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Abstract

Greater tolerance and understanding of homosexuality, transgenderism, and other forms of gender nonconformity have sparked an increased effort to reach out to and help sexual minorities (i.e., groups whose sexual identity, orientation, or practices differ from cisgender heterosexuality), especially those who experience mental health challenges. Despite immense progress in society, deeply rooted social stigma, prejudice, and discrimination have often left sexual minorities feeling bullied, ostracized, and isolated, which tends to reinforce a host of negative mental health outcomes, such as increased risk of major depressive disorder (MDD) and suicidality (Hatchel et al., 2018). While mental health clinicians have become increasingly aware of hardships faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals (particularly youth), they have yet to implement customized therapeutic approaches that cater to the unique circumstances and experiences of LGBTQ individuals (Painter et al., 2018). Treating depression in sexual minorities the same as depression in cisgender heterosexuals tends to be less effective and should be replaced by a more social, relationship-focused approach (Willging, Salvador, & Kano; Painter et al., 2018). Future research should focus on identifying and testing novel therapeutic orientations in an effort to help LGBTQ individuals with MDD to develop and strengthen meaningful relationships in their lives.

According to a large-scale census survey of over 2,500 lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, 31% reported having current symptoms of major depressive disorder (MDD); four times greater than the prevalence in the general population (National Institute of Mental Health, 2017; Yarns, Abrams, Meeks, & Sewell, 2016) (see Figure 1). According to the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, MDD is characterized by a depressed mood or a loss of interest/ pleasure, along with at least four of the seven following symptoms: significant weight fluctuation, sleep disturbances, feelings of worthlessness, psychomotor agitation, loss of energy, concentration disturbances, and recurrent thoughts of death or suicide (American Psychiatric Association, 2013). Because MDD is such a prevalent disorder, researchers and mental health clinicians are currently seeking to better understand its etiology in hopes of alleviating the pain and suffering it causes in so many.

Research to better understand MDD among sexual minorities, (i.e., any group whose sexual identity, orientation, or practices differ from cisgender heterosexuality), along with societal efforts to reduce discrimination and stigmatization, have significantly grown in recent decades. As a result, a large body of research demonstrates that the LGBTQ community reports significantly higher levels of peer-victimization, discrimination, and thoughts of suicide, along with lower levels of self-acceptance than heterosexuals (Drescher, 2015; Hatchel et al., 2018; Roi et al., 2016). However, less research examines the effectiveness and quality of therapeutic treatments specific to LGBTQ individuals. In order to provide the most effective treatment methods for LGBTQ youth with MDD, mental health clinicians must consider and understand important factors that make this community unique.

In the general population, MDD occurs more commonly among members of the same family, with a prevalence about three times greater among first-degree relatives (Lyons & Martin, 2014). However, the etiology of MDD among the LGBTQ community does not appear to be as genetically rooted. According to Hatchel et al. (2018), peer-victimization, bullying, and feelings of loneliness among LGBTQ

youth generally precede symptoms of depression. Diamond et al. (2011) also found that a loving, nurturing, and accepting relationship between LGBTQ youth and their parents strongly predicted decreased depressive symptoms and suicidal behavior. Findings like these suggest that negative factors around one's relationships and social environment significantly contribute to MDD among the LGBTQ community, especially during adolescence.

Understanding that social and relational influences have a greater influence on MDD in the LGBTQ community than in the general population, mental health clinicians must avoid the tendency to view all patients with a universal sameness or blanket approach. Willging et al. (2006) reported that mental health clinicians' attempts to treat sexual minority patients with the same therapeutic approach as heterosexual cisgender patients had negative effects on LGBTQ patients. Although mental health clinicians have historically treated mood disorders equally across varying sexual orientations and gender identities, LGBTQ youth would benefit from more customized, relationship-focused therapy, because key biological, psychological, and social differences in the etiology and course of MDD may necessitate a unique therapeutic approach in the LGBTQ community.

