Psychology of Sexual Orientation and Gender Diversity

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Community Support for Sexual and Gender Diversity, Minority Stress, and Mental Health: A Mixed-Methods Study of Adolescents With Minoritized Sexual and Gender Identities

Phillip L. Hammack[1], David R. Pletta[2], Sam D. Hughes[1, 3], Julianne M. Atwood[1], Elliot M. Cohen[1], and Richard C. Clark[4]

[1] Department of Psychology, University of California, Santa Cruz
[2] Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health
[3] Center for Positive Sexuality, Burbank, California, United States
[4] Department of Psychology, Graduate Center, City University of New York

The 21st century has been a time of change in recognition of sexual and gender diversity (SGD) in the United States, but we know little about how community-level variability in support for SGD shapes the experience of youth who hold minoritized sexual or gender (MSG) identities. This study used mixed methods to examine regional variability in community climate for SGD and its relationship with minority stress and mental health for adolescents with MSG identities (e.g., asexual, bisexual, gay, lesbian, transgender, nonbinary). Findings revealed differences in objective indicators, self-reported perceptions, and informant narratives of community climate, but survey and narrative data revealed that adolescents experienced heightened levels of depressive symptoms and minority stress processes across communities. Adolescent informants constructed narratives that identified anxiety/depression and self-harm as primary mental health challenges across communities, linking these experiences to societal stigma and insufficient education about SGD. Sources of resilience included mental health services, in-person resources (e.g., school gender–sexuality alliances [GSAs]), online resources, and peer support. Findings reveal the endurance of cultural ideologies that reinforce stigma (e.g., heterosexism, cissexism), activate minority stress processes (e.g., internalized stigma), and contribute to negative mental health (e.g., depressive symptoms), even for adolescents in supportive community settings.

Public Significance Statement

Disparities in mental health exist for adolescents with minoritized sexual or gender identities, but we lack sufficient knowledge of how different types of communities might exacerbate or ameliorate minority stress processes. This mixed-methods study allowed for a deep interrogation of the experience of minority stress and mental health for adolescents, providing information on possible interventions (e.g. formal education about sexual and gender diversity) to promote health and well-being.

Keywords: LGBTQ, adolescence, community, gender, sexuality

The 21st century represents a time of considerable social and historical change with regard to cultural understandings of gender and sexuality and support for sexual and gender diversity (SGD; e.g., Hammack, 2018a; Risman, 2018; Russell & Fish, 2019). Whereas the 20th century was characterized by a more singular cultural narrative opposing SGD and a more uniform level of cultural hostility (Hammack et al., 2013; Herek, 2010), the 21st century is characterized by a proliferation of competing narratives about the legitimacy of SGD. Widespread cultural and legal recognition of same-gender relationships in the United States reveals how same-gender attraction is now considered a form of legitimate intimate diversity (Russell & Fish, 2016). Recognition of gender diversity and transgender rights, however, remains unresolved, with continuing attempts to limit transgender rights and to legally define gender in a way that does not serve the interest of transgender people (Eckes, 2017; Mezey, 2019). Indeed, recognition of gender diversity is highly contested in the current cultural and political landscape, with heightened stigma toward transgender and

Phillip L. Hammack https://orcid.org/0000-0003-2203-858X

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Correspondence concerning this article should be addressed to Phillip L. Hammack, Department of Psychology, University of California, Santa Cruz, 1156 High Street, Santa Cruz, CA 95054, United States. Email: hammack@ucsc.edu

gender nonconforming people causing public health concern (e.g., Barbee et al., 2022; Horne et al., 2022).

Members of "Generation Z," those born at the start of the 21st century (Dimock, 2019), have experienced adolescence and emerging adulthood at a time of significant political and cultural polarization—a time of elevated minority stress (Brown & Keller, 2018; Gonzalez et al., 2018) and heightened tension with families and communities of origin (Gonzalez et al., 2018) for those with minoritized sexual or gender (MSG) identities.[1] Despite improvements in the recognition of SGD in the 21st century, there is considerable variability in support across communities. Community settings for youth with MSG identities have long been considered central for identity development and psychological wellbeing (e.g., D'Augelli & Hershberger, 1993; Gerstel et al., 1989; Pilkington & D'Augelli, 1995), yet few contemporary studies focus directly on adolescents' experience of community (cf. Paceley et al., 2017).

The purpose of this study was to use mixed methods to examine community variability in support for SGD and its implications for adolescent mental health. Our aims were to (a) document this variability using community-level data via community climate assessment (CCA; Oswald et al., 2010), (b) interrogate adolescents' experience of community climate using qualitative and self-report survey methods, and (c) examine variability in minority stress processes and mental health based on community climate. Our equal-status mixed-methods design (Creswell, 2009) allowed us to triangulate data sources to capture the experiential story of a unique cohort of adolescents linked by historical time but dispersed across divergent community settings.

Stigma, Stress, and Mental Health: Community Climate for Adolescents With MSG Identities

While it is assumed that those with MSG identities inhabit a broad cultural context of heterosexism and sexual stigma (Herek, 2009a, 2009b), communities within the United States may vary in the extent to which they confer rights, protections, and resources that benefit those with MSG identities. Analyzing and measuring community climate is critical to understanding minority stress processes and the well-being of youth with MSG identities, since minority stress theory assumes that circumstances in the environment activate stress processes (Brooks, 1981; Meyer, 2003; Rich et al., 2020).

Advances in the conceptualization and measurement of community climate have emerged to facilitate the study of community variability in support for SGD. Oswald et al. (2010) have defined *community climate for sexual diversity* as "the level of community support for homosexuality" (p. 215) and suggest that it can be measured through publicly available data by assessing religious and political affiliations, legal rights regarding same-gender relationships, workplace opportunities and policies, the presence of community members with MSG identities, and services targeting MSG people. Based on theories of social capital and health (e.g., Kawachi et al., 2008), Oswald et al. (2010) argued that a positive community climate for those with minoritized sexual identities provides structural social capital through a sense of collective efficacy, thus producing a positive effect on psychological well-being.

Prior CCAs using objective indicators or community member self-report reveal a link between social context and mental health. Hatzenbuehler (2011) analyzed data from the Oregon Healthy Teens (OHT) Survey conducted from 2006 to 2008, using CCA (Oswald et al., 2010) to identify variability in the social environments of youth. He found that the risk of suicide attempt was 20% greater for lesbian, gay, and bisexual youth living in negative environments, and more supportive environments were associated with fewer suicide attempts after controlling for individual risk factors (Hatzenbuehler, 2011). In an online survey of adolescents with MSG identities living in the U.S. Midwest, Paceley et al. (2017) found that those who reported more hostile community climates also reported higher levels of victimization and depression, anxiety, and stress. Youth residing in communities considered unsupportive reported the need to conceal their sexual or gender identities (Higa et al., 2014), representing an internalized source of minority stress (Brooks, 1981; Meyer, 2003). Hatzenbuehler and McLaughlin (2014) discovered that youth raised in highly stigmatizing environments showed a blunted cortisol response, suggesting that these stigmatizing environments have biological effects similar to trauma.

Research with adolescents has suggested a link among rural community settings, minority stress experiences (e.g., victimization), and psychological distress. Youth in rural settings report more experiences with victimization and bullying based on sexual or gender identity (Ballard et al., 2017; Kosciw et al., 2015). Youth in rural settings also report higher levels of suicide risk, school violence, drug use, and sexual risk behavior than heterosexual youth (Ballard et al., 2017).

It is important to recognize, however, that communities are not necessarily experienced homogeneously and that many factors within communities can impact the experience of youth with MSG identities. In their qualitative study with adolescents from smaller and rural towns, Paceley et al. (2017) found that youth received emotional support, relationship advice, and protection from both friends with MSG identities, as well as those with nonminoritized identities (e.g., cisgender, straight). The relative presence of supportive organizations, such as GSAs in high schools, can influence the experience of youth in low-support communities (Hackimer & Proctor, 2015).

Increased attention to contextual variability in the experience of youth with MSG identities may help to explain why, even as society advances toward greater acceptance of SGD, psychological challenges and health disparities endure (Holman & Oswald, 2016). To gain a more context-sensitive and empirical approach to the study of youth with MSG identities, multilevel (e.g., community, individual) and mixed-methods (i.e., qualitative and quantitative) studies are needed.

The Current Study

This study utilized mixed methods to examine variability in community climate toward SGD and its relationship with minority stress

[1] We use the term *minoritized sexual or gender* (MSG) identities instead of sexual and gender minority (SGM) people to highlight subordination as an active, socially constructed process and to challenge the notion that those with non-normative identities necessarily constitute a distinct "subspecies" of people (e.g., Foucault, 1978; Hammack et al., 2013). This terminological shift is consistent with research on race and ethnicity in which non-White racial and ethnic groups are recognized as minoritized in societies historically dominated by White people (e.g., Harper, 2015).

and mental health among MSG adolescents. At the level of the community, we used CCA (Oswald et al., 2010) to provide quantitative indicators of support for diversity. At the level of the individual, we used interview and survey methods to obtain reports of individual perceptions and narrative meaning-making of community climate, minority stress, and mental health.

Our study embraced a question-driven, pluralistic epistemological approach that combined hypothetico-deductivism in our use of quantitative methods and interpretivism in our use of qualitative methods. This mixed-method design assumed equal status of methods (Creswell, 2009) to address different aspects of our research questions (RQs) and to provide a holistic picture of youth experiences of community climate, minority stress, and mental health.

> *RQ 1:* How Do Communities Historically Considered More or Less Supportive of SGD Diverge or Converge Across Objective Indicators, Self-Reported Perceptions, and Narratives?

To address this question, we utilized both quantitative (i.e., CCA, self-report survey) and qualitative (i.e., informant interviews) data. We hypothesized that (a) communities historically supportive of SGD would score higher on a quantitative index measuring objective factors in the environment (i.e., the CCA), (b) self-reports of support for SGD would be higher among adolescents in high-support communities, and (c) narratives of youth informants would reveal divergent support across communities.

> *RQ 2:* Do More Supportive Communities Mean Less Minority Stress and Better Mental Health for MSG Adolescents?

