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Age Trends in Bias-based Bullying and Mental Health by Sexual Orientation and Gender Identity

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Abstract

Disparities in mental health and bullying between SGM youth and their heterosexual, cisgender peers are well-established. There remain questions about whether the onset and progression of these disparities differ across adolescence—knowledge critical for screening, prevention, and intervention. To address this, the current study estimates age-based patterns of homophobic bullying, gender-based bullying, and mental health across groups of adolescents defined by sexual orientation and gender identity (SOGI). Data are from the 2013–2015 cycle of the California Health Kids Survey (n = 728,204). We estimated the age-specific prevalence rates of past-year homophobic bullying, gender-based bullying, and depressive symptoms using three- and two-way interactions by (1) sex and sexual identity and (2) gender identity, respectively. We also tested how adjustments for bias-based bullying alter predicted prevalence rates of past-year mental health symptoms. Results showed that SOGI differences in homophobic bullying, gender-based bullying, and mental health were already present among youth aged 11 and younger. SOGI differences by age were attenuated when adjusting models for homophobic and gender-based bullying, particularly among transgender youth. SOGI-related bias-based bullying and mental health disparities were present early and persisted throughout adolescence. Strategies that prevent exposure to sexuality- and gender-based bullying would significantly reduce disparities in mental health across adolescence.

Sexual and gender minority youth (SGMY; e.g., lesbian, gay, bisexual, transgender, queer, and questioning [LGBTQ] youth) demonstrate elevated rates of depression, suicidality, and other markers of poor mental health when compared to heterosexual peers (Fish et al., 2020; Russell & Fish, 2016). SGMY are 1.5–3.0 times more likely than heterosexual, cisgender youth to report depressive symptoms and have 3.0–6.0 greater odds of suicidal behavior (Johns et al., 2018, 2019). Despite continued documentation of sexual orientation and gender identity (SOGI)-related disparities in mental health, a dearth of large, longitudinal panel data that include SOGI measures have limited our ability to understand when these disparities emerge and how they might persist across adolescence (Fish, 2020; Mustanski, 2015) – a

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Conflicts of Interest

The authors have no conflicts of interest to report at this time.

Ethics Approval

The University of Texas Institutional Review Board approved the current study.

developmental period when youth are vulnerable to developing mood and anxiety disorders and suicidal behaviors (Kessler et al., 2012; Nock et al., 2013). However, this understanding is crucial to inform prevention, screening, and intervention efforts to improve health among SGMY(Fish, 2020).

SGMY and Mental Health During Adolescence

Generally, depressive symptoms and suicidality increase across adolescence, peaking in young adulthood (CDC, 2020; Nock et al., 2013). Research on SGMY mental health trends and trajectories is limited (Gilbey et al., 2020), particularly among gender minority youth. Studies using data from the National Longitudinal Study of Adolescent to Adult Health find that sexual orientation differences in depressive symptoms are present by mid-adolescence and persist across the transition to adulthood (Fish & Pasley, 2015; Jager & Davis-Kean, 2011; Marshal et al., 2013; Needham, 2012), although studies vary as to whether disparities decline or remain stable over time. Some prior studies analyze trajectories with multiple waves of data from a wide age range of youth (e.g., 7^{th}-12^{th} grades); such wave-based designs obscure developmental distinctions in mental health (Fish & Pasley, 2015; Needham, 2012), which limit understanding of when and how disparities emerge during adolescence. Findings from international panel studies from the United Kingdom and the Netherlands, however, suggest that sexual orientation disparities in depression are observed by age 10 or 11 (Irish et al., 2019; la Roi et al., 2016). One recent U.S. study using prospective data found that compared to other-sex attracted youth, same-sex attracted youth showed greater depressive symptoms by age 12 and anxiety symptoms by age 15 (Pachankis et al., 2021).

Notably, these prior studies focus on sexual minority youth. Studies tracking trends in adolescent mental health by gender identity are woefully lacking. Existing studies have been based on samples that combine gender minority youth with their cisgender, sexual minority peers (Birkett et al., 2015; McConnell et al., 2015; Mustanski et al., 2016). Still, cross-sectional studies that assess cisgender-transgender differences in mental health suggest that disparities are present in samples of children (Becerra-Culqui et al., 2018; Spivey & Edwards-Leeper, 2019), adolescents (Becerra-Culqui et al., 2018; Johns et al., 2019; Price-Feeney et al., 2020), and adults (Downing & Przedworski, 2018).

