The Impact of Anti-LGBTQ+ Policies on the Mental Health of LGBTQ+ Youth in the United States

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In 2023, 525 anti-LGBTQ+ bills were introduced nationwide, leading the Human Rights Campaign to declare a state of emergency for LGBTQ youth in the United States. This study explored how state policies (e.g., safe school non-discrimination law, LGBTQ+ curriculum, bans on best medical practice for transgender youth, hate crime laws, and anti-bullying laws) impact depression in LGBTQ+ youth. The participants included 420 sexually diverse U.S. youth ages 14-24 enrolled in school who completed a survey. Analyses were conducted using R software for descriptive analysis, reliability testing, and bivariate correlation between key variables. Multivariate linear regression analyses were conducted to investigate the relationship between LGBTQ+ state-level policies (including safe school non-discrimination law, LGBTQ+ curriculum, bans on transgender youth participation in sports, bans on best medical practice for transgender youth, hate crime laws, and anti-bullying laws) and depressive symptoms. Control variables of age, gender, sexual orientation, and U.S. region were included in the regression models as covariates. Analyses of the participants revealed that LGBTQ+-affirming school curricula were associated with less depression amongst LGBTQ+ youth. Findings highlight the mental health impact of legislation on LGBTQ+ youth and spotlight several ways educational institutions can nurture identity-safe environments to support LGBTQ+ students' well-being. Our research also provides additional evidence indicating that policies and laws that target or oppose LGBTQ+ rights can negatively impact the well-being of gender and sexual minority students. Overall, these results further showcase the significant damage that discriminatory legislation can inflict upon young LGBTQ+ individuals and underscore the importance of affirmative and accepting school cultures in upholding the healthy development of LGBTQ+ students.

Keywords: *LGBTQ+ Mental Health, Anti-LGBTQ+ Bills, LGBTQ+ Youth*

Introduction

Over the last ten years, significant strides have been made in advancing LGBTQ+ rights, including school policies to protect LGBTQ+ students from discrimination, achieving marriage equality, more significant inclusion in the military, and increased representation in the media[1]. For example, in March 2021, President Joe Biden signed an executive order guaranteeing an educational environment free from discrimination based on sex, including sexual orientation or gender identity[1]. This policy is the first federal order to protect LGBTQ+ K-12 students against discrimination in academic settings. Further, many states have developed anti-discrimination policies to protect LGBTQ+ students from harassment and bullying targeting sexual orientation, gender identity, and gender expression[1], as well as expanding and funding LGBTQ+ supports in school contexts through inclusive clubs, resources, and curricula for LGBTQ+ students and families[2]. In addition to these vital advancements for gender and sexual minority students, open LGBTQ+ military service following the reversal of "Don't Ask, Don't Tell," allowing lesbian, gay, and bisexual soldiers to serve openly, has increased the representation of gender and sexual minorities in the military[3]. Moreover, over the past decade, more and more prominent figures in the media have publicly come out, which has significantly increased the visibility of LGBTQ people in media[4] and been an important advancement in the inclusion of LGBTQ+ people in the public eye.

However, despite these important advances, LGBTQ+ youth continue to experience the adverse impacts of discrimination tied to sexual and gender identity[2,5,6]. LGBTQ+ youth are more likely to experience bullying or harassment from peers based on actual or perceived sexual orientation or gender identity, be excluded from activities, events, or opportunities, and have difficulty navigating their identities where there is a lack of inclusive educational curricula that validate LGBTQ+ people[7]. For example, in a 2021 survey, nearly one-third of LGBTQ high school students reported being physically harassed due to their sexual orientation or gender identity[8]. Furthermore, almost an equal proportion of these students felt unsafe at school that they skipped classes in the previous month[8]. Moreover, LGBTQ+ youth may be denied access to faith-based social services programming, homeless, foster care, or mentoring programs due