To address this question, we utilized self-report survey data to examine differences in minority stress and mental health across communities. We hypothesized that adolescents who reside in more supportive communities would report better mental health, less minority stress, and greater resilience than those who reside in less supportive communities.

> *RQ 3:* How Do Youth Narrate Their Experience of Mental Health Across Diverse Communities?

To address this question, we utilized findings from our analysis of informant interviews. Grounded in an interpretive epistemology (e.g., Josselson & Hammack, 2021), our aim was to understand how youth informants narrated specific mental health challenges facing youth in their communities and what resources were available to address them.

Novel in its aims, design, and epistemological pluralism, our study sought to triangulate data sources to illustrate how different methods elicit distinct forms of evidence about the nature and meaning of community variability for youth with MSG identities.

Method

Overview and Researcher Descriptions

Our mixed-methods design blended sequential and concurrent approaches (Creswell, 2009), with Phase 1 occurring first and informing site selection for Phases 2 and 3, which took place concurrently. Phase 1 was conducted from January through June of 2015 and constituted a CCA (Oswald et al., 2010) of support for SGD in 10 randomly selected counties in California. Phase 2 was a 20-month ethnography conducted from November 2015 through July 2017 in four of the 10 counties assessed in Phase 1. In Phase 3, an online survey of 314 youth with MSG identities residing in one of the four counties targeted in Phase 2 was conducted from October 2016 through June 2017. All procedures were approved by the Institutional Review Board at the University of California, Santa Cruz.

For reflexivity, we note that the authors hold diverse identities relevant to the project, including cisgender (AFAB, AMAB[2]), genderfluid trans femme (AMAB), gay (AMAB), bisexual (AFAB, AMAB), straight (AMAB), and queer (AMAB). The authorship team consisted of individuals who identify as White and Black and from diverse social class backgrounds, with most of the research team one generation older (i.e., "Millennials") than the cohort of study. The researchers were committed to a process of reflexivity in which they reflected on the ways in which these identities—and the absence of other perspectives on the research team—might impact data collection or analysis.

Grounded in an interpretive and constructionist epistemology (Madill et al., 2000), we recognized the co-constructed nature of the relationship between researchers and participants. In contrast to a postpositivist or realist epistemology, which seeks to manage researcher "bias" in recognition of an underlying "truth" in the data (Madill et al., 2000), our epistemology called upon us to be consistently explicit about our roles and positions in the co-construction of the knowledge produced. Reflexive practices in this epistemology to ensure methodological integrity center especially on writing and sharing our perspectives throughout the data collection and analysis process (see Levitt et al., 2017). We provide further detail on these practices in the following text.

Phase 1: CCA

Using data from 10 randomly selected counties and their most populous municipalities, we assessed support for SGD in two distinct regions of California—San Francisco Bay Area and Central Valley. These regions were selected for their historic support (in the case of the Bay Area) or hostility (in the case of the Central Valley) to provide an appropriate contrast in settings to examine our RQs. Eight indicators of community climate were assessed. At the county level, indicators included the following (1) proportion of supportive religious adherents; (2) proportion of supportive political affiliates; (3) proportion of employment in management, business, science, and arts (4) proportion of same-sex headed households; (5) proportion of high schools with an active "gay-straight" or "gender-sexuality" alliance (GSA); (6) presence of Pride celebration in the county; and (7) proportion of high schools formally commemorating Harvey Milk Day. At the municipal level, we calculated (8) the number of supportive businesses and organizations within a county's most populous municipality. All indicators except 5, 6, and 7 were taken from Oswald et al.'s (2010) original CCA. Indicators 6 and 7 were added because of their specific relevance to California. We note that, because the original focus of the CCA was more narrowly on sexual diversity, rather than sexual and gender diversity, it does not account well

[2] AFAB = assigned/assumed female at birth; AMAB = assigned/assumed male at birth.

for indicators which may be specific to support for transgender and nonbinary people (e.g., existence of all-gender facilities in schools, presence or absence of trans-affirming legislation).

Indicator 1: Supportive Religious Adherents

Using the Religious Congregations and Membership Study (Grammich et al., 2012) of the Association of Statisticians of American Religious Bodies, we recorded the number of LGBTQ-supportive religious institutions in each county. We documented all congregations located within a county and searched each denomination's national website to assess whether they "explicitly stated that they welcomed GLBT people as they are" (Oswald et al., 2010, p. 222). Examples of supportive religious denominations included Episcopal, Evangelical Lutheran Church, and United Church of Christ. We recorded the number of supportive religious adherents located within each county and divided the number of adherents by the county's 2010 population (U.S. Census Bureau, 2010) to create a standardized score.

Indicator 2: Supportive Political Climate

We identified the percentage of county voters registered with the Democratic National Party or Green Party, as these two political parties have platforms more explicitly supportive of SGD (Oswald et al., 2010). Data were obtained from the California Secretary of State's Report of Registration as of February 10th, 2015 (California Secretary of State, 2015).

Indicator 3: Creative Class Employment

Using the U.S. Census Bureau's (2013) American Communities Survey's (ACS) 5-year report (i.e., 2008 through 2013), we recorded the percentage of workers listed under "management, business, science, and arts" (MBSA) for each county. This economic indicator stems from research documenting an association between the presence of "creative class" occupations and a community's openness to diversity, including its acceptance of people with MSG identities (Florida, 2002). The proportion of employees working in MBSA-classified occupations was calculated by dividing a county's number of MBSA employees by its civilian employed population (age $\geq$16 years).

Indicator 4: Proportion of Same-Sex Headed Households

The proportion of county households headed by same-sex couples was obtained from ACS (U.S. Census Bureau, 2013) 5-year estimates (Years 2008 through 2013). *Same-sex headed households* were defined as those with either a "male householder and male partner" or "female householder and female partner."

Indicator 5: Proportion of High Schools With a GSA

We calculated the proportion of public high schools with a GSA or equivalent organization for each county. First, a researcher compiled a list of each county's public high schools using school district websites. We then compared the list of county public high schools to the GSA Network's national directory (https://gsanetwork.org/national/), which listed high schools containing a nationally registered GSA. The proportion of county public high schools with a GSA was calculated by dividing the number of public high schools containing a GSA by the county's total number of public high schools.

Indicator 6: Pride Celebration

Two researchers conducted independent searches online for Pride celebrations within the 10 counties. Pride is an annual event commonly held to commemorate the Stonewall Uprising of 1969 and represents the most widely celebrated ritual for people with MSG identities (Bruce, 2016). A Pride celebration was considered present if it occurred within the county in the past year and was hosted by a governmental body or community-based organization (0 = *absent*, 1 = *present*).

Indicator 7: Harvey Milk Day Commemoration

Harvey Milk was a major civil rights figure in California in the 1970s and one of the best known gay politicians (Faderman, 2018). Signed into California State Law in 2009; Senate Bill 572's (SB-572) amendment to California State Legislature includes proclaiming May 22 as Harvey Milk Day. The amendment states that "all public schools and educational institutions are encouraged to observe [the listed] days and to conduct suitable commemorative exercises as follows: . . . On Harvey Milk Day, exercises remembering the life of Harvey Milk, recognizing his accomplishments, and familiarizing pupils with the contributions he made to this state" (California SB-572, 2009). We contacted all public high schools located within the 10 counties and inquired with administrative staff if the school observed Harvey Milk Day in some capacity (e.g., a celebration, commemorative event). The presence of a Harvey Milk Day commemoration was dichotomously scored as 0 or 1 (0 = *absent or unsure*, 1 = *present*). The proportion of schools observing Harvey Milk Day was then calculated for each county.

Indicator 8: LGBT-Supportive Businesses and Organizations

Two researchers conducted independent online searches for LGBT-supportive businesses and organizations in the most populous municipality of each county. Websites used to identify LGBT-supportive businesses and organizations in the Bay Area included gaypinkspots.com, gaycities.com, and oaklandlocal.com. Sources for the Central Valley included gaycities.com, gayfresno.com, gayhanford.com, and gayvisalia.com. After developing independent lists, researchers merged their findings to create a comprehensive list of LGBT-supportive businesses and organizations. We then calculated a standardized score for each county by dividing the number of LGBT-supportive businesses and organizations by the municipal population (population estimates from the 2014 ACS 1-year estimates; U.S. Census Bureau, 2014).

Phase 2: Ethnography

To examine the relationship between community climate and psychological experience, we targeted counties that were the most and the least supportive of SGD. Across the 10 counties examined in Phase 1, Alameda County (adjacent to San Francisco; population 1.66 million) was determined to be the most supportive. Madera, Kings, and Tulare counties were considered the least supportive and were combined to provide a larger sample size (combined population: 771,484; analyses from Phase 1 that produced these findings are detailed in the Results section). Ethnographic fieldwork occurred over a 20-month period from November 2015 through July 2017 and consisted of participant observation at high

schools, community-based organizations, and community rituals for youth with MSG identities (e.g., Pride) and semistructured interviews with youth informants.

The fourth and fifth authors of this article served as field researchers based in the Central Valley and the San Francisco Bay Area, respectively. Field researchers completed 92 ethnographic fieldnotes following procedures outlined by Emerson et al. (2011). Researchers engaged in explicit reflexive practices in the field notes by including reflections on the way in which their own identities might have shaped the data collection process or the observational setting. The field researchers met weekly via video with the principal investigator (the first author) and/or one of the project coordinators (the third and sixth authors) to discuss their field notes and progress toward interviewee recruiting.

Informant Interviews

Youth informants (n = 28) were recruited through nominations provided by adult community leaders, as well as through recommendations of field researchers based on participant observation. Informants were eligible if they were (a) between the ages of 14 and 21 years, (b) consistently active in spaces for youth with MSG identities (e.g., GSAs), and (c) currently or previously held a leadership role in the community (though they did not need to have an official organizational title or position). We sought to recruit community leaders, reasoning that their highly active participation in the community could provide a more comprehensive picture of community climate and its impact on stress and mental health. This approach to sampling informants is consistent with established practice in ethnographic research, where the goal is to recruit those with expert knowledge (e.g., Gold, 1997; Johnson, 1990).

