Article

Not peer-reviewed version

The Epidemiology of Suicidality Among Black LGB+ Adolescents: 2023, USA

Amber Amis , Md. Aminul Islam Apu , Rachel Hoopsick , Elise Devier , Lillian Drane , Cate Drane , Rowen Silva , Andrew Yockey *

Posted Date: 3 February 2026

doi: 10.20944/preprints202602.0177.v1

Keywords: suicide; epidemiology; prevention; LGB+

 doi:10.20944/preprints202602.0177.v1

Article

The Epidemiology of Suicidality Among Black LGB+ Adolescents: 2023, USA

Amber Amis [1], Md. Aminul Islam Apu [2], Rachel Hoopsick [3], Elise Devier [1], Lillian Drane [1], Cate Drane [1], Rowen Silva [1] and Andrew Yockey [1,*]

[1] University of Mississippi

[2] Department of Nutrition, The University of Mississippi, MS 38677-1848, USA

[3] University of Illinois Urbana-Champaign

* Correspondence: rayocke1@olemiss.edu

Abstract

Suicide remains a leading cause of death among U.S. adolescents, with significant disparities observed by race/ethnicity and sexual orientation. Black adolescents and those identifying as lesbian, gay, bisexual, or using alternative sexual identity labels (LGB+) face elevated risks for suicidal ideation and behaviors, yet research examining the intersection of these identities remains limited. To examine the prevalence of suicidal thoughts and planning among Black youth in the U.S. and investigate disparities by sexual identity using a nationally representative dataset. We hypothesized that Black LGB+ youth would report higher rates of suicidal ideation and planning compared to their non-LGB+ peers. We conducted a secondary analysis of 1,381 Black adolescents from the 2023 National Survey on Drug Use and Health (NSDUH). Suicide ideation and planning were assessed via self-report of thoughts or plans in the past 12 months. Demographics, sexual orientation, mental health, and substance use were included as covariates. Weighted frequencies, Rao-Scott Chi-square tests, and multivariate logistic regression analyses were performed to examine associations. Among Black adolescents, 10.36% reported past-year suicidal ideation and 5.51% reported suicide planning. Compared with heterosexual peers, adolescents identifying as gay/lesbian, bisexual, or using alternative identity labels had significantly higher adjusted odds of suicidal ideation (AOR = 3.32–12.74) and planning (AOR = 4.81–15.28). Youth using alternative identity labels exhibited the highest risk for both outcomes. Black LGB+ youth, particularly those using nonconventional sexual identity labels, experience disproportionately high rates of suicidal thoughts and planning. These findings underscore the urgent need for culturally responsive, identity-affirming prevention strategies, improved access to mental health care, and interventions tailored to this underserved population. Future research should explore protective factors and mechanisms that buffer suicide risk among Black LGB+ adolescents.

Keywords: suicide; epidemiology; prevention; LGB+

1. Introduction

Suicide was the third-leading cause of death among adolescents aged 14 to 18 years in 2021, with an estimated 1,952 suicide-related deaths annually in the United States, resulting in a rate of 9.0 per 100,000 adolescents. [1] National data from the Youth Risk Behavior Surveillance System (YRBSS) indicated that in 2023, 20% of high school students seriously considered attempting suicide, 16% made a suicide plan, and 9% attempted suicide.[2] Moreover, significant increases in hospitalizations for suicide attempts and ideation—nearly doubling from 2008 to 2015 [3]—have made suicide a focus of several government initiatives (eg, Healthy People 2030). However, little progress in reducing suicidality among adolescents has been achieved. [5]

Significant disparities in suicidality have been recorded among adolescents who identify as lesbian, gay, or bisexual (LGB+). Additional data from the 2023 YRBSS found that compared with

 doi:10.20944/preprints202602.0177.v1

non–LGB+ adolescents, LGB+ adolescents were more likely to seriously consider suicide (41% vs 13%), make a plan (32% vs 11%), and attempt suicide (20% vs 6%). [2] Further, research using National Violent Death Reporting System data indicated that from 2014 to 2019, significant increasing trends in deaths by suicide were observed among LGB+ adolescent populations. [5]

In recent years, significant racial and ethnic disparities have also been noted, with suicide among Black youth rising at a notable rate. From 2003 to 2017, 1,810 Black adolescents died by suicide, an overall rate of 1.36 per 100,000. Black youth aged 15 to 17 years experienced the most significant increases during this period. [6] Additionally, Black/African American girls experienced suicide rates more than twice those of Black boys. [6]

Although suicidality among LGB+ youth and among Black youth has been widely documented, comparatively little research has examined their intersection. [7] This omission is notable given that more than one in five Black adolescents identify as LGB+. [8] Intersectionality theory and Minority Stress Theory provide a critical framework for understanding why Black LGB+ youth may experience heightened suicide risk. Meyer's Minority Stress model posits that sexual minority individuals experience chronic stressors—such as discrimination, concealment, and internalized stigma—that elevate mental health risk. [12] For Black LGB+ youth, these stressors are compounded by racism, heterosexism, and age-related vulnerabilities, creating a qualitatively distinct stress experience that cannot be understood by examining race or sexual orientation in isolation. [12,13]

Importantly, identity is not merely additive but relational and context dependent. For some youth, racial identity may be more salient than sexual orientation ("Black and gay") [8,9], whereas for others, sexual minority identity may be foregrounded ("gay and Black"), depending on family context, community norms, and exposure to stigma. Navigating multiple marginalized identities during adolescence [12]—a developmental period characterized by identity formation and heightened sensitivity to social evaluation—may intensify psychological distress, social isolation, and feelings of burdensomeness, all of which are well-established correlates of suicidal ideation and planning. These intersecting identity processes may help explain why recent increases in suicidality have been particularly pronounced among Black LGB+ youth.

