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# LGBTQ+ identity-related abuse during childhood and associations with depression and suicide behavior: role of adulthood cisheterosexism and expressive suppression

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**Abstract**

*Background:* Exposure to minority stressors specific to LGBTQ+ individuals, such as heterosexism and cissexism (or cisheterosexism) is not covered under the traditional adverse childhood experiences framework. This is important because childhood identity-related abuse by a parent/caregiver can lead to mental health challenges in later life through the adoption of maladaptive coping mechanisms.

*Objective:* The present study aimed to examine the role of cisheterosexism and expressive suppression as serial mediators in the associations between identity-related abuse and depressive symptoms and suicide behavior.

*Participants and Setting:* Participants included 563 LGBTQ+ identifying adults between 18 to 64 years ($M$ = 30.02, $SD$ = 9.05) from different regions of Spain and were recruited through social media (e.g., Twitter, Facebook, and Instagram).

*Method:* A serial mediation model was conducted with cisheterosexism and expressive suppression as the mediators in the associations between LGBTQ+ identity-related childhood abuse and depressive symptoms and suicide behavior.

*Results:* Findings indicated a positive indirect effect of identity-related abuse on depressive symptoms through cumulative cisheterosexism ($B$ = .628, $p$ < .01), and via cumulative cisheterosexism and suppression ($B$ = .146, $p$ < .05). No significant indirect effect was found for identity-related abuse on depressive symptoms via suppression ($B$ = .086). An indirect effect was found for identity-related abuse on suicide behavior via cumulative cisheterosexism ($B$ = .250, $p$ < .01).

*Conclusions:* Findings reveal that LGBTQ+ identity-related cisheterosexist experiences perpetrated by parents or caregivers are associated with harmful, long-term impacts on

symptoms of depression and suicide behavior via experiences of cisheterosexism and expressive suppression.

*Keywords:* LGBTQ+, depression, suicide, minority stress, identity-related abuse, heterosexism, cissexism

## LGBTQ+ identity-related abuse during childhood and associations with depression and suicide behavior: role of adulthood cisheterosexism and expressive suppression

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals face lifetime victimization, marginalization, and stigmatization related to their social minority sexual orientation and gender that can lead to mental health disparities including depression and suicide (Austin et al., 2022; Pachankis et al., 2019; Trujillo et al., 2020). Specific to childhood maltreatment, studies indicate an increased risk of exposure among LGBTQ+ individuals compared to cisgender heterosexual individuals, with a meta-analysis of 27 studies indicating rates ranging from 29.7% for sexual abuse, 28.7% for emotional abuse, and 26.5% for physical abuse (see Jonas et al., 2022). Notably, these studies conceptualize childhood adversities as per the traditional adverse childhood experiences framework (ACEs; Feliti et al., 1998) designed to assess common population-level adverse experiences including abuse, neglect, and household challenges, and do not consider adverse experiences unique to minority sexual and/or gender identities of LGBTQ+ people (e.g., shaming or physically hurting a child because of their minority sexual and gender identity; Schnarrs et al., 2022). These exposures to minority stressors, such as heterosexism—prejudice towards sexual minority individuals based on the assumption that heterosexuality is the norm and superior—and cissexism—prejudice towards transgender and gender diverse individuals based on the assumption that identifying as cisgender is the norm—shape societal invalidation of LGBTQ+ individuals.

Schnarrs et al. (2022) proposed an expanded framework for early life adversities in LGBTQ+ individuals based on the ACEs framework that conceptualized experiences of racism as an adverse event, and that racism in turn increases adversities in childhood among racially and ethnically marginalized populations (Bernard et al., 2021). Schnarrs et al. (2022) posits that the traditional ACEs framework overlooks minority sexual and gender identity-

related adverse experiences and conceptualizes that the expanded ACEs framework should include experiences of heterosexism and cissexism (henceforth referred to as cisheterosexism) as childhood adversities among LGBTQ+ individuals. Notably this study examined childhood adversities beyond those perpetrated by a parent or a caregiver (e.g., bullying at school). Furthermore, the study examined rates of adverse childhood experiences based on minority sexuality and/or gender identity and found that among adults, 57.4% reported sexual victimization and physical or verbal abuse, 67.9% were bullied at school, and 71.2% witnessed or heard an LGBTQ+ person being physically harmed (Schnarrs et al., 2022). These rates of childhood adversities encompassing anti-LGBTQ+ prejudice and discrimination are notably higher than the rates found using only the traditional ACEs framework. Therefore, further research is needed to examine the in-depth role of LGBTQ+-specific ACEs in mental health outcomes in later life, to provide a holistic and accurate picture of childhood hardship among LGBTQ+ people.

To address this gap in research, the present study investigated family/caregiver-related LGBTQ+ identity abuse during childhood (henceforth referred to as identity-related abuse) and associated mental health challenges—depressive symptoms and suicide behavior—in a sexual and gender diverse sample of LGBTQ+ adults from Spain. Addressing the role of childhood adverse experiences specific to the minority sexual and gender identities (e.g., cisheterosexism) at the hands of a primary caregiver is important to investigate, as family settings shape the formative years of development and inform quality of future relationships and mental health. Additionally, emotional, and physical abuse during childhood is more likely to be perpetrated by a family member or caregiver, followed by abuse by peers (see systematic review; Devries et al., 2017). Specifically for LGBTQ+ individuals, family dynamics around LGBTQ+ identity ranging across acceptance and

rejection during childhood can be one of the most influential factors in shaping mental wellbeing (Charak et al., 2019; Ryan et al., 2010; Schmitz & Tyler, 2018).