to their sexual orientation and gender identity[9]. They may also encounter barriers to accessing gender-affirming medical treatment like puberty blockers or hormones due to health providers' refusal on religious grounds to offer LGBTQ+-related care[10]. These discriminatory practices, on top of societal stigma, manifest through negative remarks, slurs, or denial of rights that challenge LGBTQ+ youth's well-being and opportunities to thrive[11]. The statistics for LGBTQ+ youth experiencing bullying and feeling unsafe at school are substantially higher compared to the general population of youth in the U.S.[12] For instance, while 15% of all students' report being bullied and 9% have skipped school due to safety concerns, the rates of LGBTQ+ students are approximately double[13]. Research has shown that victimization of sexual minority youth in school settings is linked to a higher likelihood of dropping out, having suicidal thoughts, engaging in substance abuse, and attempting suicide[8,14,15].

The minority stress model provides a useful framework for understanding the complex experiences of LGBTA+ youth and the impact of anti-LGBTQ+ policies on their mental health. According to Meyer (2003), minority stress refers to "the excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position." This framework illustrates how adverse health outcomes can stem from experiencing persistent prejudice and stigma. By applying the minority stress model, we can better understand how LGBTQ+ youth navigate and are impacted by the complex interplay of their identities and the oppressive structures they encounter.

The ongoing reality of bigotry towards LGBTQ+ youth is evidenced by the shocking levels of anti-LGBTQ+ legislation that have emerged over the past several years. The amount of anti-LGBTQ+ bills proposed in state legislatures doubled across 47 states between 2020 and 2023[16]. The Human Rights Campaign reports that 525 anti-LGBTQ+ bills that include targeting the rights of LGBTQ+ youth were introduced in 2022[17]. These bills include and are not limited to safe school laws, attempts to censor school curricula, policies that restrict transgender youth from participating in sports that align with their gender identity, and prohibitions on gender-affirming care. Since 2012, there has been a wave of "religious exemption" bills that have targeted LGBTQ+ people[18]. Supporters of this wave of anti-LGBTQ+ legislation claim that these policies aim to protect religious freedom; however, pro-LGBTQ policies at the municipal and state level do not impede the freedom to exercise religion. Currently, 13 states allow state-licensed child welfare agencies to refuse to provide services to children and families (including LGBTQ+ people) if it challenges their religious beliefs[19]. The "religious exemption" bills represent a small facet of growing anti-LGBTQ+ sentiments that are manifesting in federal and state legislatures.

Despite the advances in LGBTQ+ school legislation and policies, many LGBTQ+ students continue to experience academic environments that compromise their mental health and well-being. According to the Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health, which surveyed 34,000 LGBTQ+ youth ages 14-24 across the United States, 73% of LGBTQ+ youth reported symptoms of anxiety, and 58% reported symptoms of depression[13]. Further, an astounding 45% of LGBTQ+ youth seriously considered suicide[20]. Several studies indicate that supportive and affirming school contexts are found to be protective of LGBTQ+ youth's mental health, including reducing suicide[21]. Given these disturbing statistics and the current trend in state legislation towards anti-LGBTQ+ policies, the question of if and how these laws and policies impact the mental health of LBGTQ+ youth is both timely and necessary.

Therefore, by employing the minority stress model and intersectionality framework, this study seeks to contribute to the understanding of how LGBTQ+-related policies such as safe school non-discrimination laws, LGBTQ+ curriculum, bans on transgender youth participation in sports, bans on best medical practice for transgender youth, hate crime laws, and anti-bullying laws are associated with depressive symptoms among LGBTQ+ youth.

The research question that this study seeks to answer is "Is there a relationship between LGBTQ+-related policies and depressive symptoms in LGBTQ+ youth?". Based on a careful review of the literature, we hypothesize a positive direct relationship between anti-affirming LBGTQ+ policies and depressive symptoms experienced by LGBTQ+ youth. In particular, we hypothesize that youth from states that have anti- LGBTQ+ affirming policies and practices will demonstrate more depressive symptoms.