The inclusion of the "+" in LGB+ further reflects important heterogeneity within sexual minority identities. Adolescents who identify as bisexual, pansexual, queer, questioning, same-gender loving, or who report uncertainty about their sexual identity often report equal or greater levels of psychological distress compared with their gay and lesbian peers. [7] Prior research suggests that bisexual and questioning youth may experience unique stressors [5], including identity invalidation, pressure to "choose" an identity, and marginalization within both heterosexual and LGBTQ+ spaces. Identity fluidity and uncertainty may independently contribute to suicide risk by increasing rumination, concealment, and exposure to stigma, particularly in environments where nonbinary or culturally specific identity labels are poorly understood or rejected.

Additionally, barriers to mental health care remain pervasive. Black adolescents, particularly those who are LGB+, often report limited access to identity-affirming care, mistrust of health systems, and lower engagement with mental health services. [14,15] Systemic inequities—including underrepresentation of Black clinicians, cultural stigma about mental illness, and socioeconomic challenges—compound these barriers. [16,17] Consequently, Black LGB+ youth may experience the highest unmet mental health need of any adolescent group in the United States. [8,18]

Although elevated suicide risk among sexual minority youth is well documented, major gaps remain in understanding within-group heterogeneity among Black youth and why these disparities exist. Most nationally representative studies either aggregate all LGB+ youth [12]—masking meaningful differences between gay/lesbian, bisexual, and questioning identities—or lack sufficient power to examine Black sexual minority youth separately. As a result, it is unclear whether disparities in suicidal ideation and planning are uniform across sexual orientations or whether certain subgroups (e.g., bisexual or questioning Black youth) experience disproportionately higher risk. Further, existing research often treats sexual identity as fixed and clearly defined, overlooking youth who use alternative terms (e.g., queer, same-gender loving) or who report being unsure, despite

 doi:10.20944/preprints202602.0177.v1

evidence that identity uncertainty and identity-related stress may independently contribute to psychological distress. This gap limits theory development and the targeting of prevention efforts, as risk mechanisms and support needs may differ by specific sexual identity labels and levels of identity clarity within Black youth populations. The purpose of this study was to examine suicidal ideation and planning among a large sample of Black youth and investigate disparities by sexual identity using a nationally representative dataset. We hypothesized that compared with non–LGB+ youth, Black LGB+ youth would be more likely to report suicidal ideation and planning.

2. Methods

We conducted a secondary analysis of the 2023 National Survey on Drug Use and Health (NSDUH), a nationally representative, cross-sectional survey of the U.S. civilian, non-institutionalized population aged 12 years and older. The NSDUH employs a multistage area probability sampling design to ensure national, regional, and state-level representation. First, primary sampling units (PSUs) are selected from across the United States. Within each PSU, census tracts, blocks, and then dwelling units are systematically sampled. One or two individuals per household are then randomly selected to participate.

To improve the accuracy of estimates among key subpopulations, including adolescents, young adults, and racial and ethnic minority groups, the NSDUH uses oversampling techniques. Survey data are collected through in-person interviews conducted by trained field interviewers using computer-assisted interviewing methods, including both computer-assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACASI). This is to maximize confidentiality and minimize reporting bias for sensitive behaviors such as drug use. Other details of the NSDUH can be found elsewhere. [19]

3. Measures

3.1. Suicide Planning and Ideation

Two self-report items assessed suicidal thoughts and planning within the past 12 months: “At any time in the past 12 months, did you seriously think about trying to kill yourself?”; “During the past 12 months, did you make any plans to kill yourself?” Responses were coded dichotomously (Yes/No).

3.2. Sexual Orientation

Participants were asked which of the following best described their sexual orientation: heterosexual (straight), gay/lesbian, bisexual, not sure, or “use a different term.” Responses were categorized into five groups: heterosexual (reference), gay/lesbian, bisexual, unsure, and other term.

3.3. Mental Health and Substance Use

The presence of a major depressive episode (MDE) in the past year was measured using DSM-5 criteria derived from self-reported symptoms. [20] Past-year alcohol use and past-year opioid use were included as covariates due to their known associations with suicide risk. [21]

3.4. Demographics

Demographic variables included age (years), sex at birth (male/female), race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other), sexual orientation (heterosexual, gay/lesbian, bisexual, unsure, use a different term), and county status (large metropolitan, small metropolitan, nonmetropolitan). Mental health and substance use variables included past-year major depressive episode (MDE), past-year alcohol use, and past-year opioid use.

 doi:10.20944/preprints202602.0177.v1

4. Analysis Plan

For all analyses, when available, we used multiple-imputed variables provided by NSDUH to limit the amount of missing data. Frequencies were estimated to describe participant characteristics. Bivariate comparisons were estimated with Rao-Scott Chi-square tests. Multivariate logistic regression analyses were built to determine conditional associations to past-year suicidal ideation and planning. All analyses were conducted in R 4.5.1 using the 'dplyr' and 'survey' package and weighted to be representative of Black/African American US youth.