Biological Differences

Within the last half century, mental health professionals and scientists have developed a significant body of evidence demonstrating the neurobiological etiology of MDD. Although researchers have yet to identify significantly associated genes with depression, it has become increasingly clear that MDD is heritable, or genetically predisposed, with estimates of heritability ranging from 32% to 41% (Kaufman, 2018). This means that the origin of MDD in an individual's life may be explained, on average, by 32% to 41% of that person's genetic makeup. MDD is also largely influenced by hormonal and neurotransmitter levels in the nervous system. The influential monoamine hypothesis suggests that depression may be caused by a deficiency in monoamine neurotransmitters in the brain (Lyons & Martin, 2014). Many researchers have also underscored the

important role of the hypothalamic-pituitary-adrenal axis (HPA axis) in MDD (Lyons & Martin, 2014). For example, Cushing's Syndrome, a disorder resulting from abnormally high levels of HPA-related hormones, especially cortisol, is associated with an increased risk for depression (Lyons & Martin, 2014). Also, many studies suggest that blood-cortisol levels are significantly elevated in depressed patients (Benca & Peterson, 2008). While it is difficult to identify whether neurobiological, genetic, and hormonal factors precede or co-occur with MDD, all appear to play key roles in the formation and maintenance of the disorder.

Genetic Factors

With decades of evidence confirming the significant heritability of MDD, some may assume that LGBTQ individuals who experience MDD have similar genetic vulnerabilities. However, there is little to no evidence suggesting that genetic risks associated with MDD predict identifying as a sexual minority any more than such risk would predict depression in non- LGBTQ individuals (King et al., 2008; Diamond et al., 2011). In other words, people who experience significant genetic predispositions toward MDD are not more likely to identify as a sexual minority. Conversely, nothing about the genetics commonly associated with sexual minorities necessarily predicts a predisposition for MDD, which may explain (in part) why homosexuality was removed from the DSM-II as a psychiatric disorder in 1973 (Drescher, 2015). In support of this evidence, King et al. (2008) suggested that lesbian, gay, and bisexual (LGB) people may be at a higher risk for MDD because of institutionalized prejudices, social exclusion and victimization, and internalized feelings of shame and guilt about their sexual identity, not because of genetic vulnerabilities. The National Alliance on Mental Illness (2009) further confirmed that the increased risk of MDD among the LGBTQ community is strongly associated with social rejection, isolation, and internal lack of acceptance. Thus, while it is true that an individual could simultaneously identify as LGBTQ and have an increased genetic predisposition for MDD, it is unwise to causally link genetic risks of depression with disproportionally high rates of MDD among sexual minorities.

Hormonal Factors

Benca and Peterson (2008) explained that hormonal dysregulation often plays a role in MDD. They estimated that approximately half of those with MDD show some kind of abnormality in the HPA system, usually by having elevated levels of cortisol in the blood (Benca & Peterson, 2008). Because LGBTQ youth often experience inordinate amounts of stress compared to their heterosexual peers (Lewis et al., 2003), their HPA activity may be higher than normal, which could contribute to hormonal dysregulation commonly associated with MDD. In addition to cortisol, various sex hormones have been implicated in increased risk for MDD, especially estrogen (Lyons & Martin, 2014). Because mood disorders are more common in females, researchers have speculated that estrogen could play a key role in regulating mood by affecting neurotransmitter function (Steiner et al., 2003). And because hormonal imbalance seems to play a role in the formation of gender identity and sexual orientation among the LGBTQ community (Cousino et al., 2014), abnormal levels of estrogen and testosterone could be linked with a greater risk of developing MDD. However, because hormonal levels fluctuate in both men and women, evidence linking hormonal dysregulation in sexual minorities with increased risk of depression is inconclusive and minimal (Cousino et al., 2014). In fact, many researchers believe that gender or sexual nonconformity, in and of itself, does not increase risk of depression (Drescher, 2015), continuing to affirm that social rejection and discrimination are the main predictors of MDD among sexual minorities.

Psychological Differences

Because members of the LGBTQ community identify as gender or sex variant and are nonconforming with culturally defined identities and expectations (Cousino et al., 2014), psychological issues such as feelings of loneliness, poor self-esteem, and internalized homonegativity (i.e., homophobic feelings about the self), are very common (Lewis et al., 2003). These challenges often stem from and are exacerbated by peer-victimization, lack of family acceptance, and social rejection (Painter et al., 2018). As members of the LGBTQ

community, particularly youth, continue to experience mistreatment from others and societal marginalization, heightened risk of suicidality and depression become serious mental and physical health concerns that demand increased clinical attention (Kelleher, 2009).

