+ youth are also at heightened risk for nonsuicidal self-injury (NSSI) (self-injury that is engaged in without suicidal intent), with upward of 29% of sexual minority (SM) (including those with some or exclusive same-gender romantic or sexual attraction or those who experience no romantic or sexual attraction) youth and 46% of gender minority (GM) (including those who identify with any gender distinct from their birth-assigned sex) youth reporting a history of this behavior.⁴ The elevated rates of SITBs among LGBTQ+ youth are highly concerning because meta-analytic evidence suggests that both suicidal thoughts and NSSI are prospectively predictive of suicide attempts⁵ and that suicidal thoughts and suicide attempts are prospectively, although weakly, predictive of death by suicide.⁶

A major barrier to being identified as at risk for SITB outcomes and receiving appropriate treatment is nondisclosure. A growing body of literature suggests that a majority (60%–66.2%) of those who have a history of suicidal thoughts do not disclose these thoughts to others.⁷ Omitting information about one's history of SITBs when interacting with health care providers, or dishonesty when responding to direct questions inquiring about suicide risk, impedes identification and treatment. Unfortunately, there are numerous barriers to SITB disclosure, including concerns about

stigma, involuntary hospitalization, and medication prescription, as well as shame, embarrassment, and beliefs that one is unable to be helped.⁸⁻¹⁰

The minority stress model^{11,12} suggests that experiences of minority stress, including discrimination, violence, and victimization, underlie disproportionately poorer mental health outcomes (eg, depressive and anxiety symptoms, substance use) among LGBTQ+ individuals. Building on this model, sexual and gender minority (SGM) stress may result in increased psychosocial (eg, shame, peer and/or familial rejection) and mental health risk factors for the development of SITBs and thus may be central to the elevated SITB rates observed among LGBTQ+ individuals.^{13,14} Recent evidence indicates that minority stress may also be associated with lower rates of SITB disclosure among LGBTQ+ youth.¹⁵

However, no studies to our knowledge have directly compared SITB disclosure rates and barriers to disclosure between LGBTQ+ and non-LGBTQ+ youth. In addition, no studies have examined differences in SITB disclosure rates between SM and GM youth, despite evidence that minority stress is not uniform across SM and GM individuals.¹² A direct comparison is necessary to elucidate potential patterns of and barriers to disclosure that are specific to or more pronounced among SM and GM youth. Similarly, although minority stress is associated with SITB nondisclosure among LGBTQ+ youth,¹⁵ it is unclear whether disclosure varies between SM, GM, and cisgender heterosexual youth or whether minority stressors account for potential differences in disclosure between these groups. Relatedly, no studies have compared rates of SITB assessment across groups, which is

essential to examine to contextualize potential differences in disclosure rates. Such information is critical to tailor interventions to these high-risk populations so as to encourage disclosure, augment assessment accuracy, and increase treatment use.

We first aim to evaluate whether there are differences in the rate of therapists' and pediatricians' assessments of SITBs between cisgender heterosexual, SM, and GM youth. The second aim of this study is to examine whether rates of SITB disclosure patterns to friends and parents or guardians differ between cisgender heterosexual, SM, and GM youth. The third aim is to assess group differences in disclosure honesty to therapists and health care providers and in endorsed barriers to such disclosure. The fourth aim is to examine associations among minority stress (ie, discrimination experiences due to a minoritized identity) and SITB disclosure and to further examine these associations specifically among LGBTQ+ youth. Given the dearth of empirical evidence examining group differences, we consider study aims 1, 2, and 3 to be exploratory and thus do not put forth hypotheses. However, we hypothesize that we will replicate previous literature finding that greater minority stress is associated with lower suicide-related disclosure intentions among LGBTQ+ youth.¹⁵

METHODS

Participants and Procedure

We recruited participants through paid Instagram ads, which directed individuals to a Qualtrics-based eligibility screening survey. Eligibility was determined on the basis of age (13–17 years old), English language comprehension, living in the United States, having a SITB history, and having a history of

mental health treatment. Qualified individuals who provided assent received a link to the full study on Qualtrics; parental consent was waived for this study. All individuals who completed the screener and/or full study were provided with mental health resources; all participants who completed the full study were entered into a lottery for \$25 gift cards. Full details about recruitment, screening, and procedures are provided by Fox et al (K. Fox, A. H. Bettis, T. A. Burke, E. A. Hart, S. B. Wang. Exploring adolescent experiences with and impacts of disclosing self-injurious thoughts and behaviors across settings, unpublished observations). All procedures were approved by the Harvard University Institutional Review Board.