5. Results

The sample consisted of 1,381 Black youths (Table 1) were distributed almost evenly by sex at birth (50.04% male and 49.96% female). Large metropolitan regions accounted for the majority (55.90%), followed by nonmetro counties (9.99%), and small metro counties (34.11%). In terms of mental health, 14.19 percent of young people said they had gone through a severe depressive episode over the previous year. In the past year, 10.36% of respondents said they had given suicide considerable thought, while 5.51% said they had planned to attempt suicide. The majority of respondents (77.98%) identified as heterosexual, while 11.15% identified as bisexual, 3.18% as gay or lesbian, 5.07% were unclear, and 2.61% used another term. About 11.37% of respondents reported using alcohol, and 16.65% reported using opioids, within the past year. Most of the participants were in grade 10, with the highest percentage in grade 10 (17.81%), followed by grade 9 (15.93%), grade 8 (14.41%), grade 11 (14.40%), grade 7 (12.02%), school 12 (9.20%), grade 6 (4.85%), and grade 5 or below (0.51%). Just 0.58% of respondents said they were enrolled in college, 8.83% said they had a valid skip, and 1.45% did not respond. 20.85% of households reported earning $75,000 or more, while 27.51% reported earning less than $20,000, 39.83% between $20,000 and $49,999, and 11.80% between $50,000 and $74,999.

Table 1. Sample Demographics.

Variable	**Full Sample, N=1,381**	**Percentages**
Sex at birth		
Male	691	50.04
Female	690	49.96
County status		
Large Metro	772	55.90
Small Metro	471	34.11
Nonmetro	138	09.99
Youth Major Depressive Episode within the past year		

 doi:10.20944/preprints202602.0177.v1

Yes	189	14.19
No	1143	85.81
Youth seriously thought about killing self past year		
Yes	143	10.36
No	1027	74.42
Youth made plans to kill self in past year		
Yes	76	5.51
No	1158	83.91
Sexual identity		
Heterosexual, that is, straight	1077	77.98
Gay or lesbian	44	3.18
Bisexual	154	11.15
I use a different term	36	2.61
I am not sure about my sexual identity	70	5.07
Alcohol - past year use		
Did not use in the past year	1224	88.63
Used within the past year	157	11.37
Any opioids - past year use		
Did not use within past year	1151	83.35
Used in past year	230	16.65
What grade in now/will be in		

 doi:10.20944/preprints202602.0177.v1

5th Grade or lower	7	0.51
6th Grade	67	4.85
7th Grade	166	12.02
8th Grade	199	14.41
9th Grade	220	15.93
10th Grade	246	17.81
11th Grade	199	14.40
12th Grade	127	9.20
Total family income		
Less than $20,000	380	27.51
$20,000 - $49,999	550	39.83
$50,000 - $74,999	163	11.80
$75,000 or More	288	20.85

After adjusting for biological sex, county type, grade level, and family income, Table 2 shows the adjusted odds ratios (AORs) for suicide ideation and suicide planning across various sexual identity categories. Compared to adolescents who identified as heterosexual, adolescents who reported describing their sexual identity with a different term had the highest chances of suicidal thoughts (AOR = 12.74) and planning (AOR = 15.28). Additionally, those who identified as gay or lesbian had higher risks of suicidal thoughts (AOR = 7.86) and planning (AOR = 8.59). Adolescents who identify as bisexual had somewhat higher risks of suicidal thoughts (AOR = 5.51) and planning (AOR = 6.24). On the other hand, adolescents who were unclear of their sexual orientation had significantly reduced risks of suicidal thoughts (AOR = 3.32) and planning (AOR = 4.81).

Table 2. Adjusted Odds Ratios towards Suicide Ideation and Planning.

Sexual Identity	**Suicide Ideation**	**Suicide Planning**
Heterosexual, that is straight	**Reference**	**Reference**

 doi:10.20944/preprints202602.0177.v1

Gay or lesbian	**7.86**	**8.59**
Bisexual	**5.51**	**6.24**
I use a different term	**12.74**	**15.28**
I am not sure about my sexual identity	**3.32**	**4.81**

*Models controlled for biological sex, past year use of alcohol/opioids, major depressive episode, income, county status, and grade-level. Bolded ORs indicate $p<.05$.

6. Discussion

6.1. Main Findings

This study sought to examine suicidal behavior among Black LGB+ youth in relation to adverse mental health outcomes such as depression and substance use. Compared to Black non-LGB+ adolescents, Black LGB+ adolescents were at increased risk for suicidal ideation and planning. Moreover, youth who used a different term to describe their identity were at the highest risk for both outcomes, highlighting the need for further research into specific identities and intersectional components and their relationship to poor mental health.

6.2. Findings in Context

Adolescent suicide remains a critical public health issue in the United States and globally. [23] Moreover, from 2011 to 2020, the number of emergency department visits in the US associated with suicide attempts and self-harm increased nearly 20%. [24] These rates are of concern, given the low providerment of health services and screening opportunities to address suicide among youth. [25] Adolescence represents a sensitive developmental period characterized by identity formation, heightened peer influence, and ongoing neurocognitive maturation, which together may amplify vulnerability to social stressors and limit youths' capacity to regulate distress or seek support. As a result, suicidal ideation and planning during this life stage often reflect cumulative exposure to interpersonal, institutional, and structural adversity rather than isolated events.