Bias-Based Bullying, SGMY Development, and Mental Health

Minority stress theory posits that SOGI-related health disparities result from unique stressors such as anti-SGM stigma in the day-to-day lives of SGM people, including homophobic and gender-based bullying (Goldbach & Gibbs, 2017; Hatzenbuehler, 2009; Hendricks & Testa, 2012; Meyer, 2003). Indeed, research documents the pervasiveness of victimization and harassment experienced by SGMY (Kosciw et al., 2020), and these experiences help explain observed differences in mental health between SGM and heterosexual, cisgender youth (Johns et al., 2018, 2019; Katz-Wise & Hyde, 2012; Toomey & Russell, 2016). Research further suggests that experiences of bias-based harassment (i.e., bullying based on [marginalized] identity) are uniquely harmful to the well-being of youth (Mulvey et al., 2018; Russell et al., 2012). Russell and colleagues (Russell et al., 2012) found that

non-biased-based harassment from peers was related to 2.40 greater odds for depression. In contrast, bias-based harassment led to 4.0–5.0 greater odds for depression among youth. Interestingly, across different forms of bias (e.g., race-based, religious-based), sexual-minority-specific bias was among the most harmful to mental health.

Although research suggests that social attitudes towards SGM people have improved in recent decades, these social shifts help contemporary cohorts of SGMY to understand their identities earlier in the life course and disclose their SGM identities at younger ages (Bishop et al., in press; Puckett, Tornello, et al., 2021). As a result, youth come out during a developmental period characterized by greater peer prejudice regarding sexuality and gender and youths' heightened sensitivity to peer attitudes (Russell & Fish, 2019). This "developmental collision" leaves modern-day SGMY vulnerable to similar mental and behavioral health disparities documented in previous cohorts. Given that the number of youth identifying as SGMY is rising with each generation (Gallup Inc, 2021), it is imperative to consider when these disparities emerge to identify effective strategies to prevent them.

To document the timing and progression of mental health concerns and experiences of bias-based victimization, we tested age-specific differences in depressive symptoms between non-SGM and SGM youth using a large, statewide sample of Californian youth. We also assess the degree to which experiences with bias-based bullying account for sexual orientation and gender identity differences in depressive symptoms across ages δ 11 to ε 18.

Methods

Data Source and Sample

Data are from the 2013–2015 administration of the statewide California Healthy Kids Survey (CHKS), a cross-sectional school-based survey that tracks health risk and resilience among students in 7th-, 9th-, and 11th-grade classrooms. Developed by WestEd, the CHKS is administered to most secondary schools in California and is the largest statewide survey of middle and high school students in the United States. Schools participated during either the 2013–2014 school year, the 2014–2015 school year, or in limited instances, both years. Following direction from WestEd, we exclude youth with inconsistent or improbable response patterns (1.72%). Our sample is further limited to youth who provide valid responses for age, sex, SOGI, race, ethnicity, parent education, and outcomes of interest (n=728,204). The University of Texas at Austin institutional review board approved the current study. Sample demographic characteristics are presented in Table 1.

Measures

Sexual orientation and gender identity.—SOGI was assessed with a single multiple-response question: "Which of the following best describes you? (Mark all that apply)." Response options were "heterosexual (straight)," "gay, lesbian, or bisexual," "transgender," "not sure," and "decline to respond." To measure sexual orientation, we constructed a dichotomous variable of LGB and non-LGB youth (non-LGB = 0, LGB = 1). To test differences by gender identity (0 = non-trans boys, 1= non-trans girls, 2 = trans youth), we

constructed a variable from participants' reports of whether they were transgender and their sex.