Participants were included in the analytic sample if they responded to questions about sexual orientation and gender identity. Because demographics were assessed at the end of the study, this yielded a total of 931 (mean age = 15.7, SD = 1.11) of the original 1706 participants who started the study. Participants reported substantial diversity across sexual orientation and gender, with moderate racial and ethnic diversity (see Table 1). At the intersection of sexual orientation and gender identity, 117 (12.6%) participants identified as cisgender heterosexual, 338 (36.3%) as GM, and 476 (51.1%) as SM. Participants' average socioeconomic status was 5.82 (SD = 1.68, range = 1–10), as assessed with the MacArthur Scale of Subjective Social Status – Youth Version.¹⁶ Higher scores indicate higher social standing.

Measures

Screening Survey

We assessed eligibility using items from the Self-Injurious Thoughts and Behavior Interview-Revised,¹⁷ including items assessing lifetime history of NSSI, suicidal ideation,

and suicide attempts. We used single items to assess lifetime history of mental health treatment.

Demographics

We assessed age, race, ethnicity, sexual orientation, and socioeconomic status. We assessed gender using a measure with a wide range of gender identities.¹⁸ Participants were able to select multiple genders and sexual orientations.

History of SITB Disclosure

Several items were used to assess SITB disclosure. SITB history was first determined with the question “Have you ever told anyone about times where you [purposely hurt yourself without wanting to die/had thoughts of killing yourself/tried to kill yourself]?” Second, participants were asked to think of times they had engaged in a given SITB in their life. Third, participants were instructed to report who they had told about each SITB engagement using a Likert scale ranging from 0 (never) to 4 (every time); options included parent or guardian, therapist, psychiatrist or doctor (who prescribes mental health medication), doctor you see for check-ups and physicals (ie, pediatrician), another adult you trust, sibling, friend, acquaintance, someone you met online, and other. To maximize statistical power for paired analyses, we focused analysis on disclosure to friends and parents or guardians.

Future Likelihood of SITB Disclosure

We asked participants to report their likelihood of disclosing each SITB with a therapist in the future on a scale from 0 (not at all) to 4 (extremely).

Provider SITB Assessment and Honesty

We asked participants if providers (including pediatricians and/or medical providers and mental health professionals and/or therapists) had ever asked them about each SITB,

separately, with response options of “yes,” “no,” and “don't remember”; current analyses only considered yes and no responses. We also asked participants how honest they were in disclosing each SITB to pediatricians and/or medical providers and mental health professionals and/or therapists using a scale ranging from 0 (not at all honest) to 4 (completely honest).

Barriers to Disclosure

We adapted items from Hom et al⁸ to assess barriers to disclosure to mental health professionals and/or therapists. We added items relevant to adolescents (eg, telling parents or guardians) and aimed to reflect additional forms of stigma (eg, shame).

Expanded Everyday Discrimination Scale

The Expanded Everyday Discrimination Scale measures the extent to which participants experience chronic, everyday forms of discrimination (eg, “You receive poorer service than other people at restaurants or stores”). Participants were asked to rate each experience from 1 (never) to 5 (almost every day). The original scale has been validated and has strong psychometric properties in an adolescent sample.¹⁹

RESULTS

First, we examined whether therapists' and pediatricians' and/or medical providers' assessments of specific SITBs differed across identities, including participants identifying as SM or GM (ie, SGM) and cisgender heterosexual (ie, non-SGM). Results were mixed. Pearson χ^2 tests revealed a significant main effect of SGM status on therapist assessment of NSSI ($\chi^2 = 9.84, P = .007$) but no main effect of therapists' assessments of suicide ideation or attempts. For the purpose of SGM subgroup analyses, the GM group included individuals identifying as GM, some of whom

TABLE 1 Sample Demographics

Characteristics	Total (<i>N</i> = 931), <i>n</i> (%)
Birth-assigned sex	
Female	885 (95.1)
Male	36 (3.9)
Intersex	2 (0.2)
Prefer not to say	8 (0.9)
Gender	
Cisgender woman	569 (61.1)
Cisgender man	24 (2.6)
Nonbinary	97 (10.4)
Queer, expansive, or other	95 (10.2)
Questioning	63 (6.8)
Transgender	83 (8.9)
Sexual orientation	
Bisexual, pansexual, or omnisexual	358 (38.5)
Asexual	16 (1.7)
Gay	136 (14.6)
Multiple	131 (14.1)
Heterosexual	120 (12.9)
Queer	25 (2.7)
Questioning	98 (10.5)
Other	39 (4.2)
Missing	8 (0.9)
Race and/or ethnicity	
Asian American or Pacific Islander	44 (4.7)
Black or African American	26 (2.80)
Biracial or multiracial	77 (8.30)
Hispanic (inclusive of all who identified as Hispanic ethnicity, regardless of race)	159 (17.1)
White	590 (63.4)
Other (including American Indian)	19 (2.0)
Missing	16 (1.7)

also identified as SM; the SM group only included those identifying as SM (but not GM). Holm-corrected post hoc tests revealed that therapists were more likely to directly ask participants who identified as GM compared with SM about their NSSI histories, with no other differences across groups emerging. Pearson χ^2 tests revealed no main effect of pediatricians' and/or medical providers' assessments of any SITB across identities ($P > .40$).