Disparities in suicidality are especially pronounced among adolescents who identify as lesbian, gay, or bisexual (LGB+), substantiating our findings. According to the 2023 YRBSS, LGBT+ adolescents were significantly more likely than their non-LGB+ peers to report seriously considering suicide (41% vs. 13%), planning a suicide attempt (32% vs. 11%), or attempting suicide (20% vs. 6%).[2] Minority stress theory provides a useful framework for understanding these disparities, as LGB+ youth are disproportionately exposed to stigma, victimization, and identity concealment, all of which increase psychological distress and reduce access to affirming support systems.

In addition, the observed increase in suicide rates for Black youth highlight a lack of progress for this growing disparity. Previous research has shown that Black youth ages 15-17 experienced the largest increase in suicide, and Black females were twice as likely to attempt suicide compared to Black males. [26] These patterns suggest that suicidality among Black adolescents may be shaped by intersecting stressors [13] related to racism, gendered expectations, and reduced access to culturally responsive mental health care. Educational context may play a particularly important role, as Black youth are more likely to experience school-based discrimination and reduced school connectedness [8], which have been identified as factors that have been independently linked to depression and suicidality. [23] Additionally, the findings in our study contribute to the growing but low amount of research that has been conducted on Black LGB+ youth. An estimated 12.8% of Black youth in the NSDUH study sample reported experiencing a major depressive episode (MDE), a known risk factor for suicidality. Data from the 2024 Human Rights Campaign 2024 Black LGBTQ+ Youth Report [8]

 doi:10.20944/preprints202602.0177.v1

revealed that 53.3% of Black LGB+ youth screened positive for depression, but less than half (46.5%) of youth wanted therapy but could not receive it, highlighting the ongoing awareness of increasing mental health resources for underserved youth.

As research focusing on risk factors for Black and LGB+ youth continues, evidence-based protective factors remain significantly less studied, and research barely intersects the two. [27] Prior reviews have found that religious, social, familial, and personal factors could all help reduce the risk of suicidality among Black youth. [27,28] In addition, protective factors for both Black or LGB+ youth include feelings of hopefulness, a positive self-identity, having a stable environment, and community or social support.

Importantly, suicidal ideation and planning among Black LGB+ youth do not emerge in isolation but reflect the cumulative and developmentally patterned effects of social, educational, and structural stressors. Adolescence represents a sensitive developmental period marked by identity formation, heightened peer salience, and limited emotion regulation capacity, all of which may amplify vulnerability to stress-related psychopathology. Younger adolescents, in particular, may experience greater difficulty accessing coping resources or articulating distress, increasing the likelihood that stressors related to race-, sexuality-, and gender-based stigma manifest as internalized distress or suicidal ideation rather than help-seeking behaviors. Educational context further compounds this risk; school environments function as primary social ecosystems for youth, and exposure to bullying, exclusion, or curricula that erase or stigmatize Black and LGB+ identities can exacerbate feelings of invisibility, burdensomeness, and thwarted belonging.

It is important to note racial/ethnic differences in the "coming out" process. Compared to White adolescents, Black youth may "come out" expressively sooner than their white counterparts and be subjected to harassment at home and school; therefore, to cover their true identities, many LGB+ youth will deny or hide their sexuality in order survive. Prior literature has shown that among African American youth, coming out led to an initial reaction of negativity, but soon was tempered over time. [29] The socio-cognitive-behavioral model of adjustment theorizes that family members' initial responses to a child's disclosure are shaped by preexisting beliefs, cultural norms, and perceived social stigma, which may result in early rejection or distress. [30] Over time, however, cognitive reframing, increased knowledge, and ongoing interpersonal interactions can facilitate more adaptive coping and behavioral change, leading to greater acceptance and improved family relationships. This adjustment process may ultimately result in greater acceptance, improved communication, and enhanced family functioning, even within cultural contexts that initially discourage sexual minority identities. [31–33]

While suicide prevention programs exist for minority youth, studies have not been conducted to determine whether these interventions are effective for Black LGB+ youth who participate in these programs. [27] A recent systematic review and meta-analysis of psychotherapy interventions for reducing suicidal thoughts and behaviors among Black youth notes the lack of interventions and community initiatives to address this problem [28], although several interventions call for the integration of community leaders and mental health professionals to take a multi-factorial approach for addressing suicidality among Black youth. [35,36]

7. Implications for Prevention

To address suicide among Black LGB+ youth, prevention strategies must move beyond one-size-fits-all approaches that overlook the interplay between race, culture, and sexual identity. Traditional school-based suicide prevention programs, while effective for general populations, often fail to engage racial and sexual minority adolescents if they lack cultural relevance or affirming representation. [36] Efforts such as Sources of Strength and Signs of Suicide have shown efficacy in general adolescent populations, but their impact among Black LGB+ youth remains limited without adaptation for intersectional identity experiences. [37,38]

Culturally responsive and community-engaged approaches are essential for youth suicide prevention. [39] Programs co-developed with Black LGB+ youth and community leaders can enhance

 doi:10.20944/preprints202602.0177.v1

trust and relevance. Interventions that leverage community-based organizations, faith institutions, and peer mentoring networks may provide critical safe spaces that affirm both racial and sexual identity. [28] For example, the BEAM (Black Emotional and Mental Health Collective) and The Trevor Project's Black & LGB+ Initiative demonstrate how partnerships between community and clinical systems can promote identity-affirming care and crisis support. [40,41]