Homophobic bullying.—Youth indicated the frequency of past-year bullying related to their actual or perceived sexual identity: "During the past 12 months, how many times on school property were you harassed or bullied for any of the following reasons? [You were bullied if you were shoved, hit, threatened, called mean names, teased, or had other unpleasant physical or verbal things done to you repeatedly or in a severe way. It is not bullying when two students of about the same strength quarrel or fight.] Because you are gay or lesbian or someone thought you were". Response options ranged from *0 times* = 0 to *4 or more times* = 3. We dichotomized this measure (0= *0 times*, 1= *1 or more times).*

Gender-based bullying.—Using the same prompt as homophobic bullying, youth also indicated the frequency of past-year bullying related to their gender in response to: "Your gender (being male or female)." Response options ranged from *0 times* = 0 to *4 or more times* = 3. We dichotomized this measure (0= *0 times*, 1= *1 or more times).*

Depressive symptoms.—We used a single-item indicator: "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities?" Response options were 0=*no* or 1=*yes.*

Covariates.—Race/ethnicity (American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, White, Mixed (two or more) races, and unreported; and separately, Hispanic/Latinx and not Hispanic Latinx), parental education (did not finish high school, graduated from high school, attended college but did not complete four-year degree, graduated from college, and don't know), and data collection year (2013–2014, 2014–2015).

Analytic approach.—All data management and analyses were conducted in Stata 15.1. First, we reported sample demographics including SOGI prevalence of bias-based bullying and mental health outcomes (Table 1). Then, we conducted two sets of multivariable logistic regression models to estimate SOGI differences in the age-specific prevalence of homophobic bullying, gender-based bullying, and depressive symptoms. Sexual orientation differences were estimated using three-way interactions between youth age, sex, and sexual orientation (age x sex x sexual orientation), adjusting for race, ethnicity, parental education, transgender identity, and data collection year. Gender identity differences were estimated using two-way interactions between age and gender identity (age x gender identity), adjusting for race, ethnicity, parental education, LGB identity for non-transgender youth (Perez-Brumer et al., 2017), and data collection year as covariates. Predicted probabilities were then calculated to estimate the adjusted percentage of youth who report each outcome for each age year per group (e.g., the estimated prevalence of homophobic bullying among 12-year-old LGB boys). Next, we estimated models that adjusted for the effects of homophobic and gender-based bullying on depressive symptoms across SOGI subgroups. All analyses accounted for the clustering of students in schools. Lastly, we tested a series of robustness checks.

Results

SOGI Differences in Bias-Based Bullying

Age-specific predicted probabilities illustrating differences in homophobic and gender-based bullying by sexual orientation and gender identity are presented in Figure 1. Sexual minority youth reported more frequent incidents of homophobic bullying, although the degree of difference between LGB and non-LGB youth varied by age and sex. LGB boys and girls reported significantly more homophobic bullying than non-LGB boys and girls across all years. For example, among those 11 years old or younger, roughly 43% of LGB boys and 48% of LGB girls reported homophobic bullying, relative to roughly 9%-10% of non-LGB boys and girls. Rates of homophobic bullying among heterosexual youth generally were lower at older ages, where roughly 5% of 18+-year-old boys and girls reported homophobic bullying. Comparatively, LGB boys showed relatively stable rates of homophobic bullying across all ages, whereas older LGB girls showed lower rates at older ages; however, rates were still elevated relative to non-LGB girls and boys. Sexual orientation differences in gender-based bullying were less pronounced. However, both LGB boys and girls reported higher rates of gender-based bullying when compared to their same-sex non-LGB peers across all ages, excluding 16-year-olds.

Comparisons by gender identity revealed that transgender youth of all ages reported higher incidences of homophobic and gender-based bullying. Gender identity differences in homophobic bullying (~30%) were relatively stable across ages, except for higher rates among those δ 11 and ε 18. This same age-based pattern was also present for gender-based bullying. However, the differences between transgender youth and non-transgender boys and girls were less pronounced than for homophobic bullying (~20% around age 13) but widened across ages.

SOGI Differences in Depressive Symptoms

Figure 2 provides age-specific predicted probabilities of depressive symptoms by SOGI, first covariate-adjusted and then adjusted for covariates and homophobic and gender-based bullying. Starting with sexual orientation differences, the prevalence of depressive symptoms varied significantly by age, sex, and sexual identity. LGB girls had the highest prevalence rates of depressive symptoms, followed by LGB boys across all ages. Roughly 58–71% of LGB girls reported depressive symptoms across adolescence. In models adjusting for bias-based bullying, LGB boys and girls showed a 7–14% reduction in depressive symptoms. Predicted probabilities among non-LGB boys and girls were relatively unchanged.