Second, we tested for differences in the frequency of SITB disclosure to friends and parents or guardians across groups. Across SM, GM, and non-SGM participants, identical disclosure patterns emerged across SITBs (see Fig 1). Third, we examined whether SGM identity impacted self-reported honesty in disclosure to both therapists and

pediatricians and/or medical providers. Analysis of variance tests revealed that SGM identity did not significantly impact disclosure honesty across any SITB to either provider (see Fig 2).

Fourth, we explored whether barriers to SITB disclosure to therapists differed across SGM and non-SGM youth. See Table 2 for the top 5 barriers endorsed among participants identifying as SGM and non-SGM. χ^2 tests revealed that only 2 of these barriers received significantly different endorsements across SGM identity groups. Specifically, main effects were observed for the belief that the therapist would tell a parent or guardian ($\chi^2 = 8.11, P = .017$) and for fear of worrying the parent or guardian ($\chi^2 = 7.25, P = .027$). Holm-corrected post hoc tests

revealed that non-SGM participants were significantly less likely to endorse the belief that a therapist would share with a parent or guardian compared with GM participants ($P = .0346$), and relatedly, non-SGM participants were significantly less concerned that this information would worry a parent or guardian compared with both SM ($P = .024$) and GM participants ($P = .037$).

Fifth, we examined whether the frequency of discrimination experiences differed across groups and whether there were group differences in the frequency of discrimination impacting willingness and/or desire to disclose SITBs to therapists across SGM identities. As shown in Fig 3, results of Welch's one-way analysis of variance were significant. Holm-corrected post hoc tests revealed that GM participants reported significantly greater discrimination experiences than those identifying as SM (no other significant differences emerged). Regarding the impact of such experiences on future disclosure willingness, Holm-corrected post hoc tests revealed significantly greater impact for GM-identifying participants compared with both SM and non-SGM participants. See Supplemental Table 3 for the reasons for discrimination reported within the study sample.

Sixth, we conducted Pearson correlations to examine the impact of discrimination experiences on previous and future willingness to disclose SITBs both in the full sample and in only SGM participants. Among the full sample, small negative correlations were observed between discrimination experiences and past SITB disclosure; significant associations were not observed with future willingness to disclose (Fig 4). Our findings partially supported our hypotheses; when considering only