We sought to ensure diverse representation among youth informants in terms of gender, sexual, and racial/ethnic identities. Following standards in qualitative data collection (e.g., Beitin, 2012; Levitt et al., 2018), we collected data until the research team agreed we had reached saturation in terms of key themes emerging in the interviews. Median age of informants was 16 years in the Bay Area and 17 years in the Central Valley. All names used in this report are pseudonyms created by the research team to match participants' actual names in terms of gender and race/ethnicity.

Although the demographics of our informants were diverse, they reflected the pronounced visibility of certain groups in youth spaces. For example, our ethnographic observations revealed that the most visible youth across communities were AFAB. Cisgender gay boys were particularly less visible in spaces across communities. Youth in Central Valley communities were overwhelmingly Latinx.

Informants selected interview locations, which included private offices, public library rooms, and empty school classrooms. Researchers described the project as "looking to better understand what local community contexts are like across California for LGBTQ youth today, ... what resources exist in local communities, [and] the general climate in different communities with regard to sexual and gender identity diversity." All interviewees provided written informed consent or assent. A waiver of parental consent was granted by our Institutional Review Board, based on the rationale that the requirement of parental consent for youth could present a high level risk depending on their disclosure status with parents (Mustanski, 2011).

Interviewees provided information about their age, pronouns, race/ethnicity, sexual identity, gender identity, assigned sex, and length of residence in their community. The interview protocol consisted of seven sections: (a) personal background of the interviewee, including their own experience of SGD; (b) perceived community climate; (c) discrimination/violence incidents (i.e., specific instances of discrimination, violence, or bullying); (d) health and mental health concerns and resources in the community; (e) sense of community for people with MSG identities; (f) community needs to improve the lives of youth; and (g) recommendations for our fieldwork (e.g., events to observe or specific youth to interview). Interviews ranged from approximately 1 hr to 3 hr (M = 101 min, SD = 37 min) and were recorded using a digital audio recorder. Recordings were transcribed by a professional transcription company and uploaded to a secure server with identifying information redacted. Interviewees were provided a $US20.00 cash incentive for participating.

Following each interview, researchers completed case reports which included observational data surrounding the interview and provided a reflexive space to consider the role of researcher identities in the data collected. Consistent with our interpretive epistemology and our recognition of each interview as a co-constructed encounter (Josselson, 2013; Josselson & Hammack, 2021), we relied upon these reports throughout the data analytic process to ensure trustworthiness. Specifically, each report was reviewed prior to thematic coding to consider the way in which the researcher's role or identities may have shaped the narrative content. The reports also provided space to reflect on recurring themes which was used to determine saturation.

Qualitative Data Analysis

Qualitative data analysis proceeded in three stages. In the first stage, members of the research team involved in qualitative data coding (i.e., the first, fourth, and fifth authors) completed preanalysis reflexivity memos in which they reflected on their own sexual and gender identity development, their feelings about the project, expectations for data analysis, and their relative identity-based privilege. In an effort to create a unified interpretive community among researchers aware of the distinct positions from which the coders engaged with the data, the three coders met several times to discuss the memos. The goal was to make explicit the lenses through which the coders approached the data on account of their diverse positions. Rather than traditional indices of reliability, this approach followed our interpretive and constructionist epistemology which recognized the data as coconstructed both in the interview encounter and in the data analytic process. Our reflexivity procedures provided trustworthiness to the analytic process by rendering our positions explicit (see Levitt et al., 2017, 2018; Madill et al., 2000).

In the second phase of analysis, the three coders established a preliminary codebook. Codes were constructed descriptively and for use in content analysis (e.g., Hsieh & Shannon, 2005). For example, we constructed codes about "community climate" to flag content discussing the community climate toward SGD. Subcodes within this content category included any text related to our Phase 1 indicators (e.g., religious organization support, GSA-related support). Other sets of parent codes included those focused on mental health, minority stress (e.g., concealment/disclosure), and resilience factors (e.g., individual coping).

In the third phase of analysis, the three coders collaboratively coded a selection of data using Dedoose qualitative analytic software to establish interpretive and technical consistency in the application of content codes. After reaching a point of consistency, two coders (the fourth and fifth authors) independently applied codes to the data. The first author then served as an external auditor for the remaining content coding and led the process of selecting representative excerpts for presentation in this article. This approach to qualitative data analysis has previously been employed in research on SGD (e.g., Galupo et al., 2019).

Phase 3: Survey

Participants and Procedure

A self-report survey was administered online from October 2016 through June 2017. We used a venue-based purposive sampling strategy to obtain a nonprobability sample of adolescents residing in the four counties of interest. This sampling strategy was ideal to capture a diversity of perspectives among residents with MSG identities (see Meyer & Wilson, 2009) and achieves comparable goals to national probability sampling (Krueger et al., 2020). Respondents were eligible if they were between the ages of 14 and 18 years, had lived in one of the four counties for at least 1 year, and identified as transgender or nonbinary and/or lesbian, gay, bisexual, queer, or any other nonheterosexual identity.[3] A target sample of approximately 150 youth per region was determined following consultation with statisticians about planned quantitative analyses. Respondents received a $US20.00 gift card to an online retailer for their participation.

Sampling venues were selected to ensure a diversity of cultural, political, ethnic, gender, and sexual representation. To control for sampling bias related to particular venues, we recruited participants from various types of venues (e.g., community-based organizations, online settings, Pride events). A total of 314 adolescents met our eligibility criteria and provided valid data. Respondents completed the survey online using the SurveyGizmo platform (now rebranded as Alchemer).

Measures: Demographic Variables

Assigned Sex. Participants were asked to indicate their assigned sex at birth (female or male) on their original birth certificate.

Gender Identity. Following the recommended approach to assess gender identity using two items (Gender Identity in U.S. Surveillance Group, 2014), participants were asked to select any gender identity label(s) from among five options to best describe themselves: girl/woman, boy/man, transgender girl or woman/male-to-female (MTF), transgender boy or man/female-to-male (FTM), nonbinary/genderqueer. They were offered an open-response "other" option if their current gender identity did not match provided options.

Sexual Identity. Following best practices for the assessment of sexual orientation in survey research (Sexual Minority Assessment Research Team, 2009), participants were asked to select among a list of eight sexual identity labels any terms with which they identified: *straight/heterosexual*, *lesbian*, *gay*, *bisexual*, *queer*, *pansexual*, *transamorous/transattracted*, and *asexual*. They were offered an open-response option "other" to account for sexual identities not aligned with provided options. Participants who selected the asexual option or who wrote in an asexual-spectrum identity (e.g., *graysexual*) were classified as asexual.

Race/Ethnic Identity. Participants were asked to select all the race/ethnicity terms that applied to them from the options: American Indian/Alaskan Native, Asian/Asian American, Black/African American, Biracial/Multiracial, Hispanic/Latino or Spanish origin, Middle Eastern/North African, Native Hawaiian/Pacific Islander, and White/Caucasian/European American. An "other" option was available for those who identified with a race/ethnicity not listed.

Parental Education. Participants indicated the highest level of parental education attained. Response options included the following: 1 = *did not finish high school*, 2 = *graduated from high school*, 3 = *attended college but did not complete a 4-year degree*, 4 = *4-year degree*, 5 = *graduated from college*, and 6 = *do not know*.

Perceived Community Climate Measure. Based on our adaptation of the Oswald et al. (2010) CCA, we constructed a 13-item measure of perceived community climate. Participants indicated their level of agreement with a series of statements about the community on a 4-point scale (0 = *strongly disagree*, 3 = *strongly agree*). Sample statements included "My community celebrates LGBTQ+ people with events like Pride" and "I feel like my community is supportive of LGBTQ+ people in general." The measure yielded a Cronbach's alpha of .92, indicating a high level of interitem reliability.

Minority Stress Experiences and Processes Measures.

General Victimization. This eight-item measure assessed victimization in the previous 12 months. It was adapted from Herek (2009a) with four additional questions. An example item is as follows: "In the last 12 months, how often have any of the following happened to you? You were hit, beaten, physically attacked, or sexually assaulted." Participants responded on a 4-point scale (1 = *never*, 4 = *three or more times*). Responses were then dichotomized (0 = no, 1 = yes) based on whether a particular form of victimization was experienced in the last 12 months. Forms of victimization included: violence, property crime, attempted violence or property crime, threats of violence, verbal abuse, and objects thrown at the respondent. The scale demonstrated a good level of interitem reliability with a Cronbach's alpha of .81.

Perceived LGBTQ+-Targeted Victimization. If participants indicated they had experienced any form of victimization in the past 12 months (n = 212), they were asked to report their perception of the reasons they were targeted. They were asked, "If you said you had any of the experiences (being assaulted, robbed, threatened with violence, insulted, and abused), would you say they happened because of your . . .," followed by a list of 10 possible identities: age, sex (being male or female), being transgender, gender expression or appearance, race/ethnicity, income level or education, sexual orientation, physical appearance (e.g., weight, height), religion/spirituality, and disability. Participants responded to each identity category with a dichotomous response, with those who experienced victimization based on gender identity, gender expression or appearance, and/or sexual orientation being coded as having experienced LGBTQ+-targeted victimization (0 = no, 1 = yes).

Everyday Discrimination. This nine-item scale assessed the extent to which participants felt they experienced unfair treatment

[3] For Phase 3, we limited our age focus to high-school aged adolescents, rather than the more expansive age range for Phase 2 which included youth up to age 21. We note that all but two of our youth informants in Phase 2 were 18 years old or younger.

in more routine, everyday contexts. It was adapted from an LGBTQ+-oriented modification (Gordon & Meyer, 2007) of a measure originally designed to assess everyday discrimination among African Americans (Williams et al., 1997). The scale features items such as the following: "In your day-to-day life over the past year, how often did any of the following things happen to you? You were treated with less courtesy than other people." Respondents indicated their response on a 4-point scale (1 = *never*, 4 = *often*). The scale demonstrated very good interitem reliability, with a Cronbach's alpha of .90.

Perceived LGBTQ+-Targeted Everyday Discrimination. If participants indicated any experience of everyday discrimination (n = 278), they were asked to report their perception of the reasons they were targeted. They were asked, "If you said you had any of the experiences above, would you say these experiences happened because of your . . .," followed by the same list of 10 possible identities from the perceived LGBTQ+ targeted victimization variable. Participants responded to each identity category with a dichotomous response, with those who experienced discrimination based on gender identity, gender expression or appearance, and/or sexual orientation being coded as having experienced LGBTQ+ targeted everyday discrimination (0 = *no*, 1 = *yes*).