Clinician training in intersectional cultural competency represents another vital layer of prevention. Mental health professionals must be equipped to address racial trauma, heterosexism, and identity-related stress with cultural humility. [42,43] Studies show that clients report higher satisfaction, therapeutic engagement, and improved mental health outcomes when clinicians integrate affirming language and explore intersecting identities. [44,45] The American Psychological Association has emphasized that culturally competent, affirming care is a core component of suicide prevention among marginalized youth. [46]

Moreover, inclusive school climates have measurable protective effects. Exposure to supportive teachers, gender-sexuality alliances (GSAs), and inclusive anti-bullying policies significantly reduces suicide attempts among LGB+ students, with particularly strong benefits for students of color. [47,48] Gender–Sexuality Alliances (GSAs) are uniquely positioned to function as protective spaces but must move beyond symbolic inclusion to intentional engagement. GSAs can be strengthened by incorporating leadership opportunities for students of color, addressing racism within LGBTQ+ spaces, partnering with Black community organizations, and providing structured peer-support or mentorship components. GSAs that explicitly affirm racial identity alongside sexual identity may enhance belonging, reduce isolation, and foster collective efficacy—key buffers against suicidality during adolescence. Consistent actions such as using correct pronouns, displaying affirming symbols, or integrating diverse role models into curricula, can foster belonging and resilience. [49] Moreover, teachers and school staff also play a measurable role in prevention. Training educators to integrate inclusive and affirming content into curricula, particularly in history, literature, and health education, can reduce identity-based stigma and promote visibility. Simple but consistent practices, such as using correct pronouns, intervening in bias-based bullying, and acknowledging diverse family structures, have been shown to improve school climate and mental health outcomes for LGB+ students, with particularly strong effects for students of color. [47–49] These practices are especially important during early adolescence, when peer validation and adult support are critical to psychological well-being.

At the structural level, funding and policy mechanisms must explicitly prioritize intersectional populations. Programs such as the Minority Fellowship Program and Project AWARE should be leveraged to expand culturally competent mental health training and research focused on Black LGB+ youth, thereby expanding critical resources for health promotion. [50,51] Federal and state policies aimed at improving insurance coverage, expanding school-based behavioral health services, and enforcing anti-discrimination protections can function as upstream suicide prevention strategies. [52] Addressing systemic inequities, such as underrepresentation of Black clinicians and barriers to affirming care, is critical to closing the mental health gap. [53]

Finally, informal support systems play a critical protective role for Black LGB+ youth, particularly in the context of suicide risk, by offering affirmation, belonging, and culturally responsive coping resources that may be absent in families, schools, or formal institutions. House and ballroom communities—historically rooted in Black and Latinx LGB+ culture—function as chosen families that provide mentorship, emotional support, identity validation, and opportunities for leadership through roles such as "house mothers" and "house fathers," which have been associated with resilience and reduced social isolation among sexual and gender minority youth of color. [54,55] Similarly, fictive kin networks, including gay mothers, gay fathers, and peer-based family structures, serve as alternative caregiving systems that buffer the effects of rejection, homelessness, and stigma, all of which are well-established risk factors for suicidal ideation and attempts. [56] Online spaces further extend these informal supports by enabling Black LGB+ youth to access community, information, and peer validation beyond geographically constrained or unsafe

 doi:10.20944/preprints202602.0177.v1

environments, though the quality and safety of these spaces remain variable. [57] Finally, engagement in visual and performing arts including dance, music, poetry, and performance traditions embedded within ballroom culture provides expressive outlets that facilitate emotion regulation, identity exploration, and meaning-making, processes that are increasingly recognized as protective against depression and suicidality among marginalized youth. [58] Collectively, these informal support systems operate as vital, community-generated mechanisms of survival and resilience for Black LGB+ youth facing intersecting forms of racism, heterosexism, and cisnormativity.

8. Limitations

Several limitations of the current study should be noted, including self-selection bias, although the NSDUH maintained a respectable response rate of over 70% throughout the study years. While sexual orientation was assessed, gender identity was not; future research needs to examine gender identity, given that gender diverse individuals report high rates of suicide. [59] Moreover, the generalizability of our findings may be limited by the high prevalence of opioid and other substance use in some areas, which was not included in the NSDUH dataset.

9. Conclusions

This study highlights the heightened vulnerability of Black LGB+ youth to suicidal ideation and planning, underscoring the urgent need for targeted mental health interventions. Compared with Black non-LGB+ peers, Black LGB+ adolescents experience a disproportionate burden of suicidality and associated mental health concerns such as depression and substance use. Our findings emphasize that youth who describe their identities outside of conventional LGB+ labels are at especially high risk, signaling a critical gap in both research and clinical care.

Given the persistently rising rates of suicide among Black youth and the longstanding disparities affecting LGB+ adolescents, these findings call for culturally responsive, identity-affirming prevention strategies. Expanding access to mental health care, addressing structural barriers, and ensuring culturally competent providers are essential steps toward reducing these inequities. Moreover, future research should prioritize identifying and strengthening protective factors—such as social support, positive identity development, and community resources—that can buffer against suicide risk in this population.