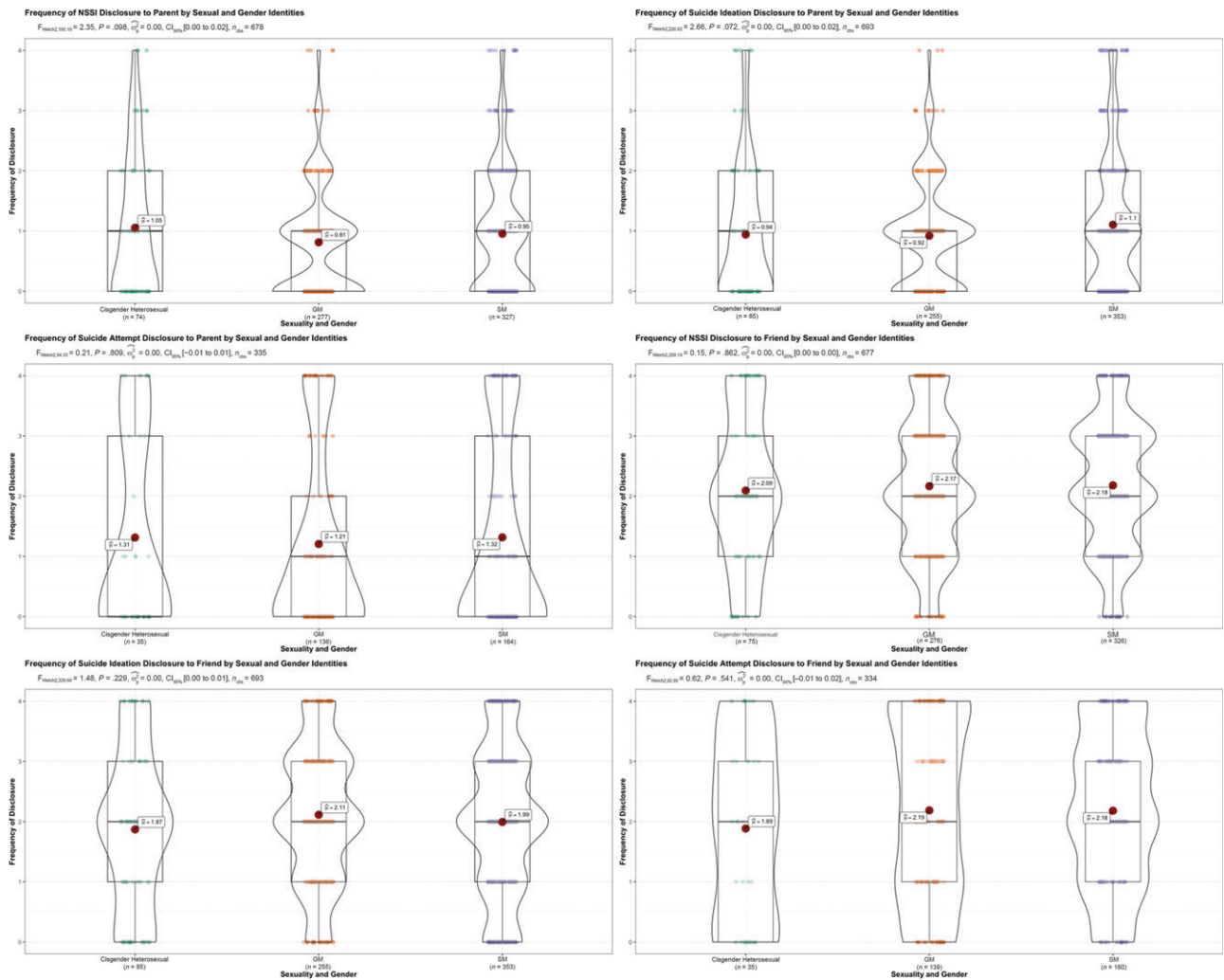


FIGURE 1 Association of sexual and gender identities with frequency of disclosure to parents or guardians and friends. CI, confidence interval; obs, observations.

participants identifying as SGM, these associations became largely insignificant, with one exception: odds of disclosing suicide attempts in the future.

DISCUSSION

The present study investigated the differences in SITB disclosure patterns between cisgender heterosexual, SM, and GM youth. Results suggested few differences in disclosure of SITBs to friends and parents or guardians and in disclosure honesty to therapists, as well as with related primary barriers to disclosure. However, our

findings provide some evidence supporting the minority stress model, revealing that minority stress experiences may interfere with SITB disclosure, particularly among GM youth.

Although patterns of disclosure were similar across SM, GM, and non-SGM youth and across provider types, some notable differences emerged. GM participants were more likely to express the concern that a therapist would share with a parent or guardian as a barrier to disclosure. Both SM and GM participants were more likely to report the related barrier to

disclosure that this information would worry a parent or guardian compared with non-SGM participants. Given that family support is tied to improved mental health outcomes in SGM youth,^{20,21} SGM youth who experience SITBs may be particularly worried about maintaining their relationship with their parents. Fear of disrupting their caregiver relationship(s) further may contribute to their SITB disclosure decision. Although no differences in rates of SITB disclosure to parents emerged, additional research examining family-related factors associated with SITB disclosure decision-