Anti-LGBTQ+ Remarks. This seven-item scale measured how often participants heard anti-LGBTQ+ slurs and negative remarks about LGBTQ+ people. It was adapted from the Gender and Sex-Based Harassment Module of the California Healthy Kids Survey (2015). It included five items taken in their entirety from the measure. To improve specificity and avoid a double-barreled question, one item ("How often do you hear anti-LGBTQ slurs at schools [e.g., when someone says 'that's so gay' to mean something bad]?") was adapted into two different additional items for this survey, one which taps the more mild forms of anti-LGBTQ remarks ("How often do you hear anti-LGBTQ+ remarks at schools [e.g., when someone says 'that's so gay' to mean something bad]?") and one which attempted to capture the use of explicit slurs ("How often do you hear other types of anti-LGBTQ remarks such as 'faggot' or 'dyke'?"). Participants responded to each item on a 4-point scale (1 = *never*, 4 = *often*). The scale demonstrated good interitem reliability with a Cronbach's alpha of .89.

Felt Stigma. This scale assessed the extent to which participants felt people in their community stigmatized LGBTQ+ people. It was adapted from a three-item scale designed by Herek (2009a). However, when assessing the interitem reliability of the scale, the three items did not demonstrate acceptable levels of reliability, with a Cronbach's alpha of .52. Consequently, an item about employment discrimination against LGBTQ+ people was dropped, as adolescent participants may have minimal experience with the job market. The remaining two-item scale included the following items: "Most people where I live think less of a person who is LGBTQ+" and "Most people where I live would not want someone who is openly LGBTQ+ to take care of their children." Respondents indicated their response on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). Eliminating the employment discrimination item raised the Cronbach's alpha to .69, slightly below our definition of sufficient interitem reliability.

Sexual Identity Concealment. This four-item scale assessed the extent to which participants concealed their sexual orientation. It was adapted from a scale used to assess the degree of sexual orientation disclosure (Meyer et al., 2002) to also include questions about outness to teachers and peers at school. To avoid conflating sexual orientation and gender identity, this scale was only administered to participants who did not identify as transgender or nonbinary/genderqueer. Participants responded to each item on a 4-point scale (1 = *out to all*, 4 = *out to none*). The scale demonstrated a good level of interitem reliability, with a Cronbach's alpha of .88.

Gender Identity Concealment. This four-item scale assessed the extent to which participants concealed their gender identity and was identical to the sexual identity concealment measure, except that it substituted "being transgender" or "being nonbinary," using the precise gender identity labels participants provided earlier in the survey. Participants responded to each item on a 4-point scale (1 = *out to all*, 4 = *out to none*). The scale demonstrated a good level of interitem reliability, with a Cronbach's alpha of .86.

Sexual Identity Internalized Stigma. This five-item scale measured the extent to which participants internalized negative attitudes about their sexual identity. It was modified from a measure of internalized homophobia (Herek et al., 2009). To avoid conflating sexual and gender identity, the scale was only administered to participants who did not identify as transgender or nonbinary/genderqueer. Participants responded to each item on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). The scale demonstrated a good level of interitem reliability, with a Cronbach's alpha of .78.

Gender Identity Internalized Stigma. This eight-item scale measured the extent to which participants internalized negative attitudes about their gender identity and expression. It was adapted from the eight-item shame subscale from the Transgender Identity Survey (Bockting et al., 2018). To avoid conflating sexual and gender identity, this scale was only administered to participants who identified as transgender or nonbinary/genderqueer. Participants responded to each item on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). The scale demonstrated high interitem reliability, with a Cronbach's alpha of .93.

Resilience Factors Measures.

Social Support. This 12-item measure assessed the extent to which participants felt they had others they can rely on for emotional support. It was taken without modification from the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988). Participants were asked to respond to each item in the measure on a 7-point scale (1 = *strongly disagree,* 7 = *strongly agree*). The measure demonstrated a high level of reliability, with a Cronbach's alpha of .91.

Youth Empowerment. This 16-item scale was adapted from a 26-item measure developed for youth in an urban schooling context (Ozer & Schotland, 2011) and measured the extent to which youth felt they had the ability to make positive change in their communities. References in the original scale to "students" were replaced with "young people," and references to "my city" were replaced with "my community" to make the scale more appropriate for respondents. Ten items were removed or merged into a single item, (e.g., "I want to have as much say as possible in making decisions in my city" and "I want to have as much say as possible in making decisions in my school" were merged into "I want to have as much say as possible in making decisions in my community") to prevent survey fatigue. Participants responded on a 4-point scale (0 = *strongly disagree*, 3 = *strongly agree*). Cronbach's alpha indicated a good level of reliability (.87).

LGBTQ+ Community Participation. This 8-item measure assessed the extent to which participants were involved in the LGBTQ+ community in both physical and online spaces. It was

adapted from two prior measures (Meyer et al., 2008; Mills et al., 2001). We updated language and removed references to spaces not applicable to adolescents (e.g., 12-step programs). We also added references to online settings, including the internet and social media. The measure included items indicating involvement in physical spaces, such as "I have been involved in an organization heavily attended by LGBTQ+ people," as well as forms of participation in isolation, such as media consumption (e.g., "I have watched videos, films, and/or shows about LGBTQ+ people or issues"). Participants responded to each item on a 4-point scale (0 = *strongly disagree*, 3 = *strongly agree*). Cronbach's alpha indicated a good level of reliability (.78).

LGBTQ+ Community Connectedness. This eight-item measure assessed the extent to which participants felt a connection with the LGBTQ+ community and was adapted from two prior measures (Meyer et al., 2008; Mills et al., 2001). Language was adapted for respondents to consider "my local LGBTQ+ community." Participants responded to each item on a 4-point scale (0 = *strongly disagree,* 1 = *strongly agree*). Cronbach's alpha indicated a high level of reliability (.90).

Mental Health Measure.

Depressive Symptoms. The 10-item Center for Epidemiological Studies-Depression (CES-D-10) measure was utilized without modification to assess the extent to which participants were experiencing depressive symptoms (Björgvinsson et al., 2013). Participants responded on a 4-point scale (1 = *rarely or none of the time [less than 1 day]*, 4 = *most or all of the time [5–7 days]*). The scale demonstrated a good level of interitem reliability with a Cronbach's alpha of .83.

Raw scores for depressive symptoms from the CES-D-10 were dichotomously coded to assess the proportion of participants experiencing clinically significant levels of depression. Cutoff scores for clinically significant levels of depression on this 0 to 40 point scale have been proposed in the literature ranging from 4 to 16 and vary by cultural, medical and social contexts (e.g., Baron et al., 2017; Björgvinsson et al., 2013; Irwin et al., 1999; Zhang et al., 2012). Given this wide range, we chose to use a cutoff score of 16, with scores $\geq$16, indicating clinically concerning levels of depression.

Results

RQ1: How Do Communities Historically Considered More or Less Supportive of SGD Diverge Across Indicators, Perceptions, and Narratives?

Indicators: CCA

We addressed this RQ using data from the CCA in Phase 1. Using the eight indicator variables of community climate, we calculated a composite Gender and Sexual Diversity Index (GSD-I) score for each county. Counties received two values for each indicator: (a) the adjusted value of the indicator (e.g., population-adjusted score) and (b) a z score depicting the value of the indicator relative to the other nine counties (i.e., a measure of how many standard deviations the value is above or below the sample mean). We then weighted these z scores based on their conceptual proximity to the lives of youth, with proximal variables receiving a weight of 2 instead of 1. Indicator variables considered to be more proximal included those that were more likely to be visible to youth in their daily lives: (a) the number of LGBT-supportive businesses and organizations per capita, (b) the proportion of public high schools with a GSA, (c) the presence of a Pride celebration, and (d) the proportion of public high schools commemorating Harvey Milk Day. The eight weighted z scores were averaged to determine a county's overall GSD-I score.

GSD-I scores for the 10 counties are presented in Table 1. Findings supported our hypothesis that communities historically supportive of SGD would score higher on the CCA, thus indicating that communities were objectively distinct in their signaling of support for SGD. Counties in the Bay Area consistently received GSD-I scores above the sample mean (M GSD-I = .61; range = .35–1.08), whereas those in the Central Valley received scores below the sample mean (M GSD-I = $-$.61; range = $-$1.02, $-$.24).

Perceptions: Survey

Sociodemographic data for the survey respondents are presented in Table 2. An overview of measures, reliabilities, and measured outcomes are presented by region in Table 3. Compared with youth in the Central Valley, youth in the Bay Area perceived their community climate as significantly more supportive of SGD, $t(280.14) = -11.99$, $p < .001$ (see Table 3).

Narratives: Informant Interviews

Sociodemographic data for the youth informants whose narrative excerpts are presented in this article are provided in Table 4. Analysis of interview data from Phase 2 broadly reflected findings from Phase 1: Youth narratives affirmed the notion that the Bay Area was more supportive than the Central Valley for SGD. Our qualitative analysis provided further elaboration and nuance, as well as evidence of contestation of these dominant narratives among youth informants within communities.

Youth informants in the Bay Area described their communities as generally supportive of SGD. The following narrative from Arjang illustrates:

> I think that just because we live in California and . . . the Bay Area . . . is such a big hub for LGBTQ+ people, I think that it's really difficult for people to be unsupportive. I think that everyone understands that this is an important issue to people, and I think at some level people understand that queer people exist and we're a fairly big part of the community. . . . There's no lack of Pride marches. If you look around right now in San Francisco, there are gay flags everywhere. . . . I'm sure to someone who's in the closet and their family doesn't support them, they can still look at that and see a lot of hope. I think it's still much, much better than living somewhere in the middle of America and in places where queerness isn't such a big part of the culture as it is in San Francisco.

Arjang's narrative suggests visibility and recognition for SGD is the norm in the Bay Area and is evident in rituals (e.g., Pride) and the presence of symbols (e.g., flags).