Methods

Participants

The cross-sectional study included 420 sexually diverse U.S. youth ages 14-24 enrolled in school. The mean age was 18.28 (SD = 2.21). 30 participants (7.2%) identified as male, 268 (63.8%) as female, 50 (11.9%) as gender non-conforming or genderqueer or non-binary, 51 (12.1%) as multi-gender, 5 (1.2%) as not sure/questioning, 4 (1.0%) as none of these, and 12 (2.9%) as transgender. Racial diversity included 165 (39.3%) White, 84 (20%) Multi-racial, 76 (18.1%) Black, and 56 (13.3%) Latinx. Of the participants, 82 (19.5%) were from the Northeast, 55 (13.1%) from the Southeast, 88 (21%) from the Southwest, 68 (16.2%) from the Midwest, and 56 (13.3%) from the West regions of the U.S.

Sampling

Qualtrics recruits panel members from various sources, including websites and social media. Demographic information like names, addresses, and birthdates were collected by Qualtrics and verified through third-party measures. Inclusion criteria for participation in this study were being between the ages of 14-24 years, being self-identified as sexually diverse such as gay, lesbian, bisexual, queer, pansexual, or asexual, being currently enrolled in school, and currently living in the U.S. Panel members who met the eligibility criteria were emailed an invitation to complete the online survey. Participants received compensation from the panel provider based on their agreement. The Institutional Review Board approved the study procedures and materials at the University of Arizona.

Measures

Depressive Symptoms: Depressive symptoms were measured using the 8-item Pediatric Depression Scale-Short Form [5]. Participants responded on a 4-point scale to items like "I was bothered by things that usually don't bother me." The scale had good internal consistency (Cronbach's $\alpha = .87$).

Key Variables

The key variables chosen for this analysis were determined based upon our literature review which highlights the role that state legislated school practices and policies have on the mental health of LGBTQ+ youth. The policies related to the LGBTQ+ rights and issues examined in the study were based on the legal landscape in the year 2021.

Political Party: States were categorized based on their dominant political party, with 0 representing Republican-controlled states and 1 representing Democratic-controlled states.

Safe School Non-discrimination Law: States with laws protecting gender identity and sexual orientation in schools were coded as 2; states with partial protections were coded as 1; states banning these protections were coded as 0.

LGBTQ+ Curriculum: States requiring LGBTQ+ curriculum in schools were coded as 2; states allowing schools to opt out of LGBTQ+ curriculum were coded as 1; and states banning LGBTQ+ curriculum were coded as 0.

Bans on Transgender Youth Participation in Sports: States allowing transgender youth to participate in sports aligned with their gender identity were coded as 1; states banning transgender youth sports participation were coded as 0.

Bans on Best Medical Practice for Transgender Youth: States with bans on surgical care and medication for transgender youth were coded as 0; states with bans only on surgical care were coded as 1; states without bans on transgender healthcare were coded as 2.

Hate Crime Laws: States with hate crime laws covering sexual orientation and gender identity were coded as 3; states covering only sexual orientation were coded as 2; states with hate crime laws not covering either were coded as 1; states without any hate crime laws were coded as 0. For analysis, hate crime laws were dummy-coded with states without any hate crime laws as the reference group.

Anti-bullying Laws: States banning schools from having anti-bullying policies were coded as 0; states with no laws explicitly protecting LGBTQ+ students from bullying were coded as 1; states with laws prohibiting bullying based on sexual orientation and gender identity were coded as 2.

Data Analysis

R software was used for descriptive analysis, reliability testing, and bivariate correlations between key variables[6]. The participants' state of residence was used to look up the current political party affiliation of each state government. In addition, the LGBTQ+ policies in each participant's state were identified and documented (i.e., Republican= 0, Democratic= 1). This information was recorded for each participant before conducting data analyses (i.e., Ban= 0, Partial Support/Protect= 1, Support/Protect= 2). In the current study, gender identity was dichotomized into two groups: 0= cisgender (i.e., exclusively "male/boy" or "female/girl") and 1= not exclusively cisgender, such as transgender, and gender diverse (i.e., not exclusively "male/boy" or "female/girl"). Sexual orientation was dummy-coded as 0= monosexual, such as gay/lesbian, and 1= not exclusively monosexual. The region was dummy-coded as 0= Northeast.