*Association of child abuse with depression and suicide*

Several studies demonstrate that rates of depression and suicide behavior are higher among LGBTQ+ adults versus cisgender heterosexuals, with 62.7% LGBTQ+ individuals reporting depressive symptoms within the past two weeks (based on the U.S. Census Bureau's Household Pulse Survey, 2022; HelpAdvisor, 2023), and 24.9% to 44.4% reporting lifetime suicide attempts (Srivastava et al., 2021). Drawing on the *minority stress framework* (Brooks, 1981; Meyer, 2003), studies have also tied disparities across mental health to experiences of LGBTQ+-identity related minority stressors that include victimization and parental abuse of children, a consequence of parents harboring heterosexist/cissexist ideologies (Schnarrs et al., 2022). Relatedly, LGBTQ+ identity-related family rejection during adolescence was found to be associated with nearly six- and nine-times higher likelihood of depression and a suicide attempt, respectively, among lesbian, gay, and bisexual young adults (Ryan et al., 2009). On the other hand, parental support of minority sexual and gender identities of youth takes on a protective role leading to higher life satisfaction and fewer depressive symptoms among LGBTQ+ young adults (Newcomb et al., 2019; Simons et al., 2013). Perceptions of family support are also critical for the wellbeing of LGBTQ+ adults as it can directly improve people's psychological health through more positive family relationships (Roberts & Christens, 2021; Schmitz & Tyler, 2018). Hence, it is important to examine identity-related abuse by parents/caregivers to identify both LGBTQ+ youth and adults vulnerable to adverse outcomes and apply findings to inform the creation of preventative strategies and interventions.

*Mediating role of cisheterosexism and expressive suppression*

Central to investigating the associations between childhood identity-related abuse and mental health challenges is examining the role of mechanistic factors that can facilitate our understanding of the underlying processes between adversity and mental health outcomes, as well as improve the design of targeted interventions. As posited by the *psychological mediation framework* (Hatzenbuehler, 2009), enduring cisheterosexism and discrimination can take a mental health toll on LGBTQ+ individuals that can increase the risk of psychological challenges, by eroding the capacity of effectively managing and responding to an emotional experience, also known as emotion dysregulation (Gross, 2001; McLaughlin et al., 2009). When [LGBTQ+] individuals endure exposure to risk, they may also develop resilience and resist marginalizing forces depending on a range of protective factors at their disposal, including supportive relationships and personal growth (Schmitz & Tyler, 2019; Schmitz et al., 2021).

Studies indicate that when individual or group-level resources are not accessible, an [LGBTQ+] individual may experience deficits in emotion regulatory skills, which could decrease an individual's ability to modulate their emotional responses to a stressful situation (Gross, 2001). A study on gay, lesbian, and bisexual (LGB) young adults found that heterosexism by caregivers was positively associated with difficulties in regulating emotions under distress, and these two constructs in turn increased alcohol use among those who had lower levels of disclosure regarding their LGB identities (Villareal et al., 2021). Similarly, expressive suppression—a response-focused emotion regulatory strategy that attempts to inhibit/reduce emotion-expressive behavior—mediated and increased the association between heterosexism and psychological distress in sexual minority women (Syzmanski et al., 2014). Prior studies have also found an association between expressive suppression and adverse affective responses including an increase in depressive symptoms, negative affect, and feeling of inauthenticity, along with a decrease in positive affect (Gross & John, 2003;

Nezlek & Kuppens, 2008). To summarize, there is consensus that experiences of cisheterosexism beginning early in one's life can lead to psychological and behavioral challenges via maladaptive coping mechanisms, such as expressive suppression.

The present study addresses gaps in the literature by examining the effects of identity-related abuse during childhood on mental health challenges in adult life among LGBTQ+ people in Spain. By focusing on LGBTQ+ adults from Spain, this study adds to existing literature that primarily focuses on LGBTQ+ samples from the United States. LGBTQ+ rights have certainly advanced in Spain, with 89% of people endorsing acceptance of homosexuality in recent times (vs. 72% in the United States; Poushter & Kent, 2020). Relatedly, the 2019 European Union LGBTI survey also suggests that Spain ranks higher on acceptance rates than many other European countries; however, LGBTQ+ individuals in Spain reported high rates of past year discrimination (42%), harassment (41%), and one in five transgender and intersex people reported being physically or sexually attacked in the past five years (European Union Agency for Fundamental Rights, 2020). A study of university students in Spain indicated that negative attitudes towards LGBTQ+ individuals persist, and are associated with political conservatism ideologies, identifying as a man including as a gay or bisexual man, and as a cisgender heterosexual person (López-Sáez et al., 2020). In sum, LGBTQ+ rights have gained momentum in Spain when compared with other countries, however, oppression and discrimination of LGBTQ+ individuals continue to exist in Spanish society.