Informants in the Bay Area also narrated that the region is "not as supportive as you might think or expect." The following narrative from Ethan illustrates:

> I think that we benefit from being in the liberal Bay Area, but not quite as much as people would expect. . . . [V]erbal bullying, physical bullying, mental health, suicide, self-harm, HIV infection, abuse, homelessness. Every single one of these affects a student at this school. . . . It's very much every . . . every statistic, every problem that you imagine in schools is there. It's just not there to the greatest extent.

Table 1
Phase 1 Results: Gender and Sexual Diversity Index (GSD-I) Scores by County

	Bay Area					Central Valley				
	Alameda	Contra Costa	Marin	San Mateo	Sonoma	Butte	Fresno	Kings	Madera	Tulare
Supportive religious adherents										
Standardized *d* score[a]	20.09	24.43	36.66	25.27	21.93	19.30	12.36	8.62	9.15	11.17
Weighted *z* score	0.13	0.63	2.01	0.72	0.34	0.05	−0.74	−1.16	−1.10	−0.88
Supportive political climate										
Proportion	56.47%	49.58%	55.67%	51.31%	53.23%	34.03%	40.04%	35.98%	33.33%	31.48%
Weighted *z* score	1.23	0.54	1.15	0.72	0.91	−1.00	−0.40	−0.81	−1.07	−1.26
Creative class employment[b]										
Proportion	45.64%	42.30%	51.64%	44.43%	35.75%	33.76%	28.50%	24.93%	25.23%	23.69%
Weighted *z* score	1.01	0.67	1.61	0.89	0.02	−0.18	−0.71	−1.07	−1.04	−1.19
Same-sex households										
Proportion	0.97%	0.62%	0.66%	0.70%	1.01%	0.45%	0.45%	0.33%	0.27%	0.37%
Weighted *z* score	1.51	0.14	0.28	0.45	1.66	−0.51	−0.50	−1.00	−1.21	−0.82
Gay–Straight Alliance (GSA) clubs in high schools										
Proportion	63.04%	70.59%	72.73%	85.71%	76.47%	30.00%	57.14%	37.50%	42.86%	50.00%
Weighted *z* score[c]	0.49	1.31	1.55	2.97	1.96	−3.13	−0.16	−2.31	−1.72	−0.94
Pride celebration										
Yes/No	Yes (1)	Yes (1)	No (0)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	No (0)	No (0)	Yes (1)
Weighted *z* score[c]	1.24	1.24	−2.90	1.24	1.24	1.24	1.24	−2.90	−2.90	1.24
Harvey Milk Day celebration										
Proportion	5.56%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Weighted *z* score[c]	5.69	−0.65	−0.65	−0.65	−0.65	−0.65	−0.65	−0.65	−0.65	−0.65
LGBT-supportive businesses and organizations[d]										
Standardized *d* score[a]	0.31	0.21	0.51	0.10	0.32	0.18	0.12	0.07	0	0.09
Weighted *z* score[c]	1.62	0.26	4.16	−1.16	1.72	−0.16	−0.92	−1.57	−2.53	−1.41
GSID-I score	1.08	0.35	0.60	0.43	0.60	−0.36	−0.24	−0.95	−1.02	−0.49

Note. GSA = Gay–Straight or Gender–Sexuality Alliance or equivalent school-based organization.
[a] The population-standardized score presented in this table has been multiplied by 1,000. [b] Defined using the occupational category of management, business, science, and arts (MBSA). [c] Due to the indicator's conceptual proximity and relevance to the life of youth, its weighted z-score was calculated by multiplying its unweighted *z* score by 2. [d] Within the most populous municipality of each county.

Similar to reports of other informants in high-support communities, Ethan's narrative suggests that a highly supportive community may lessen stress or mental health challenges without fully removing stigma-based inequities.

Youth informants in the Central Valley described their communities as generally unsupportive or outright hostile. The following narrative from Shayna illustrates:

> [My community is] conservative, definitely, and it's more scary. It's more of, like, you have to face all of this and you have to—you can't be who you are. You have to be this perfect person. I mean in [this community] there's many different people, but it's just that [being LGBTQ], it's like you can't—it's just not accepted as much.

Shayna's narrative reveals the extent to which youth in low-support communities experience fear and are unable to practice authenticity in their gender and sexuality.

Jasmine's narrative echoes that of Shayna:

> I feel like it's the area. It's the fear of either not being listened to or being rejected because I know when we did our Coming Out Day march, we did get a lot of, "That's stupid. You don't need to show it off. You don't need to do that." . . . I feel like what prevents us from doing any social or political justice is fear. Fear of not being listened to, and just fear of being the smaller group in this community.

Jasmine narrates an account of social action aimed at greater visibility in her community, in spite of the strong sense of fear in taking such action. Her narrative reveals the extent to which adolescents in low-support communities experience psychological obstacles to visibility in sexuality and gender authenticity.

Youth informants in low-support communities also constructed narratives of community that suggested "it's better than you might think" or "it's better now than ever"—a narrative which recognized the challenges of more conservative areas while reflecting an optimistic arc. Kenneth describes a sense of acceptance in his conservative community:

> Most of the community's actually very supportive. There are times where I'm with my boyfriend's family and I'll hold his hand and no one will say anything. There are also times where—very rarely actually—where they'll say something or they'll give discriminating remarks towards us because of the fact that we are gay and that we are proud and showing that we are happy.

Kenneth's narrative suggests that, despite challenges narrated by youth in low-support communities, it is possible to experience these communities as supportive.

Jasmine constructed a narrative of a community in transition toward greater support for SGD due to generational change:

> I feel that a lot of the younger generations are really accepting. Incoming freshman, eighth graders, I feel like . . . with media and

Table 2
Sociodemographic Data for Survey Respondents by Region (N = 314)

Sociodemographic variable	Bay Area (*n* = 159) *n* (%)	Central Valley (*n* = 155) *n* (%)	Test statistic (*df*) *n* (%)	*p*
Age in years *M* (*SD*)	15.95 (1.3)	16.48 (1.2)	3.73 (311)	<.001
Length of residency in county			4.95	.315[a]
1 year	0 (0)	2 (1.3)		
2 years	6 (3.8)	7 (4.5)		
3 years	5 (3.1)	1 (1.0)		
4 years	9 (5.7)	7 (4.5)		
5+ years	139 (87.4)	138 (89.0)		
Assigned sex at birth			1.24 (1)	.265
Female	110 (69.2)	97 (62.6)		
Male	49 (30.8)	58 (37.4)		
Gender identity[b]				
Boy/man	49 (30.8)	47 (30.3)	0.00 (1)	1.000
Girl/woman	66 (41.5)	75 (48.4)	1.24 (1)	.266
Nonbinary/Genderqueer	46 (28.9)	28 (18.1)	4.56 (1)	.033
Transgender boy or man/female-to-male (FTM)	11 (6.9)	7 (4.5)	0.45 (1)	.501
Transgender girl or woman/male-to-female (MTF)	3 (1.9)	6 (3.9)	1.11	.329[a]
Another gender identity	3 (1.9)	0 (0)	2.95	.241[a]
Sexual identity[b]				
Asexual	13 (8.2)	16 (10.3)	0.21 (1)	.644
Bisexual	58 (36.5)	62 (40.0)	0.28 (1)	.599
Gay	39 (24.5)	29 (18.7)	1.24 (1)	.265
Lesbian	18 (11.3)	23 (14.8)	0.57 (1)	.449
Pansexual	40 (25.2)	30 (19.4)	1.21 (1)	.272
Queer	29 (18.2)	10 (6.5)	8.97 (1)	.003
Straight/heterosexual	4 (2.5)	11 (7.1)	2.68 (1)	.101
Transamorous/transattracted	0 (0)	1 (0.7)	1.03	.509[a]
Another sexual identity	3 (1.9)	4 (2.6)	0.17	.712[a]
Ethnic/racial identity[b]				
American Indian or Alaskan Native	5 (3.1)	18 (11.6)	7.99 (1)	.005
Asian/Asian American	44 (27.7)	11 (7.1)	21.60 (1)	<.001
Biracial/multiracial	20 (12.6)	16 (10.3)	0.61 (1)	.435
Black/African American	6 (3.8)	4 (2.6)	0.36	.754[a]
Hispanic/Latino/Spanish origin	30 (18.9)	91 (58.7)	52.46 (1)	<.001
Middle Eastern/North African	5 (3.1)	1 (0.7)	3.52	.132[a]
Native Hawaiian/Pacific Islander	5 (3.1)	6 (3.9)	0.00 (1)	.966
White/Caucasian/European American	93 (58.5)	53 (34.2)	18.60 (1)	<.001
Parental educational attainment			63.48	<.001[a]
Did not finish high school	18 (11.3)	41 (26.5)		
High school diploma	15 (9.4)	31 (20.0)		
Some college, but no bachelor's degree	16 (10.1)	38 (24.5)		
Bachelor's degree	39 (24.5)	32 (20.7)		
Some graduate school, but no graduate degree	7 (4.4)	2 (1.3)		
Graduate or other advanced degree	63 (39.6)	11 (7.1)		
Missing	0 (0)	1 (0.7)		

Note. Percentages are presented as a function of the column total (i.e., region sample size). An independent samples *t* test was conducted for the continuous variable age in years. Chi-square tests were conducted for the remaining categorical variables.
[a] Due to a having a cell size <5 observations, the *p* value for the chi-square statistic was computed using Monte Carlo simulation with 2,000 replicates. [b] Question presented as "select all that apply"; variable percentages represent the number of participants in the region and may not sum to 100%.

> technology, I feel that people are getting a better education and a better look of what this is about and what we go through.

Jasmine's narrative illustrates the way in which communities were evolving at the time of data collection, with members navigating shifts in their community's predominant framing of SGD. She suggests that younger people in her community, precisely because of their more active self-education with online resources, possess a new level of support for SGD.

Distinctions emerged between support for sexual diversity (i.e., acceptance of gay, lesbian, or bisexual identities) versus gender diversity (i.e., acceptance of transgender or nonbinary identities). The following narrative from Marina illustrates:

> I feel like things are shifting from sexuality to gender. I know people are being okay with . . . gay and lesbian and stuff. As soon as you hit transgender, it just completely shifts. Sexuality is one thing, but gender is like a completely different story. . . . When you say you're gay, people know what gay means. People don't know what genderqueer means. There's so many different genders. People think sexuality is complicated. Gender is ten times more complicated than sexuality is, in my opinion.