References

1. Centers for Disease Control and Prevention. *CDC WONDER: About Multiple Causes of Death, 2018–2022*. US Department of Health and Human Services, National Center for Health Statistics; 2025. https://wonder.cdc.gov/
2. Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary and Trends Report: 2013–2023*. US Department of Health and Human Services; 2024. https://www.cdc.gov/healthyyouth/data/yrbs/
3. Plemmons G, Hall M, Doupnik S, et al. Hospitalization for suicide ideation or attempt: 2008–2015. *Pediatrics*.2018;141(6):e20172426.
4. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Reduce Suicide Attempts by Adolescents — MHMD-02. Healthy People 2030.* Accessed November 3, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-attempts-adolescents-mhmd-02
5. Ream GL. Trends in deaths by suicide 2014–2019 among lesbian, gay, bisexual, transgender, queer, questioning, and other gender/sexual minority youth. *J Adolesc Health*. 2022;71(5):609-615.
6. Sheftall AH, Vakil F, Ruch DA, et al. Black youth suicide: investigation of current trends and precipitating circumstances. *J Am Acad Child Adolesc Psychiatry*. 2022;61(5):662-675.

 doi:10.20944/preprints202602.0177.v1

7. Williams AJ, Jones C, Arcelus J, et al. A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. *PLoS One.* 2021;16(1):e0245268.
8. Human Rights Campaign Foundation. *2024 Black LGBTQ+ Youth Report.* Human Rights Campaign Foundation; 2024. https://hrc-prod-requests.s3-us-west-2.amazonaws.com/2024-Black-LGBTQ-Youth-Report.cleaned.pdf
9. Bartone MD. "Nothing has stopped me. I keep going:" Black gay narratives. *J LGBT Youth.* 2017;14(3):317-329.
10. Collins JF. The intersection of race and bisexuality: a critical overview of the literature and past, present, and future directions of the "borderlands." *J Bisexuality.* 2004;4(1-2):99-116.
11. Icard LD. Assessing the psychosocial well-being of African American gays: a multidimensional perspective. *J Gay Lesbian Soc Serv.* 1996;5(2-3):25-50.
12. Bostwick WB, Meyer I, Aranda F, Russell S, Hughes T, Birkett M, Mustanski B. Mental health and suicidality among racially/ethnically diverse sexual minority youths. Am J Public Health. 2014;104(6):1129-36. doi: 10.2105/AJPH.2013.301749. Epub 2014 Apr 17. PMID: 24825217; PMCID: PMC4062032.
13. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev.* 1991;43(6):1241-1299.
14. Wilson PA, Valera P, Martos AJ, Wittlin NM, Muñoz-Laboy MA, Parker RG. Contributions of Qualitative Research in Informing HIV/AIDS Interventions Targeting Black MSM in the United States. J Sex Res. 2016;53(6):642-54. doi: 10.1080/00224499.2015.1016139. Epub 2015 Aug 4. PMID: 26241373; PMCID: PMC4740277.
15. Alegría M, Green JG, McLaughlin KA, et al. Disparities in child and adolescent mental health and mental health services in the US. *William T. Grant Foundation Report. Retrieved from: http://cfs.cbcs.usf.edu/projects-research/_docs/Disparities_in_child_and_adolescent_health.pdf; 2015.*
16. Davis TS, Saltzburg S, Locke CR. Supporting the emotional and psychological well-being of sexual minority youth: youth ideas for action. *Child Youth Serv Rev.* 2009;31(9):1030-1041. doi:10.1016/j.childyouth.2009.05.003.
17. Poteat VP, Calzo JP, Yoshikawa H. Promoting Youth Agency Through Dimensions of Gay-Straight Alliance Involvement and Conditions that Maximize Associations. J Youth Adolesc. 2016;45(7):1438-51. doi: 10.1007/s10964-016-0421-6. Epub 2016 Jan 18. PMID: 26781740; PMCID: PMC4900925.
18. Moore KL, Lopez L, Camacho D, Munson MR. A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults. Psychiatr Serv. 2020;71(6):555-561. doi: 10.1176/appi.ps.201900399. Epub 2020 Jan 21. PMID: 31960774; PMCID: PMC7364786.
19. Center for Behavioral Health Statistics and Quality. *2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions.* Substance Abuse and Mental Health Services Administration; 2024.
20. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results From the 2021 National Survey on Drug Use and Health.* HHS Publication No. PEP22-07-01-005, NSDUH Series H-57. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2022. Accessed November 13, 2025. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report.
21. Andrew Yockey R, King KA, Vidourek RA. Correlates to Lifetime Suicide Attempts, Thoughts, and Planning Behaviors Among African American Transgender Individuals. J Prim Prev. 2020;41(6):487-501. doi: 10.1007/s10935-020-00613-0. Epub 2020 Oct 20. PMID: 33079322.
22. Ilgen MA, Bohnert ASB, Ganoczy D, Bair MJ, McCarthy JF, Blow FC. Opioid dose and risk of suicide. Pain. 2016;157(5):1079-1084. doi: 10.1097/j.pain.0000000000000484. PMID: 26761386; PMCID: PMC4939394.
23. Verlenden JV, Fodeman A, Wilkins N, et al. Mental health and suicide risk among high school students and protective factors—Youth Risk Behavior Survey, United States, 2023. *MMWR Suppl.* 2024;73(Suppl 4):79-86.
24. Bommersbach TJ, Olfson M, Rhee TG. National trends in emergency department visits for suicide attempts and intentional self-harm. *Am J Psychiatry.* 2024;181(8):741-752.