Models testing gender differences showed elevated rates of depressive symptoms among transgender youth relative to non-trans boys across all ages. Transgender youth also had higher prevalence rates of depressive symptoms relative to non-trans girls among those δ 11, 12, 13, 16, 17, and ε 18 years old, but did not differ among participants ages 14 and 15. Models adjusting for bias-based bullying showed a large reduction in gender identity differences in depressive symptoms. For example, prior to adjustments, there was a 28% difference between transgender youth and non-trans boys in depressive symptoms among those 11 years old and younger; this estimated difference was 11% after adjustments.

Interestingly, adjustments for homophobic and gender-based bullying attenuated differences to the extent that non-trans girls had the greatest estimated probability for depressive symptoms from ages 14 to 18 years.

Supplementary & Sensitivity Analyses

First, we tested whether homophobic and gender-based bullying were independent or multicollinear across SOGI subgroups. We ran logistic regression models for homophobic bullying adjusting for gender-based bullying in addition to covariates (Supplemental Figure 1, top panels), followed by a set of logistic regression models estimating gender-based bullying adjusting for homophobic bullying (Supplemental Figure 1, lower panels). We then calculated predicted probabilities for depressive symptoms across SOGI subgroups after adjusting for covariates and homophobic bullying only and gender-based bullying only (Supplemental Figure 2). These analyses showed that homophobic and gender-based bullying contribute unique variance to the outcome for distinct SOGI groups. Therefore, both should be included in adjusted models, as we present above.

Given a high degree of overlap between youth who reported LGB and transgender identities, we also tested models that excluded cisgender LGB participants from our analyses when testing gender identity differences to assess whether LGB identity might be driving our findings among non-transgender boys and girls (Supplemental Figure 3). Results showed that differences across groups remained substantively unchanged, with predicted probabilities altered by less than 3% across ages.

Discussion

Our goals were to better understand potential developmental differences in SOGI-related disparities in mental health and bias-based bullying and the degree to which experiences with bias-based bullying help explain age-specific mental health patterns across SOGI subgroups. Consistent with previous research, our findings show that SGMY are at elevated risk for depressive symptoms, homophobic bullying, and gender-based bullying relative to non-SGM peers. By implementing an age-based design, we extend this literature in two important ways. First, we showed that these disparities start early in the life course—by the age of 11 or younger. Second, we demonstrated that these disparities persist across ages, with varying patterns based on sex, sexual orientation, and gender identity.

One of our more notable findings was that SOGI differences in depressive symptoms and bias-based bullying were present by age 11 or younger. These results are consistent with data from Europe (Irish et al., 2019; la Roi et al., 2016) and more recently from the United States (Pachankis et al., 2021), which document sexual orientation disparities in depressive symptoms among youth ages 10, 11, and 12, respectively. Importantly, our findings also demonstrated these disparities in depressive symptoms among transgender youth ages 11 or younger, which is consistent with other cross-sectional studies that document mental health disparities among transgender children and adolescents (Becerra-Culqui et al., 2018; Johns et al., 2019; Price-Feeney et al., 2020; Spivey & Edwards-Leeper, 2019). We also observed disparities in homophobic and gender-based bullying between SGMY and non-SGMY youth starting at age 11 or younger, which persisted across all ages.

In addition to documenting early disparities in mental health and bias-based bullying, our findings suggest that these experiences vary by age, although differently based on sex, sexual orientation, and gender identity. SGM youth, and SM girls in particular, showed persistently elevated rates of poor mental health compared to their non-SGM peers across all age years. Our findings regarding early and persistent sex differences in depressive symptomology – across both heterosexual and sexual minority youth – align with recent meta-analyses that observe this gender disparity as young as age 12 across representative samples (Salk et al., 2017).