Multivariate linear regression models examined the link between LGBTQ+ policies (non-discrimination laws, LGBTQ+ curriculum laws, transgender sports bans, transgender healthcare bans, hate crime laws, anti-bullying laws) and depressive symptoms, controlling for age, gender, sexual orientation, and U.S. region. Full information maximum likelihood handled missing data[7].

Results

The mean, standard deviations, and correlations among study variables are reported in Table 1. As shown in Table 1, all the examined policies were highly correlated to each other.

Table 2 displays the frequency counts of political party affiliation and LGBTQ+-related policies among the study participants based on their current state of residence.

The multivariate regression results show the relationships between state policies and depressive symptoms (Table 3). There were no significant associations between state political parties, safe school non-discrimination laws, bans on transgender healthcare, hate crime laws, and anti-bullying laws predicting depres-

Variable	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Age	18.28	2.21											
2. Gender	0.29	0.45	-0.13**										
3. Sexual orientation	0.88	0.33	-0.02	-0.01									
4. Region	0.80	0.40	-0.01	0.02	-0.01								
5. State Political Party	1.46	0.50	0.06	-0.05	0.01	-0.54**							
6. Safe school non-discrimination law	0.88	0.96	0.04	-0.06	0.00	-0.44**	0.92**						
7. LGBTQ curriculum law	0.47	0.76	0.00	-0.03	-0.03	0.04	0.30**	0.34**					
8. Bans on transgender youth participation in sports	0.42	0.49	-0.00	0.02	-0.01	0.42**	-0.79**	-0.76**	-0.16**				
9. Access to medical care	1.19	0.97	0.04	-0.04	0.03	-0.42**	0.78**	0.75**	0.19**	-0.79**			
10. Hate crime laws	3.16	0.89	-0.01	-0.01	-0.05	-0.18**	0.52**	0.61**	0.37**	-0.46**	0.30**		
11. Anti-bullying laws	2.78	1.01	0.04	-0.06	-0.01	-0.36**	0.67**	0.77**	0.38**	-0.65**	0.63**	0.54**	
12. Depression	3.32	1.05	-0.00	0.12*	-0.05	-0.04	-0.04	-0.04	-0.09	0.02	-0.06	0.07	-0.02

Note. M and SD are used to represent mean and standard deviation, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 1 Means, standard deviations, and correlations of key variables

State Political Party	Frequency (%)
Republican	225 (54%)
Democratic	192 (46%)
Safe school non-discrimination law	
Ban	171 (41%)
Support	219 (52.5%)
Partly Supportive	27 (6.5%)
LGBTQ curriculum law	
Ban	289 (69.3%)
Support	69 (16.5%)
Partially Supportive	59 (14.1%)
Bans on transgender youth participation in sports	
Ban	240 (57.6%)
Support	177 (42.4%)
Bans on best medical practice for transgender youth	
Ban	162 (38.8%)
No ban on surgical care and medication	240 (57.6%)
Partial ban on surgical care	15 (3.6%)
Hate crime laws	
No hate crime law	17 (4.1%)
Existing hate crime law does not cover sexual orientation or gender identity	84 (20.2%)
State explicitly interprets existing hate crime law to include sexual orientation and/or gender identity	121 (29.1%)
Law enumerates only sexual orientation	7 (1.7%)
Law enumerates sexual orientation and gender identity	187 (45.0%)
Anti-bullying laws	
No anti-bullying policies	8 (1.9%)
Anti-bullying laws exist	167 (40.0%)
Partial	242 (58.0%)

Table 2 . Frequency distribution of political party and LGBTQ+-related policies

sive symptoms. However, laws requiring LGBTQ+-inclusive curriculum were associated with lower depressive symptoms ($\beta = -.096, p = 0.031$).