 doi:10.20944/preprints202602.0177.v1

25. Aalsma M, Keys J, Ferrin S, Shan M, Garbuz T, Scott T, Adams Z, Hulvershorn L, Downs S. Adolescent suicide assessment and management in primary care. BMC Pediatr. 2022;22(1):389. doi: 10.1186/s12887-022-03454-4. PMID: 35780090; PMCID: PMC9250265.
26. Sheftall AH, Vakil F, Ruch DA, Boyd RC, Lindsey MA, Bridge JA. Black Youth Suicide: Investigation of Current Trends and Precipitating Circumstances. J Am Acad Child Adolesc Psychiatry. 2022;61(5):662-675. doi: 10.1016/j.jaac.2021.08.021. Epub 2021 Sep 9. PMID: 34509592; PMCID: PMC8904650.
27. Meza JI, Patel K, Bath E. Black youth suicide crisis: prevalence rates, review of risk and protective factors, and current evidence-based practices. *Focus (Am Psychiatr Publ).* 2022;20(2):197-203.
28. Siff L, Molock S. Pathways to hope: redefining suicide prevention for Black LGBTQ youth. *Ment Health Sci.* 2025;3(1). doi:10.1002/mhs2.70004.
29. Brown TR, Lee SS, Schiff SJ, Jansen MO, Bath E, Meza JI. A Systematic Review and Meta-Analysis: Psychotherapy Interventions for Reducing Suicidal Thoughts and Behaviors Among Black Youth. J Am Acad Child Adolesc Psychiatry. 2025;64(9):1030-1046. doi: 10.1016/j.jaac.2024.08.007. Epub 2024 Aug 22. PMID: 39179023.
30. Potoczniak D, Crosbie-Burnett M, Saltzburg N. Experiences regarding coming out to parents among African American, Hispanic, and White gay, lesbian, bisexual, transgender, and questioning adolescents. J Gay Lesbian Soc Serv. 2009;21(2-3):189-205. doi:10.1080/10538720902772063.
31. Crosbie-Burnett M, Foster TL, Murray CI, Bowen GL. Gay's and lesbians' families-of-origin: A social-cognitive-behavioral model of adjustment. Fam Relat. 1996;45:397-403.
32. Ryan C. Engaging families to support lesbian, gay, bisexual, and transgender youth: the family acceptance project. Prev Res. 2010;17(4).
33. Fields E, Morgan A, Sanders RA. The Intersection of Sociocultural Factors and Health-Related Behavior in Lesbian, Gay, Bisexual, and Transgender Youth: Experiences Among Young Black Gay Males as an Example. Pediatr Clin North Am. 2016;63(6):1091-1106. doi: 10.1016/j.pcl.2016.07.009. PMID: 27865335; PMCID: PMC5127594.
34. LaSala MC. *Coming out, coming home: Helping families adjust to a gay or lesbian child*. New York, NY: Columbia University Press; 2010.
35. Robinson WL, Whipple CR, Jason LA, Flack CE. African American adolescent suicidal ideation and behavior: The role of racism and prevention. J Community Psychol. 2021;49(5):1282-1295. doi: 10.1002/jcop.22543. Epub 2021 Mar 6. PMID: 33675671; PMCID: PMC8222079.
36. Mak J, Shires DA, Zhang Q, Prieto LR, Ahmedani BK, Kattari L, Becerra-Culqui TA, Bradlyn A, Flanders WD, Getahun D, Giammattei SV, Hunkeler EM, Lash TL, Nash R, Quinn VP, Robinson B, Roblin D, Silverberg MJ, Slovis J, Tangpricha V, Vupputuri S, Goodman M. Suicide Attempts Among a Cohort of Transgender and Gender Diverse People. Am J Prev Med. 2020;59(4):570-577. doi: 10.1016/j.amepre.2020.03.026. Epub 2020 Aug 12. PMID: 32798005; PMCID: PMC7508867.
37. Wyman PA, Brown CH, Inman J, Cross W, Schmeelk-Cone K, Guo J, Pena JB. Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. J Consult Clin Psychol. 2008;76(1):104-15. doi: 10.1037/0022-006X.76.1.104. PMID: 18229988; PMCID: PMC2771576.
38. Aseltine RH Jr, James A, Schilling EA, Glanovsky J. Evaluating the SOS suicide prevention program: a replication and extension. BMC Public Health. 2007;7:161. doi: 10.1186/1471-2458-7-161. PMID: 17640366; PMCID: PMC1941734.
39. Meza JI, Bath E. One Size Does Not Fit All: Making Suicide Prevention and Interventions Equitable for Our Increasingly Diverse Communities. J Am Acad Child Adolesc Psychiatry. 2021;60(2):209-212. doi: 10.1016/j.jaac.2020.09.019. Epub 2020 Oct 14. Erratum in: J Am Acad Child Adolesc Psychiatry. 2021;60(6):789. doi: 10.1016/j.jaac.2021.03.012. PMID: 33068754.
40. Black Emotional and Mental Health Collective. Programs & Initiatives. https://beam.community/programs/. Accessed December 22, 2025.
41. The Trevor Project. Supporting Black LGBTQ+ Youth Mental Health. https://www.thetrevorproject.org/resources/guide/supporting-black-lgbtq-youth-mental-health/. Accessed December 22, 2025.