Disparities in homophobic and gender-based bullying among transgender youth were also present across all ages. Previous research among English youth has shown that SM youth, particularly SM boys, are subject to elevated rates of peer victimization relative to heterosexual peers across adolescence that narrowed as youth aged, particularly around ages 18–19 (Robinson et al., 2013). We did not observe this same narrowing among neither SM nor transgender youth with our data, which suggests that the youth in our study experienced homophobic and gender-based bullying early – and often – throughout this developmental period (Russell & Fish, 2019). The distinction in the pattern by age may be related to differences in youth's victimization experiences and our measure, which was bias-based bullying.

Among the transgender youth in our sample, we also observed that rates of bias-based bullying were distinctly elevated for youth δ 11 and ε 18 years of age. Given that our analyses used a school-based sample, the youth in these age groups are "off-time" with respect to their peers – either younger or older than most students in their grade. It could be that youth who are younger and older than their same-grade peers stand out socially and may be particularly susceptible to exclusion and bullying. Relatedly, because these students' ages are unique for their grades, there are smaller numbers of youth in these age categories, which may also contribute to these differences.

The likely impact of these bias-based experiences on SGMY mental health were also captured in our analysis, showing the degree to which statistical adjustments for biased-based bullying partly account for SOGI differences in depressive symptoms across all ages. For example, predicted probabilities of depressive symptoms among SM girls dropped between 7–14%, depending on age, when models accounted for homophobic and gender-based bullying. Similar drops were observed in models estimating gender identity differences. For example, 47% of 17-year-old transgender youth are estimated to have depressive symptoms, which dropped to 35% after adjusting for homophobic and gender-based bullying. These findings highlight the importance of instituting enumerated anti-bullying policies that protect youth based on SOGI. At this point, there is compelling evidence that enumerated anti-bullying policies are associated with fewer experiences of bullying and victimization and more feelings of safety (Hatzenbuehler et al., 2015; Meyer et al., 2019; Watson et al., 2021). Similarly, recent evidence suggests that long-term SOGI-supportive educator training impact SGM youths' perceptions of school climate and experiences of victimization (Ioverno et al., 2022). Thus, implementing enumerated anti-bullying and educator training policies and the subsequent reduction in peer victimization and bullying would help attenuate SGM-related disparities in depressive symptoms.

Findings regarding the early onset of disparities also highlight the importance of early prevention and intervention. There is a dearth of data on the childhood experiences of SGM youth, particularly in the school context. Future studies should consider how to better capture experiences in the early life course of SGM youth to understand the circumstances that contribute to the onset of SGM-related mental health disparities, including the role of teachers and peers in reinforcing hetero- and cisnormativity and perpetrating bias. Such understanding could inform early intervention and training to mitigate mental health inequities for SGMY. Even without this knowledge, schools can integrate practices that affirm SGM youth through efforts that eliminate gender-based instructions (e.g., "line up by boys and girls") and expectations (e.g., those are "girl toys") and include books and activities that reflect and normalize diverse genders, gender expressions, and family structures (e.g., same-sex parents) (Clark, 2016).