**The current study**

Based on the minority stress framework (Brooks, 1981; Meyer, 2003), the present study aimed to contribute to the understanding of LGBTQ+ identity-related adverse childhood experiences and their associations with depressive symptoms and suicide behavior. Additionally, in line with the psychological mediation theory (Hatzenbuehler, 2009), the

present study examined the role of cisheterosexism and expressive suppression as serially mediating the associations between identity-related abuse and depressive symptoms, and suicide behavior. The following hypotheses were examined:

1. Identity-related childhood abuse would have a positive and indirect effect on depressive symptoms through an increase in recent exposure to cisheterosexism.
2. Identity-related childhood abuse would have a positive and indirect effect on depressive symptoms through an increase in expressive suppression.
3. Identity-related childhood abuse would have a positive and indirect effect on suicide behavior through an increase in recent exposure to cisheterosexism.
4. Identity-related childhood abuse would have a positive and indirect effect on suicide behavior through an increase in expressive suppression.
5. Identity-related childhood abuse would have a positive and indirect effect on depressive symptoms through recent exposure to cisheterosexism and expressive suppression.
6. Identity-related childhood abuse would have a positive and indirect effect on suicide behavior through recent exposure to cisheterosexism and expressive suppression.

## Method

### Participants

Participants included 563 LGBTQ+-identifying adults between 18 to 64 years old ($M$ = 30.02, $SD$ = 9.05) from different regions of Spain, including urban (83.3%, $n$ = 465) and rural (16.7%, $n$ = 93) areas. Most participants identified as cisgender (women: 30.8%, $n$ = 172; men: 44.5%, $n$ = 249) and to a lesser extent as transgender (women: 2.5%, $n$ = 14; men: 8.0%, $n$ = 45; and non-binary/unlabeled: 11.6%, $n$ = 65) and other (2.5%, $n$ = 14). Participants identified their sexual orientation as lesbian (12.3 %, $n$ = 69), gay (39.2 %, $n$ = 222), bisexual (38.5%, $n$ = 215), heterosexual (3.2%, $n$ = 18), and

pansexual/asexual/unlabeled (6.4 %, *n* = 36). Details of participant demographic profiles are presented in Table 1.

**Measures**

**Identity-related childhood abuse.** LGBTQ+ identity-related abuse during childhood was measured with eight items that asked about adverse experiences involving abuse related to their sexual/gender identity by parents or caregivers (e.g., did a parent/caregiver ever verbally harass or name-call you because of your LGBTQ+ identity? did a parent/caregiver ever pressurize you to be more (or less) masculine or feminine?). These items were originally used in the Family Acceptance Project (Ryan, 2010) and were forward translated and back translated (English-Spanish) by our research team. Items were measured with participants indicating if the abuse happened to them (Yes = 1) or not (No = 0) and include one item measuring physical abuse and the remaining items measuring psychological abuse. Cronbach's $\alpha$ of this scale ($\alpha$ = .77) was acceptable.

**Daily heterosexist and cissexist experiences (DHE).** The Daily Heterosexist Experiences Questionnaire (DHEQ; Balsam et al., 2013; Ronzón-Tirado et al., 2023) measures the minority stressors of heterosexist and cissexist experiences during the past 12 months**.** The DHEQ is a 50-item self-reported measure designed to assess the unique aspects of minority stress for LGBTQ+ adults across nine domains. In the present study, only 35 items were included in the survey (see Ronzón-Tirado et al., 2023) as they are most frequently used in the minority stress literature and reliably capture heterosexist experiences of cis- and transgender LGBQ+ individuals (Landes et al., 2021; Vencill et al., 2018). These 35 items represent the subscales of gender expression (i.e., harassed in public because of your gender expression), vigilance (i.e., watching what you say and do around heterosexual people), discrimination/harassment (i.e., verbally harassed because you are LGBT), vicarious trauma (i.e., hearing about LGBT people you know being treated unfairly), rejection by

family of origin (i.e., rejected by your mother for being LGBT), and isolation (i.e., few people you can talk to about being LGBT). Each item is measured on a six-point Likert-scale indicating the presence/absence of the stressor and the impact on the individual (0 = *Did not happen/not applicable to me*, or *It happened, and* 1= *it did not bother me at all*, 2 = *it bothered me a little bit*, 3 = *it bothered me moderately*, 4 = *it bothered me quite a bit*, 5 = *it bothered me extremely*). As recommended by Balsam et al. (2013), items were recoded as present (1) if the participants responded with options 1-5, and absent (0), to calculate total scores. A total cumulative score was calculated by adding all the items and ranged from 0 to 34. In our study, the total score demonstrated an acceptable internal consistency ($\alpha$ = .70). Each subscale demonstrated an acceptable internal consistency (i.e., gender expression: $\alpha$ = .71; vigilance: $\alpha$ = .77; discrimination/harassment: $\alpha$ = .77; vicarious trauma: $\alpha$ = 70; rejection by family of origin: $\alpha$ = .75; and isolation $\alpha$ =.68).