 doi:10.20944/preprints202602.0177.v1

42. Fischer O, Cox DW, Kassan A, Tomfohr-Madsen LM. Cultural humility, knowledge, and identity salience when working with sexual and gender minority clients. Psychol Sex Orientat Gend Divers. 2025; doi: https://psycnet.apa.org/doi/10.1037/sgd0000860.
43. Freeman-Coppadge DJ, Langroudi KF. Beyond LGBTQ-affirmative therapy: Fostering growth and healing through intersectionality. In: Queer Psychology: Intersectional Perspectives. Cham, Switzerland: Springer International Publishing; 2021:159-179.
44. Bochicchio L, Reeder K, Ivanoff A, Pope H, Stefancic A. Psychotherapeutic interventions for LGBTQ+ youth: A systematic review. *J LGBT Youth*. 2022;19(2):152-179.
45. Chen-Hayes SF. Challenging multiple oppressions in counselor education. In: Croteau JM, Lark JS, Lidderdale MA, Chung YB, eds. *Deconstructing Heterosexism in the Counseling Professions: A Narrative Approach*. Thousand Oaks, CA: Sage; 2005:53-58.
46. American Psychological Association, APA Task Force on Psychological Practice with Sexual Minority Persons. *Guidelines for Psychological Practice with Sexual Minority Persons*. 2021. https://www.apa.org/about/policy/psychological-practice-sexual-minority-persons.pdf. Accessed December 22, 2025.
47. Hatzenbuehler ML, Birkett M, Van Wagenen A, Meyer IH. Protective school climates and reduced risk for suicide ideation in sexual minority youths. Am J Public Health. 2014;104(2):279-86. doi: 10.2105/AJPH.2013.301508. Epub 2013 Dec 12. PMID: 24328634; PMCID: PMC3935661.
48. Toomey RB, Ryan C, Diaz RM, Card NA, Russell ST. Gender-nonconforming lesbian, gay, bisexual, and transgender youth: school victimization and young adult psychosocial adjustment. Dev Psychol. 2010;46(6):1580-9. doi: 10.1037/a0020705. PMID: 20822214.
49. Kosciw JG, Clark CM, Truong NL, Zongrone AD. The 2019 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools. New York, NY: Gay, Lesbian and Straight Education Network (GLSEN); 2020.
50. Substance Abuse and Mental Health Services Administration. *Minority Fellowship Program*. https://www.samhsa.gov/about/careers/fellowships/minority-fellowship-program. Accessed December 22, 2025.
51. Substance Abuse and Mental Health Services Administration. Project AWARE. https://www.samhsa.gov/mental-health/children-and-families/school-health/project-aware. Accessed December 22, 2025.
52. Shapiro VB, Derr AS, Eldeeb N, McCoy H, Trujillo MA, Vu CT. Ensure Healthy Development for Youth. In: Social Work and the Grand Challenge to Eliminate Racism: Concepts, Theory, and Evidence Based Approaches. 2023:127.
53. Wilson SL, Dinnerson QL. Bridging the gap: addressing mental health disparities in the African American community. In: Building Health, Resiliency, and Unity in the Black Community. IGI Global Scientific Publishing; 2025:205-240.
54. Bailey MM. Butch Queens Up in Pumps: Gender, Performance, and Ballroom Culture in Detroit. Ann Arbor, MI: University of Michigan Press; 2013.
55. Huynh J. "Family Is the Beginning but Not the End": Intergenerational LGBTQ Chosen Family, Social Support, and Health in a Vietnamese American Community Organization. J Homosex. 2023;70(7):1240-1262. doi: 10.1080/00918369.2021.2018879. Epub 2022 Jan 10. PMID: 35007487.
56. Frost DM, Meyer IH, Schwartz S. Social support networks among diverse sexual minority populations. Am J Orthopsychiatry. 2016;86(1):91-102. doi: 10.1037/ort0000117. PMID: 26752447; PMCID: PMC4878705.
57. McConnell E, Néray B, Hogan B, Korpak A, Clifford A, Birkett M. "Everybody Puts Their Whole Life on Facebook": Identity Management and the Online Social Networks of LGBTQ Youth. Int J Environ Res Public Health. 2018;15(6):1078. doi: 10.3390/ijerph15061078. PMID: 29861439; PMCID: PMC6025558.
58. Hudson KD, Romanelli M. "We Are Powerful People": Health-Promoting Strengths of LGBTQ Communities of Color. Qual Health Res. 2020;30(8):1156-1170. doi: 10.1177/1049732319837572. Epub 2019 Mar 28. PMID: 30920896.
59. Horwitz AG, Berona J, Busby DR, Eisenberg D, Zheng K, Pistorello J, Albucher R, Coryell W, Favorite T, Walloch JC, King CA. Variation in Suicide Risk among Subgroups of Sexual and Gender Minority College

 doi:10.20944/preprints202602.0177.v1

Students. Suicide Life Threat Behav. 2020;50(5):1041-1053. doi: 10.1111/sltb.12637. Epub 2020 Apr 15. PMID: 32291833; PMCID: PMC7981781.