Discussion

This study examined the association between LGBTQ+-related policies and the mental health and well-being of sexual and gender minority youth in the United States. The study's findings indicate that there was a significant relationship between LGBTQ+ curriculum laws and depressive symptoms. Youth who live in states with anti-affirming LGBTQ+ curriculum laws reported more depressive symptoms. This finding is not surprising considering the large role schools can play in supporting the mental health of today's youth.

In 2001, in response to a growing mental health crisis among youth, the World Health Organization (WHO) called for schools to support students' mental health using a strengths-based public health approach [13]. They proposed a Health Promoting Schools (HPS) model emphasizing environments that support physical and mental health, reducing stigma and discrimination and fostering a culture of acceptance of all people, including gender and sexual minority individuals. However, anti-curriculum laws send a loud and clear opposing message – that gender and sexually non-conforming youth are not accepted or supported. Thus, it may abruptly halt the progress in improving social and emotional well-being in schools over the past decade. According to the results of the 2022 National Survey on LGBTQ+ youth mental health, students who found their school to be LGBTQ+-affirming reported lower rates of attempting suicide [20].

Schools have long been promoted as safe havens for children, with measures such as anti-bullying laws and kindness initiatives to support feelings of safety within schools. Gender and sexual-affirming practices in schools, such as the representation of gender and sexual minorities in teaching materials and open and inclusive discussion involving sexual and gender diversity, can enhance a sense of safety for LGBTQ+ youth, thereby supporting positive mental health. Research shows that in-school allyship and inclusion significantly improve mental health outcomes for LGBTQ+ youth [22]. Thus, restricting class-

	B	SE	β
Age	0.008	0.023	0.018
Gender (1= female)	0.266*	0.114	0.115*
Sexual orientation (1= not exclusively monosexual)	-0.120	0.159	-0.037
Region	-0.205	0.150	-0.076
Safe school non-discrimination law	-0.106	0.119	-0.097
LGBTQ Curriculum law	-0.131*	0.078	-0.096*
Ban on transgender youth participating in school sports	-0.037	0.237	-0.017
Bans on best medical practice for transgender youth	-0.063	0.102	-0.058
Anti-bullying laws	0.038	0.087	0.036
Hate crime laws 1	0.205	0.309	0.078
Hate crime laws 2	0.371	0.277	0.163
Hate crime laws 3	0.596	0.343	0.282
R^2			0.018

Table 3 Hierarchical Multiple Regression Results for LGBTQ+ Policies Predicting Depressive Symptoms

room discussions and literature related to gender and sexual diversity that jeopardizes the sense of safety for LGBTQ+ youth may adversely impact their mental health.

It is worthwhile to mention that the high correlation among the various LGBTQ+-related policies investigated in the study might have influenced the statistical significance of the coefficients for other school-related policies in predicting depressive symptoms. The strong interconnectedness between these policies could have made it more challenging to identify the unique impact of each individual policy on the participants' mental health outcomes, potentially masking the significance of some school-related policies in the analysis[23]. While the effect sizes of the associations between LGBTQ+-related policies and depressive symptoms may appear small, it is important to consider that even seemingly minor effects can have substantial impacts when considering the broader context of population health. As Rutledge and Loh (2004) point out, small effects can still lead to significant consequences regarding the total number of people affected and the associated social costs[24]. The observed correlation between anti-LGBTQ+ curriculum laws and depressive symptoms, in contrast to the absence of such a correlation with other school-related policies like anti-bullying laws and nondiscrimination laws, may stem from the fact that these latter laws have been established for years, with efforts of the WHO to promote mental health in schools by fostering inclusivity. This sentiment transcends state and political boundaries, with the majority of Americans prioritizing the well-being of young people and striving to cultivate supportive school environments. Conversely, the emergence of anti-curriculum laws is a relatively recent phenomenon, driven by the demand for representation of LGBTQ+ individuals in what is being taught in the classroom. The resurgence of states enacting laws that prohibit the open discourse and inclusion of LGBTQ+-related issues in educational settings conveys a troubling message that there is something inherently "wrong" with addressing these topics, thus perpetuating a damaging narrative that something is also "wrong" with LGBTQ+ youth. This harmful message may help explain why we observed a correlation between anti-curriculum laws and depression while not finding a similar correlation with other school-related policies.