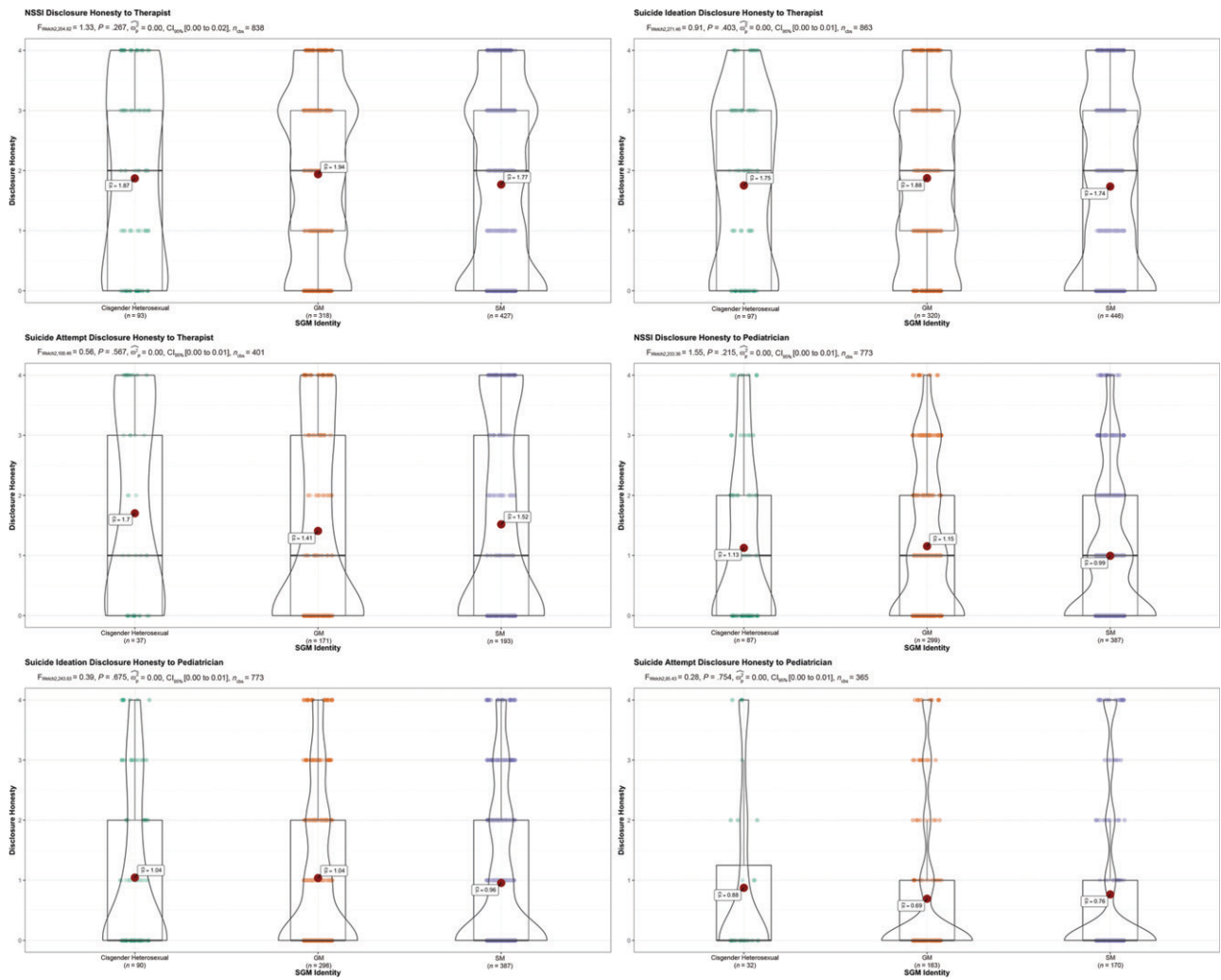


FIGURE 2 Association of sexual and gender identities with honesty of disclosure to providers. CI, confidence interval; obs, observations.

making is warranted. Results highlight the need to provide psychoeducational resources for parents both to mitigate such barriers and to respond to initial disclosure in a manner that will facilitate ongoing disclosure.

GM youth also reported significantly greater discrimination experiences than those identifying as SM, and these discrimination experiences impacted their willingness to disclose SITBs in the future more so than their SM and non-SGM peers. Results