Marina, who identifies as genderqueer, provides a narrative of the challenge of acceptance and intelligibility unique to those who embody gender diversity, in contrast to sexual diversity.

Table 3
Overview of Survey Measures, Reliability, and Measured Outcomes by Region (N = 314)

Measure	Bay Area (*n* = 159) *n* (%)	Central Valley (*n* = 155) *n* (%)	Cronbach's α[a]	Test statistic[b]	*df*	*p*
1. Perceived community climate, *M* (*SD*)	26.53 (5.30)	18.03 (6.85)	0.92	−11.99	280.14	<.001
2. General victimization[c], *n* (%)			0.81			
Violence	30 (18.87)	33 (21.29)		0.14	1	.712
Property crime	20 (12.58)	29 (18.71)		1.74	1	.187
Attempted violence or property crime	17 (10.69)	24 (15.48)		1.20	1	.274
Threatened with violence	47 (29.56)	47 (30.32)		0	1	1.000
Verbal abuse	99 (62.26)	87 (56.13)		1.29	1	.256
Objects thrown	48 (30.19)	55 (35.48)		0.58	1	.445
3. Perceived LGBTQ+ targeted victimization[c] *n* (%)	63 (39.62)	65 (41.94)		0.09	1	.763
4. Everyday discrimination[c], *M* (*SD*)	17.72 (6.35)	19.07 (7.19)	0.90	1.73	294.18	.084
5. Perceived LGBTQ+ targeted everyday discrimination[c], *n* (%)	91 (57.23)	95 (61.29)		0.38	1	.537
6. Anti-LGBTQ+ remarks, *M* (*SD*)	19.69 (5.39)	22.18 (5.61)	0.89	3.98	305.42	<.001
7. Felt stigma, *M* (*SD*)	4.70 (1.85)	6.60 (1.86)	0.69	9.06	309.67	<.001
8. Sexual orientation concealment, *Mdn* (IQR)	12 (7)	12 (4.25)	0.88	3707		.926
9. Gender identity concealment, *Mdn* (IQR)	13 (4)	12 (4.25)	0.86	978.50		.077
10. Sexual Orientation internalized stigma, *Mdn* (IQR)	9 (7.75)	9 (6)	0.78	4727		.334
11. Gender identity internalized stigma, *Mdn* (IQR)	22 (11.50)	19 (12)	0.93	1643		.270
12. Social support, *M* (*SD*)	59.6 (13.01)	56.8 (16.24)	0.91	−1.66	288.81	.097
13. Youth empowerment, *M* (*SD*)	28.59 (7.12)	26.76 (7.34)	0.87	−2.20	301.40	.029
14. LGBTQ+ community participation, *M* (*SD*)	12.52 (5.11)	12.27 (5.49)	0.78	−0.41	303.13	.680
15. LGBTQ+ community connectedness, *M* (*SD*)	16.17 (4.50)	15.77 (5.02)	0.90	−0.74	302.89	.461
16. Clinical depression[d], *n* (%)	68 (42.77)	62 (40.00)	0.83	0.15	1	.703

Note. The means and standard deviations are reported for continuous, normally distributed data. The median and interquartile range (IQR) are reported for continuous, nonnormally distributed data. The number (*n*) and percentage of positive responses (i.e., yes responses) are reported as a function of the regional sample size (i.e., using regional sample size as the denominator).
[a] Cronbach's alpha calculated for each measure using the full sample (*n* = 314). Interitem reliability was considered sufficient at the $\alpha \geq .70$ level. [b] Due to having both normally and nonnormally distributed data across scales, a mixture of parametric and nonparametric tests were used to compare outcomes by region. Independent sample t tests were conducted for Measures 1, 6, 7, 12, 13, 14, and 15. Mann-Whitney U tests were conducted for Measures 8, 9, 10, and 11. Chi-square tests were conducted for Measures 1, 2, 3, 5, and 16. [c] Experienced item within the last 12 months. [d] Indicated by a clinical cut-off score ≥ 16 on the CES-D-10.

RQ2: Do More Supportive Communities Mean Less Stress, More Resilience, and Better Mental Health?

To address this RQ, we examined differences in self-reports of minority stressors, resilience factors, and depressive symptoms across communities. Consistent with minority stress theory (e.g., Meyer, 2003), we hypothesized that supportive communities would attenuate the impact of cultural stigma, thus adolescents in more supportive communities would report lower levels of minority stress and depressive symptoms and higher levels of resilience factors (e.g., social support).

Youth in the Central Valley reported more anti-LGBTQ+ remarks, $t(305.42) = 3.98$, $p < .001$, and higher levels of felt stigma, $t(309.67) = 9.06$, $p < .001$), whereas youth in the Bay Area reported higher levels of empowerment, $t(301.40) = -2.20$, $p = .029$). No statistically significant differences were observed for

Table 4
Sociodemographic Information for Youth Informants

Pseudonym	Community	Pronouns	Age	Race/ethnicity	Sexual identity	Gender identity	Assigned sex
Arjang	High support	They/them, he/him	15	South Asian	Queer	Agenderflux	Male
Danny	Low support	He/him	17	Latinx	Gay	Nonbinary boy	Female
Ethan	High support	He/him, she/her	19	White	Queer	Nonbinary	Male
Jasmine	Low support	She/her	16	White	Bisexual	Girl/woman	Intersex
John	High support	He/him	16	Mexican/Vietnamese	Gay	Boy/man	Male
Kenneth	Low support	He/him	17	Hispanic	Homosexual	Boy/man	Male
Marina	Low support	She/her, They/them	17	Mexican	Gay	Genderqueer	Female
Rob	High support	He/him	14	Black	Questioning	Trans boy	Female
Rosa	High support	She/her	21	Puerto Rican	Straight	Trans woman	Male
Sean	High support	He/him	16	White	Polysexual	Boy/man	Female
Shayna	Low support	She/her	15	Black/Mexican	Lesbian	Girl/woman	Female
Sue	High support	She/her	17	Asian	Pansexual	Girl/woman	Female
Tiana	High support	She/her	17	African American	Pansexual	Girl/woman	Female

Note. Sociodemographic data are provided for youth informants whose narrative excerpts are presented in the current article (*n* = 13). All identity terms reflect those used by informants. Pseudonyms matched for Anglicization when applicable.

other minority stress variables, resilience factors, or depressive symptoms between youth from different communities.

Despite finding few differences across communities, the prevalence of victimization and depressive symptoms within the full sample was concerning. We discovered that 41% of youth (n = 128) experienced LGBTQ+targeted victimization, and 59% (n = 186) experienced LGBTQ+-targeted everyday discrimination. In addition, 41% (n = 128) reported clinically concerning levels of depressive symptoms (i.e., CES-D-10 score $\geq$ 16).

RQ3: How Do Youth Narrate Their Experience of Mental Health Across Communities?

Qualitative data analysis added nuance, elaboration, and greater understanding of the relationship between community climate and mental health. We identified the central mental health challenges across communities as (a) *anxiety/depression*, which most informants linked together experientially, and (b) *self-harm*, including suicide and suicidal ideation. Our analysis also yielded two resource-related factors which exacerbated these mental health challenges: (a) insufficient education about SGD and (b) lack of cultural competence among mental health providers. Finally, our analysis yielded four sources of resilience as ameliorating factors for mental health: (a) mental health services, (b) in-person resources, (c) online resources, and (d) peer social support.

Mental Health Challenges

Youth narratives of the experience of anxiety and depression not only described them as mental health challenges, but also provided explanation for their heightened occurrence. Informants referenced key components of minority stress theory (e.g., Meyer, 2003) in their narratives, especially *oppression and homophobia, victimization,* and *concealment/disclosure stress.* Ethan's narrative provides an example of how informants linked depression and anxiety to a stigmatizing environment privileging heteronormativity and cisnormativity, in turn creating a context in which youth are subjected to bullying and victimization:

> [It's] bullying . . . from the community and the people around you that damage[s] your self-esteem. I think [it] exacerbates . . . existing mental health problems, creates mental health problems like depression, anxiety, and also spurs a lot of drug use. . . . I think the homophobic environment and bullying is a big issue in that. . . . I know that we have, a lot of us have so many mental health problems—depression and anxiety especially. I've just seen it time and time again exacerbate those things. The bullying that is, homophobia.

Ethan identifies the root cause of depression and anxiety as the bullying youth experience in a homophobic society.

Informants highlighted the unique experience of transphobia and transphobic bullying in the roots of experience with depression, particularly for transgender girls. The narrative of Rob, a transgender boy, illustrates:

> I obviously don't have the experience as a trans girl, but I feel like that would just be harder. The ones I know seem much more affected by depression, and they've definitely been bullied more. . . . It gets kind of harder being a trans person. . . . I just think people are less accepting because of ideas of what it means to be a man and what it means to be a woman. Just even a lot of cis girls I know will say, "Oh, I could be gender fluid or whatever." They don't really mean it, but it would be so easy for them to say, "I'm gender fluid," and everyone would just kind of be okay with it, but I feel like if someone I knew who was not assigned female birth said it, it would just be a lot harder for them.

Rob's narrative highlights the unique challenges with stigma of transgender girls and others assigned male embodying gender diversity.

Transphobia constituted a unique form of stigma experienced in institutional settings such as schools and other settings. Rosa, a transgender girl, highlighted stigmatizing experiences at the Department of Motor Vehicles (DMV):

> We've had a lot of instances where even the DMV are really rude to the trans girls, where they're being harassed by the DMV, not letting them change their name or gender because of some new form that magically appeared, in the last week or so. Yeah, we've had a lot of issues with DMV. They're really rude, especially when someone comes up with their gender marker change, and they're still calling them a male, when they're a girl, or vice versa. That happens a lot.

Informants reported instances of direct violence against transgender youth in the use of bathrooms, representing another example of unique stigmatizing experiences for gender diverse youth. Jasmine recounted an instance of a transgender boy who had been attacked for using the boys' bathroom in school the year prior:

> He was trying to use the boys' restroom, and a bunch of eighth graders just went in there and jumped him. Beat him pretty bad. From there, he only ever used the nurse's restroom. Because he didn't feel right using the girls' restroom.

