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The Influence of State Laws on the Mental Health of Sexual Minority Youth

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Suicide is the second leading cause of death among adolescents aged 15 to 24 years.[1] Youth who are sexual minorities (ie, those who identify as lesbian, gay, or bisexual [LGB]; report persistent same-sex attractions; or engage in same-sex sexual behavior) represent one of the groups at highest risk for suicidal ideation and attempts. A review of more than 2 decades of research indicated that LGB youths are between 2 and 7 times more likely to attempt suicide than their heterosexual peers.[2] Recently released data from the first nationally representative study of LGB high school students indicated that more than 40% of LGB adolescents have seriously considered suicide, and 29% reported having attempted suicide, during the past 12 months (compared with only 15% and 6% of heterosexual adolescents, respectively).[3] Identifying the determinants of sexual orientation disparities in suicidality among adolescents therefore represents a significant public health priority.

Stigma is one of the most frequently hypothesized risk factors for explaining sexual orientation disparities in suicide outcomes.[4] Stigma—which occurs when labeling, stereotyping, separation, status loss, and discrimination unfold within a context of power—is conceptualized as existing at multiple levels, ranging from individual to structural.[5] *Individual stigma* refers to the psychological processes in which stigmatized individuals engage in responses to stressors associated with stigma, such as internalizing negative societal attitudes about one's group (a process known among LGB individuals as *internalized homophobia*).[6] *Interpersonal stigma*, in contrast, refers to interactions that occur between stigmatized individuals and nonstigmatized individuals, such as rejection by family members.[7]

Research on stigma and mental health (including suicidality) among youth who are sexual minorities has existed almost exclusively at the individual and interpersonal levels of analysis. This research is important because it has documented many of the ways in which stigma operates to harm the mental health of members of this group. However, this literature has tended to overlook broader, structural forms of stigma—or "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized."[8(p2)] According to this definition, laws represent an important mechanism through which stigma is promulgated. Laws that affect sexual minority

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populations have proliferated in the last 2 decades and include, among others, same-sex marriage, employment nondiscrimination, fostering and adoption of children among same-sex couples, religious exemptions, conversion therapy, and protections against hate crimes. Despite the prominence of these laws in the public discourse, empirical research on the health consequences of laws among youth who are sexual minorities is only beginning to emerge. This is owing, in part, to a lack of data structures that include measures of sexual orientation and health and that provide sufficient geographical variation in exposure to different legal contexts to detect an effect (should one exist).

The study by Raifman and colleagues[9] in this issue of *JAMA Pediatrics* therefore comes at an important moment. The authors used data from the 1999–2015 Youth Risk Behavior Surveillance System, which provides a sample that is representative of students at the state level in grades 9 to 12 (N = 762 678 from 47 states). Using a difference-in-differences analysis, the researchers compared changes in past-year self-reported suicide attempts among high school students before and after states permitted same-sex marriage with yearly changes in suicide attempts in states without same-sex marriage. Same-sex marriage policies were associated with a 0.6–percentage point reduction in suicide attempts among all youth, a finding that is equivalent to a 7% relative reduction in the proportion of high school students attempting suicide. These results were concentrated among youth who identified as LGB: among this group, there was a decline of 4.0 percentage points in suicide attempts associated with same-sex marriage, equivalent to a 14% relative decline in the proportion of past-year suicide attempts among LGB youth.

This study has a number of methodological strengths. First, the authors used state fixed effects, which control for different rates of suicide attempts between states, thereby ensuring the results are not biased by the fact that the outcome differs across states at baseline. This statistical approach also controls for time-invariant factors, such as political climate, that may influence both the exposure and outcome (although such an approach cannot control for state-level factors that did change during the course of the study). In addition, the authors ran a series of sensitivity analyses to ensure the robustness of these results, including a falsification test, in which they determined that there was no association with outcomes that should not be affected by same-sex marriage laws (eg, consumption of fruit juice). This sensitivity analysis was particularly important, given that the Youth Risk Behavior Surveillance System does not include measures of certain factors that affect mental health, such as socioeconomic status. The fact that there was no association between same-sex marriage and these alternative outcomes helps to decrease the likelihood that the results are owing to omitted variables. Finally, an alternative explanation for the association between state laws and mental health is that healthy sexual minorities move to states where the policy regime is more favorable to their group. However, the fact that this study was conducted among adolescents substantially minimizes selection effects because adolescents rarely choose where they live.

Questions about the role of state laws and other forms of structural stigma in the production of sexual orientation disparities in mental health cannot be resolved using the experimental method, as it is of course unethical to randomly assign individuals who identify as sexual minorities to states with and without protective laws. Rather than turn away from this

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question, researchers have used a variety of approaches to address issues of causal inference,[10] including a broad and diverse set of methods that permits the triangulation of evidence. Using daily diary studies,[11] cross-national comparisons,[12] quasi-experiments,[13] and audit studies,[14] researchers have shown that laws limiting the rights and protections afforded to LGB populations are robustly associated with adverse health, psychosocial, and economic outcomes among this group. However, most of this work has been conducted with adult samples. By expanding the range and rigor of methods used to study state laws and mental health specifically among youth who are sexual minorities, the study by Raifman and colleagues[9] provides a substantive contribution to this growing literature.

Their study also raises several critical questions for future research. In 2015, the US Supreme Court legalized same-sex marriage in the United States; thus, state-level variation in these laws no longer exists. Nevertheless, numerous laws and policies affecting sexual minorities remain openly contested, including lack of protections related to students' sexual orientation (and gender identity) in harassment and/or bullying laws, which are currently covered in only 19 states and the District of Columbia. Studying these and other laws in future research will provide important information regarding the generalizability of the results of the study by Raifman and colleagues.[9] The identification of mediators and moderators of the association between indicators of structural stigma (eg, state laws) and suicide attempts also represents an important avenue for future study. If links between structural stigma and intervening mechanisms can be drawn, it suggests potential targets for suicide prevention programs with youth who are sexual minorities. Moreover, the identification of moderators will determine which LGB youth in environments of high structural stigma are most at risk for suicidality, aiding in the development of targeted secondary prevention efforts.

A national conversation has emerged about the prevention of suicides among LGB populations. Yet comprehensive, evidence-based suicide prevention programs still do not exist for adolescents who are sexual minorities. Although no single factor can fully explain a complex behavior such as suicide, the study by Raifman and colleagues[9] suggests that structural stigma—in the form of state laws—represents a potentially consequential but thus far largely overlooked contextual factor underlying suicidality in LGB youth. The legal climate surrounding this population therefore deserves greater attention among medical professionals dedicated to reducing sexual orientation disparities in suicidality among adolescents.

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