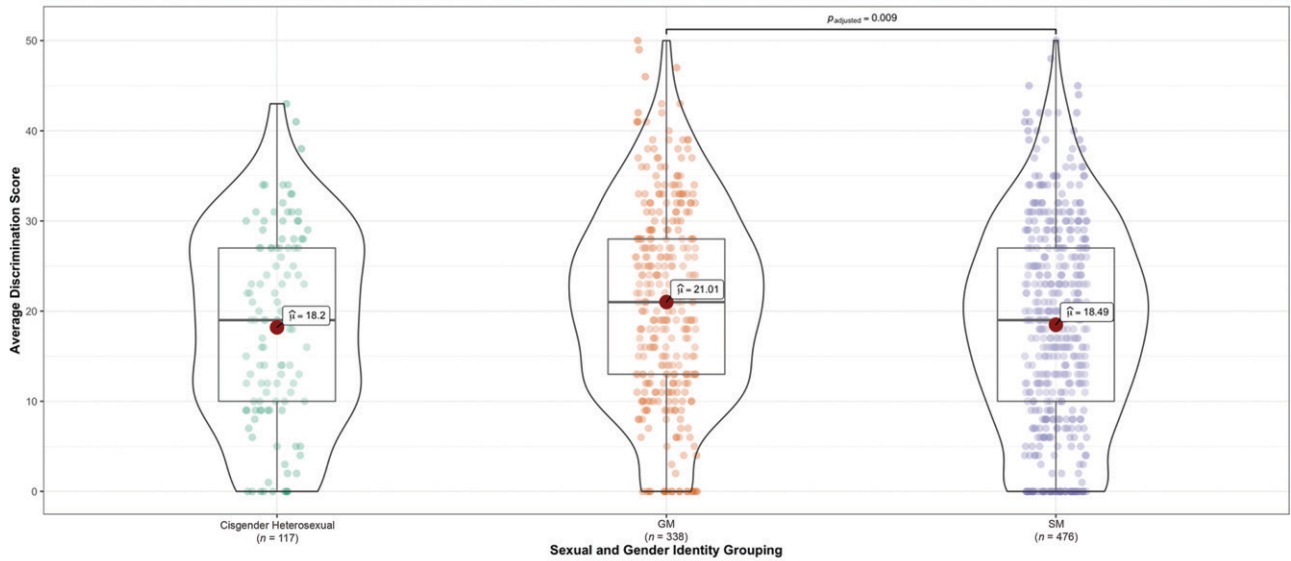
are somewhat consistent with previous work that found minority stress was associated with lower likelihood of SITB disclosure.¹⁵ Prospective research is needed to determine if discrimination experiences predict disclosures over

TABLE 2 Top 5 Endorsed Barriers to Disclosing SITBs to a Therapist

SGM Youth	Non-SGM Youth
1. Fear that they would share with parent or guardian (77%)	1. Fear that they would share with parent or guardian (69%)
2. Fear of being hospitalized (64%)	2. Feelings of shame or embarrassment (52%)
3. Fear that parent or guardian would worry about them (60%)	3. Fear of being hospitalized (50%)
4. Feelings of shame or embarrassment (55%)	4. Thought that the provider would assume they were suicidal (53%)
5. Thought that the provider would assume they were suicidal (53%)	5. Belief that they could handle it on their own (50%)

Average Discrimination Experiences Across Identities

$F_{\text{Wein2},326,00} = 6.17, P = .002, \omega_p^2 = 0.01, CI_{95\%} [0.00 \text{ to } 0.03], n_{\text{obs}} = 931$



Impact of Discrimination on Disclosure Willingness Across Identities

$F_{\text{Wein2},301,70} = 11.58, P = < .001, \omega_p^2 = 0.02, CI_{95\%} [0.01 \text{ to } 0.05], n_{\text{obs}} = 870$

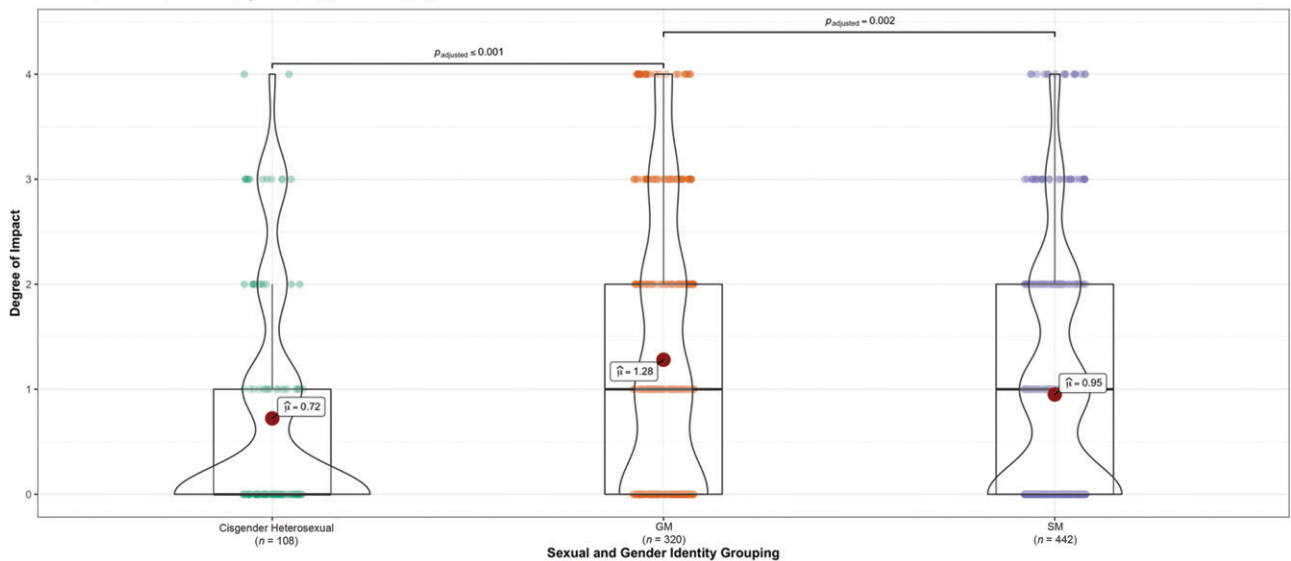


FIGURE 3

Discrimination and its impact across sexual and gender identities (pairwise comparisons: Games-Howell test; adjustment [*P* value]: Holm). Discrimination was assessed with the Expanded Everyday Discrimination Scale. CI, confidence interval; obs, observations.