Although other school policies were not significantly predictive of LGBTQ+ youth in the current study, it is crucial to maintain and improve these laws to protect LGBTQ+ youth from discrimination[25]. It is also important to note that improvements to the school environment for LGBTQ+ youth can be made through local or state-level initiatives[26]. For example, peer-led gay/straight alliances (GSAs) aim to foster support and acceptance, while the inclusion of LGBTQ+ protections in anti-bullying laws seeks to safeguard youth from harm and harassment[27]. Policyholders should encourage these protections to be implemented at the school district, municipal, or state level, with statewide enumerations often being part of broader anti-bullying laws present in all 50 states[26]. Stakeholders should advocate for the adoption of the HPS model in schools, which emphasizes environments that support physical and mental health, reduce stigma and discrimination, and foster a culture of acceptance for all people[28]. Furthermore, policymakers should allocate funds to better provide targeted mental health resources for LGBTQ+ individuals, especially within and outside educational contexts, to address the unique challenges they experience[29].

While this study provides valuable insights, several limitations must be considered. First, using a convenience sample in this study constrains the generalizability of the results. Participants were recruited through the Qualtrics panel service, which prioritizes sexually diverse youth who have previously seen Qualtrics advertisements, thus contributing to skewing the sam-

ple in unseen ways. Additionally, cismale sexually diverse youth (7.1%) and monosexual youth (12.4%) were underrepresented in the analytic sample. This underrepresentation might be attributed to the challenges of reaching out to the sexual minority population, particularly those who have not disclosed their sexual orientation to others. The larger project, of which this study is a part, aimed to address experiences across various stages of the disclosure process, ranging from complete concealment to being completely open about one's sexual orientation. These factors were the primary reasons for opting for online panel recruitment as a method to gather participants for the study. Therefore, the findings may not generalize to sexually diverse youth without access to Qualtrics or to cismale and/or monosexual youth. More research is needed with a larger sample of cismale and monosexual youth to determine if the current findings replicate in broader sexually diverse populations. Furthermore, it is important to note that the study's cross-sectional design limits the possibility of determining causality or directionality between anti-LGBTQ+ policies and depressive symptoms. Future studies should employ recruitment methods that can access a more representative distribution of sexual identity subgroups. Second, the reliance on cross-sectional data does not allow us to make inferences about the directionality and causal relationships between the variables examined. Thus, longitudinal research is needed to elucidate the pathways over time and establish stronger inferences regarding the associations found. Further research should examine associations between state-level anti-LGBTQ+ laws and mental health factors like suicidality among LGBTQ+ youth. Further, this paper did not investigate the differences in mental health status between LGBTQ+ and non-LGBTQ+ youth by state. This information could provide insight into the overall mental health status of today's youth across the US and provide valuable information on the impact of discriminatory practices on all youth. Lastly, it is important to recognize that the study's findings may have been influenced by other contextual factors, such as the COVID-19 pandemic, which could have acted as an additional confounding variable. The pandemic may have affected the way in which anti-LGBTQ+ policies shaped mental health outcomes for the study participants, potentially altering the observed relationships between these policies and the participants' mental health well-being.

Despite the above limitations, our findings add to the current body of research that points to the possible detrimental effects that anti-LGBTQ+ legislation can have on gender and sexual minority youth. In particular, our study highlights the crucial role of an affirming and inclusive school culture, including representation of the LGBTQ+ community in what is being taught in the classroom, in supporting the mental health of LGBTQ+ youth.

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