**Expressive suppression.** The Emotional Regulation Questionnaire **(**ERQ [Spanish form], Gross & John, 2003; Cabello et al., 2012) is a 10-item self-report questionnaire that assesses two emotion-regulation strategies: cognitive reappraisal (6 items) and expressive suppression (4 items). This scale has been translated into the Spanish language and validated and used in a sample from Spain wherein it showed adequate internal consistency, test-retest reliability, and convergent and discriminant validity (Cabello et al., 2012). Item responses were recorded using a 7-point Likert scale (1 = strongly disagree, 7= strongly agree). The original scale had good convergent validity when compared with other measures of emotional regulation and coping strategies and good discriminant validity when compared with personality, cognitive, and impulsivity measures (Gross & John, 2003). Additionally, the ERQ two-factor structure has been corroborated in previous studies and measurement invariance analysis has indicated no differences in the structure across gender or race/ethnicity (Melka et al., 2011). For the present study, only the expressive suppression

items were added into the model based on the proposed hypotheses. Total score was calculated by adding the four items and the Cronbach's alpha coefficient showed good reliability ($\alpha$ = .80).

**Depressive symptoms.** The Patient Health Questionnaire 9 (PQH-9 [Spanish form]; Spitzer, et al., 1999) is a 9-item scale that measures participants' symptoms of depression during the last two weeks. Every item is measured in a Likert-type scale with 4 response options (0 = *not at all*, 1 = *several days*, 2 = *more than half the days*, and 3 = *nearly every day*). The PHQ-9 has been validated in clinical and non-clinical samples from Spain (Marcos-Nájera et al., 2018; Pinto-Meza et al., 2005). The total score of the scale ranges from 0 to 27, where higher scores represent higher levels of depression. A cutoff score of 10 or greater indicates major depression disorder in samples from Spain with 84% sensitivity and 92% specificity. In the present study, the PHQ-9 had good reliability data with Cronbach's alpha coefficients equivalent to .92.

**Suicide behavior.** The Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman, et al., 2001) Spanish form (SBQ-R; Gómez-Romero, et al., 2019) comprises four items that measure different dimensions of suicidality. Item 1 assesses lifetime suicide ideation and attempt, item 2 the frequency of suicide ideation over the last 12 months, item 3 the threat of suicide behavior, and item 4 evaluates self-reported likelihood of suicide behavior. The total score is calculated adding the four items with scores ranging from 0 to 18. A score equal to or greater than 6 indicates a suicide risk with 93% sensitivity and 95% specificity. The original SBQ-R showed good internal consistency ($\alpha$ = .76–.87) and test-retest reliability at two weeks ($r$ =.95; Osman, et al., 2001). The Spanish version also showed good internal consistency ($\alpha$ = .81) and test-retest reliability ($r$ = .88; Gómez-Romero, et al., 2019). Additionally, previous research has found that the SBTQ-R showed good criterion validity

when correlated with other scales (i.e., suicide risk, self-stem; Gómez-Romero, et al., 2019). In the present study, the SBQ-R obtained good reliability (Cronbach's $\alpha$ =.81).

**Procedure**

First, the childhood identity-related abuse items were translated and back translated into Spanish by two bilingual independent researchers, one from Spain (ICG) currently residing in the U.S., and one from Mexico (RRT) currently residing in Spain. A third bilingual researcher (MC) in the United States (country of origin Argentina) carried out the backtranslations of the scale to promote semantic equivalence. Any discrepancies among the researchers were discussed until an agreement was reached. The remaining questionnaires were available in Spanish language, and these were used in the present study. Participants were recruited through social media (e.g., Twitter, Facebook, and Instagram). Additionally, LGBTQ+ associations in Spain and LGBTQ+ influencers active in Spain were contacted to request their collaboration through posting the link for the survey on their social media profiles. The study was advertised as "Experiencias heterosexistas, relaciones interpersonales y salud mental en población LGBTQ+ adulta" (English translation: Heterosexist experiences, interpersonal relationships, and mental health in LGBTQ+ adults). Participants were recruited during March 2021 to May 2021. Inclusion criteria were (a) identifying as an LGBTQ+ person, (b) residing in Spain, and (c) being 18 years or older. Participants completed the online questionnaire available in the Spanish language and the informed consent via the Qualtrics platform which included questions on demographics, minority stressors, and mental health outcomes. Multiple attention-check questions (e.g., if you are reading this item, check option 2) for assessing response validity were included and individuals who failed even one attention-check item were removed from the final analytic sample ($n$ = 5; 0.97%). Survey completion took an estimated 35-50 minutes.