time, particularly in GM youth, and to explore specific mechanisms that may play a role in this relationship. In addition, although both SM and GM youth report elevated rates of SITBs, some research suggests that GM youth may be at particularly high risk because of higher levels of

discrimination and lower levels of acceptance across family, peers, and society.⁴ Additional research is necessary to elucidate how GM youth’s specific experiences with discrimination may impact SITB disclosure to inform clinical guidelines and intervention efforts for these youth.

Across the full sample, previous discrimination experiences were associated with lower rates of previous SITB disclosure honesty but not future disclosure willingness. Reasons for this discrepancy necessitate future prospective research. For example, it is possible that positive disclosure

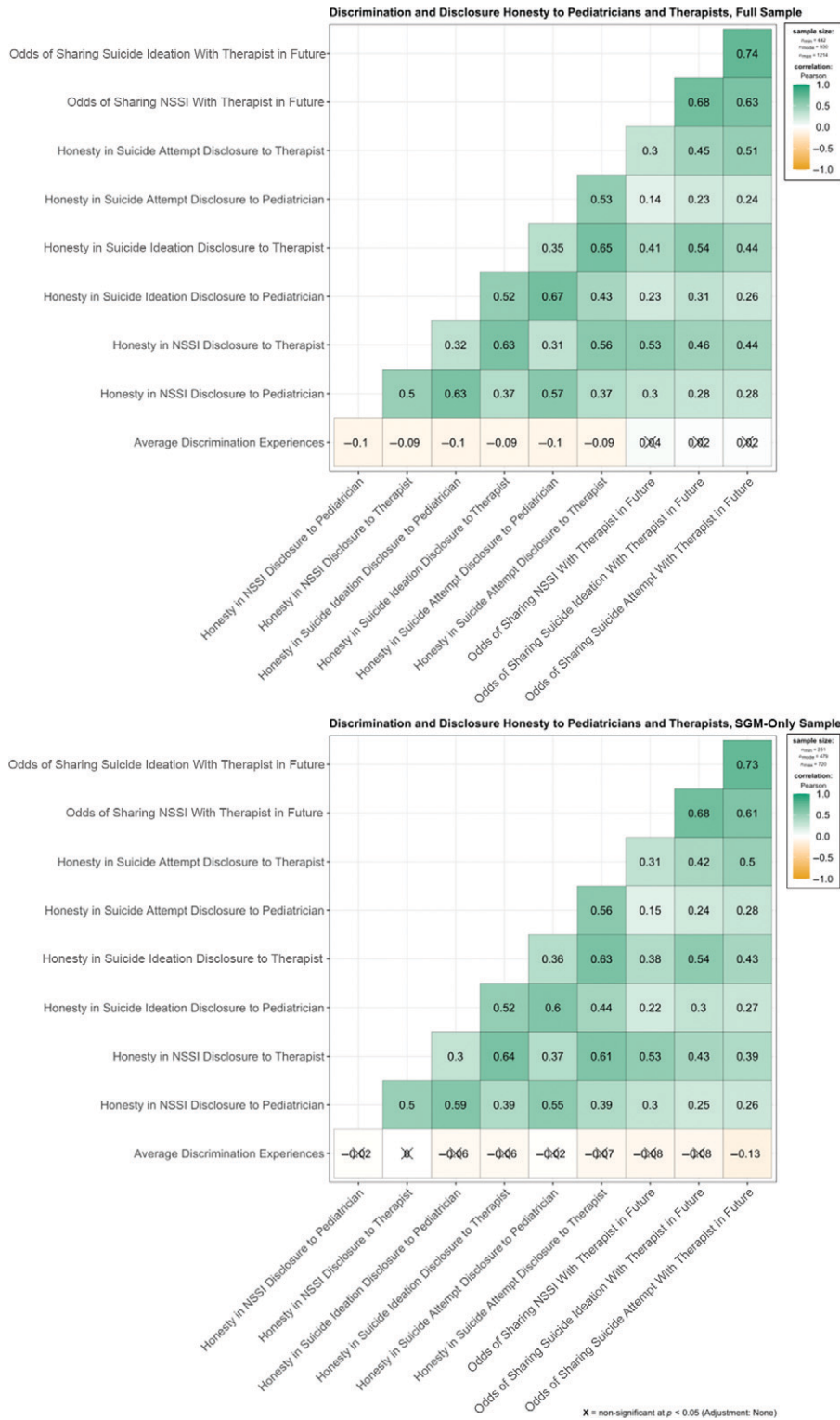


FIGURE 4 Relationships between discrimination and disclosure honesty to pediatricians and therapists. Discrimination was assessed with the Expanded Everyday Discrimination Scale. X, nonsignificant at $P < .05$ (adjustment: none).

experiences may influence individuals' willingness to disclose in the future, despite previous experiences of discrimination. Alternatively, the relationship between minority stress exposure and disclosure honesty may depend on their temporal connection or may differ on the basis of the specific domain of minority stress assessed (eg, family rejection, health care discrimination, peer victimization). Disentangling discrimination factors, both specific to LGBTQ+ youth and experienced across other minoritized identities, that contribute to how youth make decisions to disclose SITBs will be an important area of future investigation.

Finally, although most associations among discrimination experiences, disclosure honesty, and future disclosure willingness were not statistically significant in this sample of SGM youth, one important association emerged. Greater discrimination experiences in SGM youth were associated with lower intention of disclosing suicide attempts, but not suicidal ideation or NSSI, in the future. Results did not replicate those of Chang et al,¹⁵ who found that greater minority stress was associated with lower intention to disclose suicidal thoughts in the future. Lack of replication here may relate to differences in measurement of minority stress; Chang et al¹⁵ employed a specific measure of SGM stress, whereas the measure used in this study was not specific to SGM experiences.

Strengths and Limitations

Strengths include the recruitment of a large sample of adolescents with a history of SITBs and the successful employment of targeted recruitment efforts to increase the proportion of LGBTQ+ youth in our sample. We also assessed disclosure and related barriers across a range of SITBs because both rates of disclosures

and barriers to disclosures may differ across SITB types.