Suicidality

According to Painter et al. (2018), youth who experience high levels of LGBTQ-specific victimization are around 5.6 times more likely to attempt suicide. Similarly, another study indicated that sexual minority youth were 6.2 times as likely to have ever attempted suicide, and 5.4 times more likely to report suicidal ideation than their heterosexual counterparts (Painter et al., 2018). However, youth simply identifying as LGBTQ does not cause suicidality in and of itself (Ryan et al., 2009). Many researchers have found that peer victimization and lack of familial acceptance increase the risk of suicidality dramatically (Ryan et al., 2009). For example, Diamond et al. (2011) reported that LGB young adults who reported high levels of family rejection were over eight times more likely to have attempted suicide in the past six months than LGB youth who reported low levels of family rejection. In support of this finding, Burton et al. (2013) found that peer-victimization and bullying were almost always present with suicidality in a longitudinal study of LGBTQ youth. Mental health clinicians must constantly keep in mind not only the high prevalence of suicidal ideation and attempts among LGBTQ adolescents but the specific social, and relational reasons that underlie this phenomenon.

Internalized Homonegativity

Along with disproportionately high rates of suicidality, LGBTQ youth also experience high levels of homonegativity. This often manifests itself in a lack of self-acceptance along with feelings of intense shame, guilt, and self-hatred (Lewis et al., 2003). Similarly, Hatchel et al. (2018) emphasized the reciprocal and overlapping interaction between the individual and their environment, explaining that external messages conveying a lack of acceptance from peers and/or loved ones may lead to the internalization of automatic negative thoughts by the individual (see Figure 2). According to Lyons

and Pepping (2017), these automatic negative thoughts primarily consisted of internalizing and accepting others' stigmas as being true, which often led to a concealment of sexual identity and greater fear about coming out. In a longitudinal study of gay-identifying individuals, researchers found that low levels of psychological and emotional support in adolescence predicted increased internalized homonegativity and sexual identity concealment (Lyons & Pepping, 2017). In line with this, Lewis et al. (2003) also showed that LGB-related stress and discrimination independently predicted depressive symptoms among LGB individuals, making them 2.5 times more likely to have clinical depression than the general population (Painter et al., 2018). Consistent ostracism, bullying, and lack of acceptance, therefore, may generate and reinforce chronic feelings of self-hatred, guilt, and shame, exacerbating symptoms of MDD among LGBTQ youth.

Self-esteem

Closely related to internalized homonegativity, LGBTQ youth who experience homophobic stigma and victimization also demonstrate decreased levels of self-esteem and confidence (Hatchel et al., 2018) (see Figure 2). In a sample of 300 self-identifying LGBTQ youth, Kelleher (2009) found that homophobic bullying and harassment predicted an increase in symptoms of MDD and a decrease in levels of self-esteem. According to the minority stress theory, as self-esteem decreases because of social stigma, prejudice, and discrimination, general performance on academic and extracurricular tasks suffers (Hatchel et al., 2018). During adolescence, a stage in life where positive self-image is particularly important, sexual minority youth are vulnerable to experiencing lower levels of self-esteem, which likely intensifies symptoms of MDD (Kelleher, 2009).

Social Differences

LGBTQ youth report significantly higher rates of sexual harassment peer victimization, and lack of family acceptance than heterosexual youth (Hatchel et al., 2018). These trends may contribute to negative mental health outcomes, especially a high prevalence of MDD and suicidal thoughts/behaviors (Boza & Perry, 2014).

Throughout decades of studying MDD among sexual minorities, researchers have shown that gender nonconformity of any kind does not, in and of itself, produce depressive symptoms and suicidality (Painter et al., 2018; Ryan et al., 2009). Instead, LGBTQ-specific victimization and mistreatment from friends, family, or both, seem to be the greatest predictor of MDD among LGBTQ youth.