**Data analytic approach**

First, descriptive statistics and mean comparisons of the study variables were conducted in IBM SPSS version 26. Second, a serial mediation model was carried out to test the impact of childhood identity-related abuse on mental health outcomes, namely, depressive symptoms and suicide behavior through the accumulative effect of heterosexism (Mediator 1) and expressive suppression (Mediator 2; see figure 1). Note that the correlation coefficients of age with childhood identity-related abuse, expressive suppression, cumulative cisheterosexism, depressive symptoms, and suicidal behavior were in the low ranges (range *r*: -.004 to -.064) and non-significant ($p < .05$), and hence age was not included in the mediation model. To test the mediation model, identity-related abuse was used as a latent variable as the measure gauging identity-related abuse is not a standardized questionnaire, and the remaining of the variables were treated as manifest/observed variables. Model fit indices were used to check the acceptability of the model. Goodness-of-fit for the model was assessed with the indices of chi-square ($X^2$), the comparative fit index (CFI), the Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA), and the Standardized Root Mean Square Residual (SRMR). Acceptable model fit was considered when the chi-square was non-significant, and CFI and TLI were greater than .90. Moreover, RMSEA with a value less than .05 indicates close fit and values up to .08, indicating reasonable errors of approximation, and SRMR with a value less than .08 are considered a good fit (Hu & Bentler, 1999).

The magnitude of the indirect effect was examined using the product-of-coefficient approach (Bishop et al., 1975) to calculate standard errors of the indirect effects. The coefficient of the indirect effect is divided by its standard error and compared to a critical value with a z-test. The model was estimated using maximum likelihood estimator (ML) and bias-corrected bootstrapping procedures for confidence intervals with a total of 10,000 bootstrapped samples used to corroborate findings from the product-of-coefficient tests

(Preacher & Hayes, 2008). The bootstrapping method is recommended over the traditional causal steps approach, as the former has higher power while maintaining reasonable control over the Type I error rate (MacKinnon et al., 2004). In the present study, a 95% confidence interval not containing a zero was considered statistically significant.

## Results

Table 1 provides the descriptive details of the study variables. Nearly 62% ($n$ = 357) of participants indicated exposure to LGBTQ+ identity-related abuse during childhood, and nearly all participants (99.8%, $n$ = 509) had at least one instance of cisheterosexist experience in the past year. Table 2 describes the prevalence of each of the childhood identity-related abuse items, with more than half of the participants (57%) reporting being under pressure to act masculine or feminine against their will, and nearly 1 in four (25.7%) were told that they brought shame to the family because of their LGBTQ+ identities. Regarding mental health outcomes, nearly 20% ($n$ = 78) met the cut off for depression, and around 46% for suicide behavior ($n$ =195).

Table 3 describes the $t$-test analyses of the study variables across gender identity (transgender and gender diverse [TGD] versus cisgender) and sexual orientation. Results indicated that when compared with cisgender people, TGD individuals indicated higher levels of identity-related child abuse, cumulative cisheterosexism, symptoms of depression, and suicide behavior with a medium effect size (range of Cohen's $d$: .61 to .75; see Table 4). Additionally, between subjects ANOVA were carried out to compare the mean scores on the study variables and sexual orientation (i.e., gay/lesbian vs. bisexual vs. asexual/pansexual/sexual orientation not covered in the survey; Table 4). Results indicated that significant mean differences were only found for symptoms of depression and suicide behavior ($\eta^2$ =.04; see Table 4). Tukey's HSD test for multiple comparisons found that the mean score of depressive symptoms was higher for individuals who identify as bisexual

($Mean_{difference}$ = 2.97; 95% *CI* = [-4.75, -1.19]) and people who identify as asexual/pansexual/sexual orientation not covered in the survey ($Mean_{difference}$ = 3.32; 95% *CI* = [-6.15, -.49]) when compared with people identifying as lesbian or gay. Similarly, the mean score of suicide behavior was higher for individuals who identify as bisexual ($Mean_{difference}$ = 1.34, 95% *CI* = [-2.15, -.53]) and as asexual/pansexual/sexual orientation not covered in the survey ($Mean_{difference}$ = 1.60, 95% *CI* = [-2.91, -.30]) when compared with people who identify as lesbian or gay.

**Serial mediation**

A serial mediation was carried out in M*plus* 8.4. First, model fit indices indicated good model fit ($\chi^2$ = 58.872, *df* =48; CFI = .995; TLI = .994; RMSEA = .020 [.001 .036]; SRMR = .052). All the path values of the model are displayed in Figure 1. Almost all the structural regression pathways were statistically significant. Figure 1 and Table 5 show the direct and indirect effects of the models. Results indicated identity-related abuse during childhood did have a small direct effect on depressive symptoms. Additionally, results indicated a positive indirect effect of identity-related abuse on depressive symptoms through cumulative cisheterosexism. A positive indirect effect was also found between childhood identity-related abuse and depressive symptoms via cumulative cisheterosexism and suppression. Notably, there is no significant indirect effect of identity-related abuse on depressive symptoms via suppression. Regarding suicide behavior, a positive direct effect of identity-related abuse during childhood on suicide was found. Also, an indirect effect of identity-related abuse during childhood on suicide behavior via cumulative cisheterosexism was found.