These types of encounters in institutional settings constitute unique stressors for gender diverse youth compared with sexual diverse youth who are cisgender and gender conforming, importantly recognizing distinctions in the navigation of mental health challenges for youth with MSG identities.

As conceptualized in minority stress theory (Brooks, 1981; Meyer, 2003), the stigmatizing social environment creates prejudice that leads people with MSG identities to experience internalized stigma and stress related to concealment and disclosure. This conceptual pathway was prominent in informant narratives. Shayna's narrative illustrates:

> . . . You're kind of just trapped in your own little bubble, and you're keeping this secret in that's pretty much eating you alive. . . . Like it's gonna hurt everybody else, might as well just keep it to myself. Definitely [experience] depression and anger because you do not fit in, and you're not—it just seems like everybody hates it and that's why there's no safe comfort zone to go. . . . That's how you feel. It's more of like everybody hates that you're this way and you're wrong and that's not right. That's how you grew up—or most people grew up, that it's not right, and that's how I grew up. I still have these feelings [of same-gender attraction] and I still—it never went away. It never stopped. You feel very trapped cause you can't express yourself because it's wrong.

Shayna's account reveals an inner struggle which can lead to greater challenges with anxiety and depression for youth with MSG identities, rooted in the internalization of stigma and the subsequent compulsion to conceal.

Sean provides another account:

> I think that a lot of LGBT people do experience a lot of anxiety and depression and general mental disorders like that. I think that ties back into the silence thing, and how they've been holding onto this huge secret that they thought was wrong their entire lives. . . . I started to experience symptoms of depression in seventh grade. That's when I started to really realize that I wasn't the same as everybody else. I felt different, but I didn't know how to address those feelings, and I didn't know that they were even okay or even a thing that people, other people, were experiencing. I thought that something was wrong with me and I didn't belong. It was this huge secret that I couldn't tell anyone ever. That was a lot of anxiety built up inside of me. That anxiety turned into depression.

Sean's account of feeling "different" provides voice to adolescents developing in a context of continued compulsions to conform to heteronormativity or cisnormativity. This sense of difference creates internalized stigma which compels youth to conceal their identities and, ultimately, the development of anxiety and depression symptoms.

Following anxiety and depression, the second major mental health challenge youth informants described across communities was self-harm. Informants identified thoughts and acts of self-harm, including those related to cutting, burning, eating disorders, and suicide, as an outgrowth of depression. Sean explained as follows:

> I know a lot of LGBT people have tried it [suicide] at least once, if not more than once. A lot of people that I know with depression also do self-harm. I think they go hand in hand a lot of the time.

Given that youth informants linked depression and self-harm, it is not surprising that within their narratives self-harm was connected to societal stigma and minority stressors such as internalized stigma, rejection fears, and concealment/disclosure stress. Sue captured this account in the following narrative:

> The reason I felt [suicidal in the past] was because my family's not accepting, and I had trouble living with the knowledge that if I were outed, my family would shun me. That's my problem. I think that's the same problem that's experienced by a lot of the other kids that I know, and then, also, being accepted by society and how hard it is knowing how many people would shun you, did they know, or do shun you if you're someone who's out. . . .

Sue constructs an account of her own experience of suicidal ideation rooted in fear of family rejection—itself the product of a stigmatizing society—and speculated that such an experience was common for other adolescents with MSG identities.

Exacerbating Factors

Informants described two resource-related factors that exacerbated mental health challenges: (a) insufficient education about SGD and (b) lack of cultural competence among mental health providers. The narrative that insufficient education contributed to mental health challenges emerged mainly among Bay Area informants, perhaps because the more progressive cultural and political climate led them to expect such resources to be available. Arjang's narrative provides an account of what they and other informants saw as a direct link between mental health problems and lack of education:

> I . . . think another really major thing [affecting mental health] is that . . . sex ed was all heteronormative and cisnormative. I never really learned the basics of sexual health for queer people. All of anatomy and things were taught to me in a very heteronormative and cisnormative way. I think that that can cause issues for people who never get that training and never get that information and have to go out into the world without that knowledge and understanding that their straight and cis peers get.

Arjang's narrative suggests that adolescents with MSG identities receive education about gender and sexuality that privileges cisgender and heterosexual identities and experiences, thus contributing to the sense of difference, exclusion, and stigma leading to mental health challenges.

When asked about the greatest need facing their communities, some informants described the need for better education or access to information about SGD. Sue's narrative illustrates:

> I wanna see it talked about more in classrooms. I want it to be a more integrated part of the curriculum cause I think it could be very easily integrated into the curriculum if we had the organization to achieve that. [I think there should be] the requirements for LGBTQ issues to be taught in schools, like in the social studies classrooms. . . . I want people to have to learn about it. . . . The way it is, there's information available, but no one's really motivated to get it if they're not already part of the community or the ally community. What I want is for that information to be taught to all the people who would otherwise not get it.

Sue suggests that integrating issues related to SGD into the formal educational curriculum could not only benefit youth with MSG identities but also the larger community by increasing knowledge and awareness. She and other informants speculated that such shifts in educational practice could have a positive impact on mental health for youth with MSG identities.

The second exacerbating factor informants identified was lack of cultural competence among mental health providers to address issues related to SGD. Informants across communities noted this factor. Providers were framed as ineffective because they either lacked expertise about SGD entirely or had less knowledge than youth themselves. Shayna describes the experience of the local behavioral health center in her community:

> They don't work on—therapists there only work on, like, fixing you and about, oh, you can't come out because once again you have come out to your parents and your parents take you there. You just go there to talk about what's going on in your life, but you can't really go out and you can't really come out and say that I'm this and that. You just sit there and talk to a stranger about what problem and which problem —maybe the stranger's not even LGBTQ so they really don't understand what you're going through. There's not really anything—it's not really helpful to youth that are struggling through this.

John's narrative echoes that of Shayna:

> It's hard to talk to someone who—I feel like I would feel more comfortable talking to someone if it was directed towards my problems. Even though they're professional, they wouldn't know much about the queer community, or they wouldn't know much about my situation

> as a gay person. I try to work my best and try to figure things out with a regular therapist, but if I was allowed to talk to someone that's specifically there to help me and my situation, that would be better off.

John's narrative provides an account of the experience of working with providers who lack sufficient knowledge about SGD.

Danny provided a similar account of the perceived futility of accessing mental health services in his community:

> Um, for me, I just noticed . . . they were really uneducated, . . . to the point where I had to clarify everything for them. . . . Because of that, LGBT people are still struggling so much. Because they don't really get the help they need . . .

Danny's narrative highlighted the way in which youth who seek services often find their providers insufficiently informed about SGD, thus reducing their effectiveness.

Resilience Factors

Narrative data indicated four primary sources of resilience: (a) mental health services, (b) in-person resources, (c) online resources, and (d) peer social support. Despite experiences with cultural insensitivity among mental health providers, informants across communities described mental health services as beneficial. Their narratives did not provide elaboration beyond the presence and general value of services in their communities.

Informants also described the presence of other in-person resources such as GSAs, community-based organizations, or special events. These narratives were more frequent among informants in the Bay Area, where such resources were more prevalent. These settings were described as sources of vital information for youth to better understand their MSG identities and to find other community members, thus reducing the feelings of difference they experienced in their daily lives. They were also described as spaces in which youth experienced greater safety. In the following excerpt, Sean describes the value of his school GSA:

> The GSAs, obviously, are a completely safe place. Once you go to a GSA meeting, you can make friends in there and then you can talk with your friends in confidence. Those are always great resources.

Informants described online resources as another source of resilience. These resources were most often spontaneously narrated by informants in the Bay Area. John described the value of online resources in exposing him to "queer culture":

> When I go online or see on TV another queer person being vocal about issues and stuff like that, it's where I get most of my information and help from. It wasn't until recently where I got more help from people within my community cause . . . I became more aware about more groups around me. . . . Now that it's being more—now that it's being seen more, people get better gist of what queer culture is like. We're not much of an alien anymore. That's really helped me and other people around me understand what's it about.

John's narrative provides an account of the value of online resources prior to discovering in-person resources, and it also provides an account of the benefit of online visibility for destigmatization and greater cultural acceptance.

Several informants discussed the value of social media, especially Instagram, Twitter, and Tumblr. Tiana described an Instagram group she had discovered as follows:

> There's this one Instagram [group] and, you know, just a community. You can be in them if you're feeling like you need some help. Since I have a lot of those kinds of people that I follow, so I have a lot of those communities [to turn to].

Tiana's narrative of the value of social media was echoed by other informants who found support in those settings.

Danny describes the way in which he used Twitter to find affirmation for his experiences as he navigated his less supportive community:

> I have a private Twitter that I use . . . to vent sometimes. Because I feel like if I vent in person, a lot it's hard for me to form my thoughts into vocal words sometimes. I just feel like if I'm at home and I just need to vent a little, I just use my private Twitter. . . . I feel like it helps a lot, because it helps you feel like—whatever you're feeling, it gets out there. People don't really have to say anything about it. It's more like people are listening, and they care.

Danny's narrative highlights the way in which members of his generation use social media to meet their social and psychological needs. He highlights the value of online spaces for their anonymity and for the affirmation he and other youth with MSG identities can receive.

The most common source of resilience identified by informants across communities was peer social support. When asked about resources to promote mental health in his community, Sean highlighted the importance of peer social support:

> I think finding a good group of friends that can really help you and have maybe gone through some of what you're going through is probably the best resource.

Kenneth describes how the peer support he discovered in high school was critical to ending his self-harm behavior:

> When I came to high school there was still some bullying. Not as much as middle school, but I ended up stopping my self-harm. I met so many supportive people. I had so many friends who are actually homosexual as well or transgender. They all supported me. They all said I was stronger than all of my middle school. I could get through all of that. Then through all of those inspirational speeches they gave me I just progressed. I don't let nothing bother me anymore, and I found my boyfriend and he supports me and he protects me no matter what. The climate here in high school, it's still a little sketchy cause you never know who's against your decisions and who's for it, who supports you. All we can do is persevere.