Peer Victimization

School environments have often been places where bullying, ridiculing, and teasing are common. As a socially stigmatized minority, most LGBTQ youth have been victims of such behaviors and have suffered serious mental health challenges as a result. Hatchel et al. (2018) reported that 64.4% of LGBTQ youth experienced sexual harassment at least once, significantly higher than the prevalence of the general population. About half of these LGBTQ youth reported being victims of unwelcomed sexual comments, jokes, or gestures, with a third of them reporting homophobic slurs as the most distressing event they had ever experienced at school (Hatchel et al., 2018). Such treatment may lead to feelings of isolation, lack of belongingness, decreased self-esteem, increased levels of depression, and higher risks of suicide (Kelleher, 2009). Thus, many researchers believe that peer victimization precedes and contributes to the onset of MDD in many LGBTQ youth (Hatchel et al., 2018; Painter et al., 2018). To support this notion, Hatchel et al. (2018) and Painter et al. (2018) have shown that sexual minorities who report increased feelings of school belongingness and peer acceptance do not experience depressive symptoms and suicidality nearly to the degree that bullied and victimized sexual minorities do. These findings suggest that social and relational factors, especially at school, have profound implications on the etiology and course of MDD among LGBTQ youth.

Familial Acceptance

Although most parents become increasingly accepting of their child's sexual orientation over time, Diamond et al. (2011) found that approximately thirty-five to forty percent of one parental sample either outwardly rejected or were inwardly intolerant of their child.

Some maintained their rejecting stance for years, particularly those who saw gender nonconformity and untraditional sexual orientation as immoral or conflicting with religious beliefs (Diamond et al., 2011). A lack of tolerance and acceptance in a relationship as proximate and intimate as parent-child can have severely negative effects on the mental well-being of LGBTQ youth (Ryan et al., 2009). In a study of gay male adolescents, researchers found that half of the participants attributed their past suicide attempts to problems with family members (Remafedi et al., 1991). More recently, another team of researchers found that sexual minority young adults who reported high levels of family rejection were over eight times more likely to have been suicidal in the past six months and four times more likely to suffer from MDD, compared to sexual minorities who reported low levels of family rejection (Ryan et al., 2009). The importance of accepting, nurturing, and loving familial relationships with sexual minorities cannot be overstated. Contrary messages of disapproval, disappointment, and rejection often leave LGBTQ youth feeling alone, hopeless, and isolated, increasing risks of depression and suicidality.

Conclusion

While genetic and hormonal factors have important implications on risk for depression, there is little to no evidence suggesting that gender nonconformity and nontraditional sexual orientation alone increase the risk of depressive symptoms and suicidality. Instead, a vast and replicated body of research suggests that peer victimization and family rejection induce and exacerbate feelings of homonegativity and low self-esteem, which drastically increases risk of suicidality and depression (Hatchel et al., 2018). Therefore, traditional antidepressants coupled with conventional forms of psychotherapy may not sufficiently address the social and relational factors of MDD among sexual minorities.

Researchers are beginning to suggest that mental health clinicians should focus primarily on peer and family relationships when treating LGBTQ youth with mood disorders. For example, Diamond et al. (2011) found that family-focused therapy, which seeks to target and strengthen family relationships, significantly decreased

levels of depression and suicidality in LGBTQ youth. Similarly, Painter et al. (2018) found that increasing the focus on social support in therapy acts as a safeguard for both depression and suicidality. Thus, a therapeutic focus on important peer and family relationships of sexual minority youth appears to have promising implications for future mental health outcomes among the LGBTQ community.

Mental health clinicians must focus on the specific needs and circumstances of their LGBTQ patients by focusing their prevention and treatment efforts on bolstering and strengthening the quality of important relationships (Painter et al., 2018). Recognizing that MDD among LGBTQ individuals is often exacerbated by social and relational wounds, therapists should seek to help bind these wounds through social and relational healing. There is an urgent need for future research evaluating and developing specific treatment methods that can accomplish this goal. Despite remaining uncertainties about the most optimal treatment methods for LGBTQ youth with MDD, making large-scale societal changes about how marginalized groups like the LGBTQ community are treated, accepted, and loved will perhaps have more immediate power than anything else.

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