## Discussion

Findings indicated a vast range of exposure to childhood identity-related abuse from 5.2% (physically abused because of one's LGBTQ+ identity) to 57.5% reporting being under

pressure to act feminine or masculine against their will. Additionally, findings indicate that compared to cisgender individuals in the present sample, TGD individuals reported higher rates of childhood identity-related abuse, recent experiences of cisheterosexism, and depressive symptoms and suicide behavior (medium effect size). Noteworthy is that a comparison of these effect sizes with prior studies suggests that identifying as a TGD (vs. cisgender) ($d$ = .63) has a relatively larger effect size than established sociodemographic risk factors for clinical depression including identifying as woman ($d$ = .40), low socioeconomic status ($d$ = .33), and work-life stress ($d$ = .33) (Dagnino et al., 2020), and suicide (including marital problems and employment status; Yoshimasu et al., 2008). Similarly, compared to lesbian and gay people, those who identified as bisexual and as asexual/pansexual/unlabeled reported higher scores on depressive symptoms and suicide; however, the effect size was small. These results support previous research findings that, within the LGBTQ+ community, TGD individuals are at a heightened risk of experiencing abuse, victimization, and mental health challenges (Bockting et al., 2013; Thoma et al., 2021), and among minority sexual orientations bisexual and asexual/pansexual people are at an increased risk of experiences detrimental mental health outcomes (Charak et al., 2019; Feinstein & Dyar, 2017; McInroy et al., 2022). To our knowledge, our findings are the first to investigate rates of LGBTQ+ identity related abuse and recent cisheterosexism experiences among LGBTQ+ adults from Spain where LGBTQ+ rights are growing in the midst of persistent anti-LGBTQ+ social ideologies. Detailed explanations of our findings are presented below.

In line with the minority stress hypothesis (Brooks, 1981; Meyer, 2003), the indirect effects of identity-related childhood abuse on depressive symptoms, and suicide behavior via recent cisheterosexism, was evident in the present study (hypotheses 1 and 3 supported, respectively). Building on the importance of conceptualizing childhood cisheterosexist experiences as adverse experiences (Schnarrs et al., 2022), our findings support that identity-

related childhood abuse "cisheterosexism by a parent or caregiver" adversely impacts adulthood depressive symptoms and suicide behavior, either directly or indirectly through adulthood cisheterosexism. For instance, experiences of childhood identity-related abuse had a direct effect on suicide behavior in adulthood as also found in prior studies (Ryan et al., 2009).

Accumulation of recent cisheterosexist experiences along with expressive suppression, serially mediated the association between identity-related abuse and depressive symptoms (hypothesis 5 supported). This linkage is supported by the psychological mediation framework (Hatzenbuehler, 2009), in that stigma-related stressors such as childhood and adulthood cisheterosexist experiences contribute to increased psychopathology through key processes, such as the maladaptive coping via expressive suppression that requires an individual to constantly manage their emotional responses (Nezlek & Kuppens, 2008; Syzmanski et al., 2014). These repeated efforts to constrain one's emotions depletes an individual's cognitive resources and can lead to negative feelings about the self, avoidant behavior, and interpersonal problems (John & Gross, 2004).

Furthermore, identity-related abuse did not have a significant direct effect on depressive symptoms suggesting that experiences of *revictimization* in the form of cisheterosexist experiences in childhood (i.e., caregiver perpetrated ACEs) and adulthood, and related emotion dysregulation, are key factors for targeted clinical interventions to alleviate depressive symptoms. This is not to say that childhood identity-related abuse in the absence of exposure to cisheterosexism is not potentially harmful, as adverse experiences are at their core a violation of human rights and dignity. However, the combination of identity-related abuse in childhood, exposure to recent cisheterosexism, and coping via expressive suppression may put LGBTQ+ adults at significantly elevated risk for severe depressive symptoms.

It is noteworthy that expressive suppression—an emotional (dys)regulatory mechanism—on the other hand, did not independently emerge as a significant mechanistic factor (hypothesis 2 and 4 not supported) nor was there a significant indirect effect of identity-related abuse on suicide behavior through cisheterosexism and expressive suppression (hypothesis 6 not supported). While these findings contrast with prior studies (Gross & John, 2003), it may be that expressive suppression does not play a central role in the associations between identity-related childhood abuse and suicide behavior, rather it is the repeated exposure to cisheterosexism across childhood and adult that is impacting suicide behavior. The replication of present findings is warranted in future research.

*Limitations*

The present study's results should be interpreted with the following limitations in mind. First, the present study involved a convenience sample (i.e., online data collection) and findings may not be generalizable to all LGBTQ+ adults. Second, the causal associations between recent cisheterosexism, expressive suppression, depressive symptoms, and suicide behavior are assumptions informed by the minority stress (Brooks, 1981; Meyer, 2003) and psychological mediation frameworks (Hatzenbuehler, 2009). It is possible that the associations are bidirectional in nature. Future studies should assess these associations using a longitudinal design. Third, self-report questionnaires were used to obtain stressors such as childhood identity-related abuse which can lead to recall bias. However, prior studies suggest that when behaviorally specific questions are used to assess victimization (as done in the present study), the accuracy of reporting may increase (Fricker et al., 2003). Additionally, prior research supports the stability and reliability of the ACE score irrespective of depression status (Frampton et al., 2018). Fourth, current exposure to cisheterosexism was included as a cumulative variable despite representing several distinct subscales. Future research should examine the potential mediating role of the distinctive subscales to better

determine the forms of cisheterosexism that are particularly related to prior identity-related abuse and current psychosocial problems. Fifth, childhood abuse was limited to physical abuse (measured via 1 item) and psychological abuse related to LGBTQ+ identities. Although this was the focus of the present study, future research should explore if other forms of childhood abuse (e.g., sexual abuse) are related to or account for the apparent effects of this specific form of childhood abuse.