Whereas Kenneth's narrative acknowledges the continued challenges of a less supportive community and school, it reveals the way in which youth find resilience through peer support.

Ethan's narrative suggests the value of peer social support over and above other sources of resilience:

> I think peers are really, really important, and having a place where you can meet your peers and talk to them about gay things is important. . . . I think that [is] combating the effects of the homophobia and the

> bullying that are exacerbating existing mental health conditions. I think that community building and community outreaching are important things that happen organically, and at this point not necessarily through institutions.

Ethan's account of the value of peer relationships reveals the way in which these organically formed networks provide a force for resistance against the minority stress youth experience in the context of a stigmatizing society.

Discussion

This study used mixed methods to interrogate the relationship among community climate, minority stress, and mental health for adolescents with MSG identities. A key finding of our study was that, although real differences existed in community support for SGD, adolescents with MSG identities reported high levels of LGBTQ+ targeted victimization (41%) and clinically concerning levels of depressive symptoms (41%) across communities. The latter finding is particularly concerning, given that epidemiological studies of adolescents in California with the same measure tend to find a prevalence rate of about 10% (Bazargan-Hejazi et al., 2010). Although narratives of youth informants acknowledged the real differences across communities, the shared experience of marginalization in a society that continues to privilege heterosexuality and cisgender identities created more commonalities than differences in minority stress and mental health.

Communities determined to be objectively more supportive of SGD were indeed interpreted as supportive, but youth narratives revealed a higher level of expectation for support that was not met (e.g., "we benefit . . . not quite as much as people would expect"). Less supportive communities were indeed perceived as such by youth, but youth narratives revealed a lower level of expectation and an optimistic stance (e.g., "it's getting better"). This contrast in narrative meaning making across communities might subvert the benefits of more supportive settings, where youth expectations are higher, and the risks of less supportive settings, where youth expectations are lower. The endurance of heterosexism, cissexism, and sex-negativity appears to transcend communities. These ideologies legitimize social injustice toward those with MSG identities (Hammack, 2018b) and the psychological injustice of homophobic and transphobic bullying that activates minority stress processes (Rivers, 2011). The lack of sufficient resources and education related to SGD perpetuates stigma through silence (Gegenfurtner & Gebhardt, 2017).

Our findings challenge the assumption that supportive communities are necessarily contexts in which narratives of positive mental health proliferate for adolescents with MSG identities. The implication is that, while the CCA method appears to provide a reliable indicator of adolescents' experience of community, it may not be a reliable indicator of positive mental health. The notion that community settings might moderate the impact of minority stress warrants further investigation.

In spite of claims that the 21st century might usher in a new context of decreased mental health challenge for adolescents with MSG identities (e.g., Savin-Williams, 2005), research has continued to reveal the endurance of such challenges (e.g., Meyer et al., 2021; Russell & Fish, 2016). With ages of disclosure to self and others declining and visibility rising for people with MSG identities (e.g., Bishop et al., 2020; Hammack et al., 2022; Watson et al., 2020), we do not necessarily see evidence of declining psychological struggle. Russell and Fish (2019) have described this phenomenon as a "developmental collision" for adolescents: experiences common to adolescence, such as social identity development and the importance of peer inclusion, might conflict with goals for heightened visibility and authenticity for youth with MSG identities.

Beyond developmental collision (Russell & Fish, 2019), our study suggests that members of Generation Z are developing in the midst of a *cultural* collision in which ideologies related to gender and sexuality are in flux. Narratives of youth across communities revealed a close engagement with and internalization of ideologies that have historically privileged heterosexuality and cisgender identity. Youth recognized the basis of mental health challenges in the endurance of these ideologies and their perpetuation of stigma, prejudice, and minority stress processes. Yet in their identities and their accounts of resilience, they also revealed the rise of a new cultural ideology in which SGD was acknowledged and appreciated.

Given that cultural ideologies related to gender and sexuality are linked to institutions, rituals, policies, and practices (e.g., Pascoe, 2007), it stands to reason that youth identified targets for broader change in their schools (e.g., formal educational curricula) and their services (e.g., cultural competence among mental health providers). Although the inclusion of SGD education has the potential to occur in K-12 through multicultural education initiatives, districts have struggled to move forward out of fear of resistance among parents and adults in communities (Flores, 2012). In fact, legislation explicitly banning discussion of issues related to sexual and gender diversity has recently increased, and inclusion of such issues is widely divergent across geographic settings in the United States (Garg & Volerman, 2021). Resources and ideas for developing such curricula are increasing (e.g., Chappell et al., 2018), but their implementation lags behind the pace at which adolescents are challenging prior dominant ideologies by embracing broader forms of SGD in their identity development (Hammack et al., 2022). As a consequence, this cultural collision is likely to persist and continue to create psychological challenges for youth.

Although youth informants narrated the benefits of mental health services across communities, they expressed concern about the cultural competence of providers. Given the multiple pathways for training and credentialing as a mental health provider in the United States, it is difficult to discern whether this experience was tied to the training of providers or the lack of exposure to SGD on par with today's adolescents. Future research ought to probe this experience with more depth, perhaps contrasting competence for different types of providers. Regardless, all mental health provider training programs would benefit from formal education about SGD (see Bettergarcia et al., 2021), as well as mandated continuing education as our knowledge in this area continues to undergo substantial growth and revision. In particular, the shifting language of sexuality and gender represents a key target for the demonstration of competency among providers (Rossi & Lopez, 2017), as youth use a new and broader vocabulary to describe their identities (Hammack et al., 2022; Watson et al., 2020).

Consistent with previous research, youth informants identified resilience factors within in-person resources such as GSAs, online resources, and peer support. It is worth highlighting our finding of the value of online resources such as social media, especially in a

context of broader cultural narratives detailing the mental health risks of social media for adolescents (e.g., Wallace, 2021). Social media provides minoritized youth with a sense of community and inclusion, thus increasing social capital (Escobar-Viera et al., 2020). Furthermore, social media provides a context for identity development through informal learning and teaching experiences (Fox & Ralston, 2016) and a context for general mental health support (e.g., Cannon et al., 2017). Future research should examine the role of social media as a resilience factor for adolescents with MSG identities. Research on youth experiences of different platforms would be especially beneficial, as different platforms utilize distinct forms of media. For example, TikTok has emerged as a popular platform that was not active during the time of our study. This platform uses videos, whereas those more popular at the time of our study utilized either photos, text, or some combination (e.g., Instagram, Tumblr, Twitter).

Our study is the first to use mixed methods to interrogate the relationship among community climate, minority stress, and mental health for youth with MSG identities. In contrast to previous research, we did not find a difference in most minority stress processes or mental health indicators across communities. Our research design allowed us to make meaning of these findings by highlighting contrasting interpretive stances toward community that likely reduced the benefit of more supportive communities and the burden of less supportive communities. The central takeaway from this research is that cultural ideologies and practices continue to delegitimize and denigrate SGD across communities, regardless of objective levels of community support. Toward that end, this research suggests that the key target for intervention is a broader culture of prejudice and stigma, which can best be interrupted through education about SGD.

This study was limited by its use of a nonprobability sample of adolescents who participate in spaces for youth with MSG identities. As a result, the research excludes perspectives of the full population of youth, many of whom may not participate in such spaces. In addition, our use of a single measure to assess mental health (i.e., the CES-D-10) limits the extent to which we can speak more broadly about different aspects of mental health beyond depressive symptoms, and we lacked a sufficient sample size to have sufficient power to conduct more complex statistical analyses (e.g., structural equation modeling). Finally, the CCA's lack of inclusion of indicators focused on support for gender diversity (e.g., presence of all-gender facilities in schools, presence of trans-affirming legislation in the community) limited our ability to disaggregate support for sexual and gender diversity. The adaptation of the CCA to include such indicators would represent an important contribution to the field.

The strength of this study lies in its innovative mixed-method design, which was grounded in multiple epistemologies and intended to capture distinctions in tangible community resources and the ways in which youth interpret those distinctions. Indeed, these methods revealed that differences in objective community support may not directly translate into differences in minority stress and mental health outcomes, and the use of qualitative methods offered nuance, elaboration, and explanation.

Implications for Clinical Practice

The findings of this study offer several implications for clinical practice with adolescents who hold MSG identities. First, clinicians should be mindful of the continued link between stigma and mental health, even in supportive communities. The adolescents in our study experienced clinically concerning levels of psychological distress at much higher rates than their cisgender and heterosexual peers, even in communities supportive of SGD. Adolescents continue to experience cisgender and heterosexual identities as privileged and their own experience as marginalized and denigrated, which is affirmed through minority stress experiences such as bullying, harassment, and victimization. Our narrative data revealed the extent to which adolescents internalized stigma and experienced depression, anxiety, and self-harm. Clinicians should remain aware of this cycle of minority stress for adolescents with MSG identities and not presume that a supportive community setting necessarily moderates the relationship between stigma and mental health.

A second implication of our study is that clinicians be mindful of the extent to which adolescents with MSG identities value mental health services but also experience reluctance to access services due to concerns about cultural competence of clinicians. Given how rapidly the context of SGD is evolving in our society, it is important for clinicians to educate themselves about the novel and unique ways in which members of Generation Z are approaching gender and sexuality. To the extent that clinicians can be fluent in new vocabulary and more expansive understandings of gender and sexuality (e.g., Cover, 2019; Hammack et al., 2022; Rossi & Lopez, 2017), they can likely better be experienced as culturally competent by youth. This experience of cultural competence is likely to enhance the therapeutic relationship and hence result in better mental health outcomes (e.g., Kattari et al., 2016).

Conclusion

While the 21st century represents a time of heightened visibility and greater recognition of the legitimacy of SGD, mental health disparities remain between cisgender, heterosexual adolescents and those who hold MSG identities (Russell & Fish, 2016). Local and regional variability in support for SGD may provide more tangible resources for adolescents, but the endurance of cultural ideologies that privilege heterosexual and cisgender identities perpetuates stigma (Hammack, 2018b). Shifts in cultural practices and policies that systematically undercut these ideologies (e.g., formal education about SGD in K–12 settings, mental health provider training programs) are likely to benefit all adolescents developing their gender and sexual identities.

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