That said, several issues limit generalizability of results. Most notably, we did not assess whether participants were "out" to close others, including parents, friends, or providers; results may differ as a function of outness and may not generalize to older LGBTQ+ populations. Additionally, this study relied on adolescent self-report. Observational and/or medical record data from health care providers (eg, assessing rates of provider SITB assessment) may be useful in future research. Future researchers should also consider incorporating qualitative methods to identify additional LGBTQ+-specific factors, as well as individual differences, that may influence SITB disclosure. The cross-sectional nature of this study precludes causal inferences; prospective data are needed to better understand disclosure likelihood as well as barriers and their association with SITBs over time. General psychopathology and distress may have impacted retrospective recall related to disclosure. However, we did not measure current levels of psychopathology or distress in the current study and thus cannot rule out their impact on findings. Although recruiting a large proportion of LGBTQ+ youth was a strength of this study, there remain limitations regarding our assessment of multiple minority identities and minority stress experiences. Because of the sample's racial and ethnic homogeneity, we were unable to explore whether differences also emerged for racial and ethnic minority groups. We were also unable to examine differences within subgroups of LGBTQ+ identities. Research suggests bisexual individuals are at elevated risk for SITBs compared with both those who identify as lesbian or gay and

those who identify as heterosexual²²; whether similar differences emerge in rates of or barriers to disclosure in this subpopulation is an important area for investigation.

Clinical Implications

Intervention targeting SITBs in youth relies, in part, on adolescents' willingness to share their SITB experiences. Results from the current study highlight the importance of considering the parent-child relationship when inquiring about and treating youth SITBs. Parents may benefit from direct guidance around how to support their child in discussing SITB experiences, particularly parents of GM youth. In addition, clinical interventions that address effective ways to cope specifically with discrimination experiences are needed.

CONCLUSIONS

Disclosure honesty is a critical component of SITB assessment and intervention in youth. In the current study, we explored whether SM, GM, and cisgender heterosexual youth report differences in SITB disclosures, and few differences emerged. Findings highlight the need for prospective research examining SITB disclosures over time as well as mechanisms that may contribute to disclosure likelihood and honesty in youth.

ABBREVIATIONS

GM: gender minority
LGBTQ+: lesbian, gay, bisexual, transgender, gender nonconforming, queer, and questioning
NSSI: nonsuicidal self-injury
SGM: sexual and gender minority
SITB: self-injurious thought and behavior
SM: sexual minority

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