*Clinical implications*

Findings from this study highlight the importance of assessing past exposure to identity-related abuse by parents/caregivers to address the long-term detrimental impact on the mental health of LGBTQ+ adults. When working with LGBTQ+ clients, clinicians should be mindful of the impact of minority stress including those occurring in childhood on the presenting illness or current distress. In highlighting the potential mediating role played by adult exposure to cisheterosexism and coping via expressive suppression, findings can also inform case conceptualizations and pinpoint areas for targeted interventions. Notably, recent cisheterosexist experiences emerged as a significant mediator in the association between identity-related abuse and depressive symptoms and suicide behavior; expressive suppression was significant only alongside recent cisheterosexist experiences in serially mediating the link between identity-related abuse and depressive symptoms. These findings suggest a differential impact of mechanistic factors and highlight the importance of including minority stressors in case conceptualization and treatments. Relatedly, a recent study on sexual minority individuals supports the use of the STAIRCaSE approach for case conceptualization (Goldfried, 2003) of the minority stress adapted model for providing LGBQ-affirmative psychotherapy (Pachankis et al., 2023. Such approaches and adaptations serve as a tool for clinicians in incorporating unique experiences of LGBTQ+ individuals along with transdiagnostic mechanisms (e.g., emotion suppression) for targeted interventions.

Findings regarding the underlying psychological processes (e.g., expressive suppression) linking identity-related stressors and psychopathology were similar across diverse groups of sexual and gender minority adults. Future studies should continue to examine the effects of these stressors on diverse sexual and/or gender groups, using longitudinal designs to identify trajectories of psychopathology and resilience that are found across these groups as well as differentially for specific sub-groups. Importantly, in light of the key role that identity plays, studies should examine the prevalence and role of identity-related abuse within family systems when working with LGBTQ+ individuals.

*Conclusion*

To summarize, study findings support the importance of examining childhood cisheterosexist experiences (identity-related abuse) as adverse childhood events as proposed by Schnarrs et al. (2022). The present findings indicated childhood identity-related abuse associations with depressive symptoms and suicide behavior, either directly or via mechanistic factors of adulthood cisheterosexism and expressive suppression. Future studies should focus on examining these associations using a longitudinal design and across diverse sexual and/or gender groups to facilitate thorough case conceptualizations and effectively tailor treatments and interventions for specific populations.

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Table 1

*Prevalence and Descriptive of the Study Variables and Sample Characteristics*

| | *n* (%) | *M* | *SD* | Range |
|---|---|---|---|---|
| Identity related childhood abuse | 350 (62.2) | 1.46 | 1.81 | 0-8 |
| Cisheterosexism cumulative | | 17.99 | 6.16 | 0-34 |
| Expressive suppression | | 15.18 | 5.80 | 4-28 |
| Depressive symptoms | 88 (21.1) | 10.86 | 7.27 | 0-27 |
| Suicide behavior | 195 (46.5) | 6.90 | 3.35 | 3-17 |
| Suicide attempt | 45 (10.7) | | | |
| Suicide ideation | 48 (11.5) | | | |
| *Gender identity* | | | | |
| Cisgender women | 172 (30.8) | | | |
| Cisgender men | 249 (44.5) | | | |
| Transgender women | 14 (2.5) | | | |
| Transgender men | 45 (8.0) | | | |
| Nonbinary/unlabeled | 65 (11.6) | | | |
| Identity not mentioned in the survey | 14 (2.5) | | | |
| *Sexual Orientation* | | | | |
| Lesbian | 69 (12.3) | | | |
| Gay | 222 (39.2) | | | |
| Bisexual | 215 (38.5) | | | |
| Heterosexual | 18 (3.2) | | | |
| Pansexual/asexual/unlabeled | 36 (6.4) | | | |
| *Race/ethnicity* | | | | |
| Caucasian/white | 495 (88.4) | | | |
| Latinx | 42 (7.5) | | | |
| Other/multiracial | 23 (4.1) | | | |
| | *n* (%) | *M* | *SD* | Range |
| *Region* | | | | |
| Urban | 465 (83.3) | | | |
| Rural | 93 (16.7) | | | |
| *Relationship Status* | | | | |
| Currently in a relationship | 301 (53.4) | | | |
| Not currently in a relationship | 262 (46.5) | | | |
| *Education* | | | | |
| High school | 88 (15.6) | | | |
| Undergraduate | 292 (51.8) | | | |
| Graduate | 183 (32.5) | | | |
| *Employment* | | | | |
| Unemployed | 75 (13.4) | | | |

| | |
|---|---|
| Employed | 212 (37.9) |
| Full-time student | 173 (30.7) |
| Employed student | 99 (17.7) |

*Note*. $N = 563$. Participants were on average 30.02 years old ($SD = 9.05$).

Table 2

*Frequencies of Childhood Identity-Related Abuse*

| | *n (%)* |
|---|---|
| *Growing up, did a parent/caregiver ever…* | |
| hit, slap, or physically hurt you because of your LGBTQ+ identity? | 29 (5.2) |
| verbally harass you or name-call because of your LGBTQ+ identity? | 85 (15.1) |
| exclude you from family events and family activities because of your LGBTQ+ identity? | 35 (6.3) |
| block you from having access to LGBTQ+ friends, events, and resources? | 92 (16.5) |
| blame you for the discrimination you experienced because of your LGBTQ+ identity? | 83 (15.0) |
| pressure you to be more (or less) masculine or feminine? | 320 (57.5) |
| tell you that God will punish you because of your identity as LGBTQ+? | 39 (7.1) |
| tell you that they were ashamed of you or how you look or act will shame the family? | 141 (25.5) |

Table 3

*T-Test Analysis of Mental Health Outcomes across Gender (Cisgender vs. Transgender and Gender Diverse Individuals)*

| | Gender [a] | *M* | *SD* | *t*-test (*df*) | Cohen's *d* |
|---|---|---|---|---|---|
| Childhood identity-related abuse | 0 | 1.19 | 1.57 | 5.529 (184.42)* | .61 |
| | 1 | 2.31 | 2.21 | | |
| Expressive suppression | 0 | 14.98 | 5.82 | 1.286 (298) | |
| | 1 | 15.83 | 5.67 | | |
| Cumulative cisheterosexism | 0 | 16.94 | 5.71 | 7.393 (504)* | .75 |
| | 1 | 21.32 | 6.04 | | |
| Depressive symptoms | 0 | 9.68 | 6.93 | 5.585 (400)* | .63 |
| | 1 | 14.18 | 7.25 | | |
| Suicide behavior | 0 | 6.27 | 3.02 | 6.458 (170.98)* | .69 |
| | 1 | 8.72 | 3.56 | | |

*Note*. [a] 0 = cisgender and 1 = transgender and gender diverse individuals.

*$p < .05$.

Table 4

*Between Subjects ANOVA Comparing Study Variable Means across Sexual Orientation*

| | Sexual orientation [a] | *M* | *SD* | *F (df)* | $\eta^2$ |
|---|---|---|---|---|---|
| Childhood identity-related abuse | 0 | 1.42 | 1.82 | 2.271 (2, 559) | |
| | 1 | 1.41 | 1.75 | | |
| | 2 | 1.96 | 1.92 | | |
| Expressive suppression | | | | .467 | |
| | 0 | 15.27 | 5.76 | (2, 400) | |
| | 1 | 15.27 | 5.83 | | |
| | 2 | 14.36 | 5.92 | | |
| Cumulative cisheterosexism | | | | 1.045 | |
| | 0 | 18.01 | 6.40 | (2, 506) | |
| | 1 | 17.55 | 5.63 | | |
| | 2 | 19.53 | 6.85 | | |
| Depressive symptoms | | | | 9.271 | |
| | 0 | 9.37 | 6.70 | (2, 401)* | .04 |
| | 1 | 12.34 | 7.24 | | |
| | 2 | 12.69 | 8.59 | | |
| Suicide behavior | | | | 9.515 | |
| | 0 | 6.23 | 3.10 | (2, 415)* | .04 |
| | 1 | 7.60 | 3.40 | | |
| | 2 | 7.83 | 3.80 | | |

*Note*. [a] 0 = gay/lesbian, 1 = bisexual, 2 = asexual/pansexual/sexual orientation not asked in the survey.

*$p < .05$.

Table 5

*Serial Mediation by Experiences of Cumulative Heterosexism and Expressive Suppression between Identity Abuse and Depressive Symptoms and Suicide Behavior*

| *Pathways* | *B* | *SE* | *95% CI* |
|---|---|---|---|
| ***Depressive symptoms*** | | | |
| *Total effect* | .860** | .290 | .325 to 1.456 |
| *Direct effect* | 1.112* | .556 | .018 to 2.186 |
| *Total indirect effect* | .1.972** | .440 | 1.110 to 2.818 |
| *Specific indirect effects* | | | |
| Idenity abuse→Cisheterosexism→ Depressive symptoms | .628** | .268 | .134 to .1.186 |
| Identity abuse→Suppression→ Depressive symptoms | .086 | .129 | -.159 to .358 |
| Identity abuse→Cisheterosexism→Suppression→ Depressive symptoms | .146* | .068 | .040 to .316 |
| ***Suicide behavior*** | | | |
| *Total effect* | .301*** | .118 | .081 to .544 |
| *Direct effect* | .773* | .259 | .259 to 1.272 |
| *Total indirect effect* | 1.075*** | .213 | .648 to 1.486 |
| *Specific indirect effects* | | | |
| Identity abuse→Cisheterosexism→ Suicide behavior | .250** | .116 | .028 to .483 |
| Identity abuse→Suppression→ Suicide behavior | .019 | .030 | -.029 to .096 |
| Identity abuse→Cisheterosexism→Suppression→ Suicide behavior | .033 | .021 | .004 to .094 |

*Note*. Bootstrap = 10,000.

*$p < .05$. **$p < .01$. ***$p < .001$.

Figure 1

*Serial Mediation Model*