Limitations and Opportunities for Future Research

There are several limitations. First, the CHKS data are cross-sectional; age-specific differences may or may not be similar to intraindividual changes over time. Future research using annually collected prospective data is necessary to assess better how experiences of bullying and mental health change over time for individual youth. Second, the CHKS measure for sexual orientation and gender identity does not allow for assessments between monosexual gay/lesbian and bisexual youth, nor for comparisons among subgroups of transgender youth (e.g., trans binary youth relative to non-binary youth). Research documents differences in risk for peer harassment and mental health among SGMY, and among bisexual people in particular (Ross et al., 2018). Given that bisexual and other non-monosexual people often reflect the plurality, if not the majority, of sexual minority populations (National Academies of Sciences, Engineering, and Medicine, 2020), future work is needed to understand how these age-related experiences may differ for these subpopulations. Relatedly, it is unclear the degree to which youth perceived their reporting of sex as a reflection of their assigned sex at birth or their current sex/gender. To best measure SOGI, population-based surveys should utilize measures that can distinguish between assigned sex and current gender identity (National Academies of Sciences, Engineering, and Medicine, 2022). Third, our bias-based bullying measures lacked specificity in that the gender-based measure did not explicitly name transgender identity, nor did the homophobic bullying measure specifically name bisexuality. Since sexism, cissexism, and biphobia are all distinct experiences, we may have had some measurement misspecification in the reported experiences of bias-based bullying among SGMY (Greensmith & Davies, 2017; Puckett, Aboussouan, et al., 2021). Fourth, our variables consist of single-item indicators, which may miss some specificity regarding mental health symptomology and severity, but also experiences with bullying. Fifth, given our analytic approach, we could not also assess how other health-relevant social identities (e.g., race/ethnicity) and experiences (e.g., racism) may alter the timing and prevalence of these experiences. We also could not ascertain whether these age-related experiences may systematically vary across social or policy contexts (e.g., schools with enumerated policies or gender-sexuality alliances). These investigations are beneficial for identifying strategies to prevent and assuage the impacts of bullying and SGMY health inequities that appear to emerge early in the life course.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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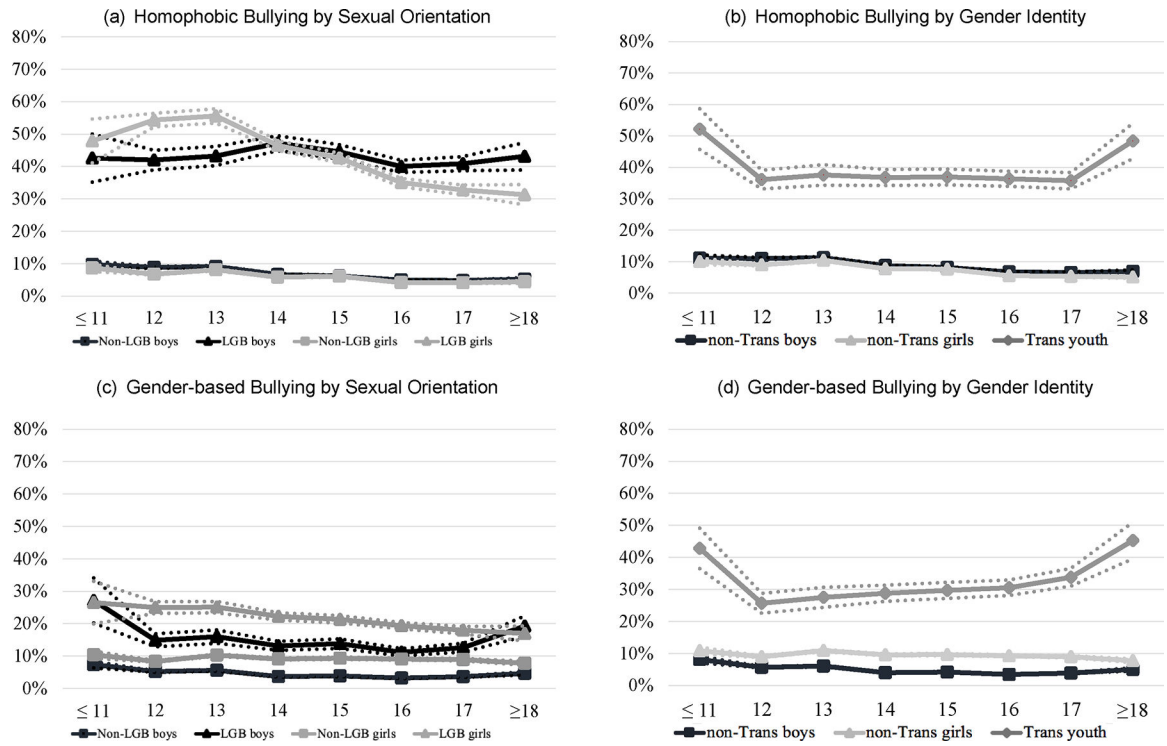

Figure 1.

Age-specific predicted probabilities of differences in homophobic and gender-based bullying by sexual orientation and gender identity. California Healthy Kids survey (2013–2015). Panel a and panel c are predicted probabilities by sexual orientation. Panel b and panel d are predicted probabilities by gender identity. All models are adjusted for covariates. All interactions are significant. Panel a: X^2= 159.75, p<.001. Panel b: X^2=188.82, p<.001. Panel c: X^2= 48.68, p<.001. Panel d: X^2= 357.07, p<.001.

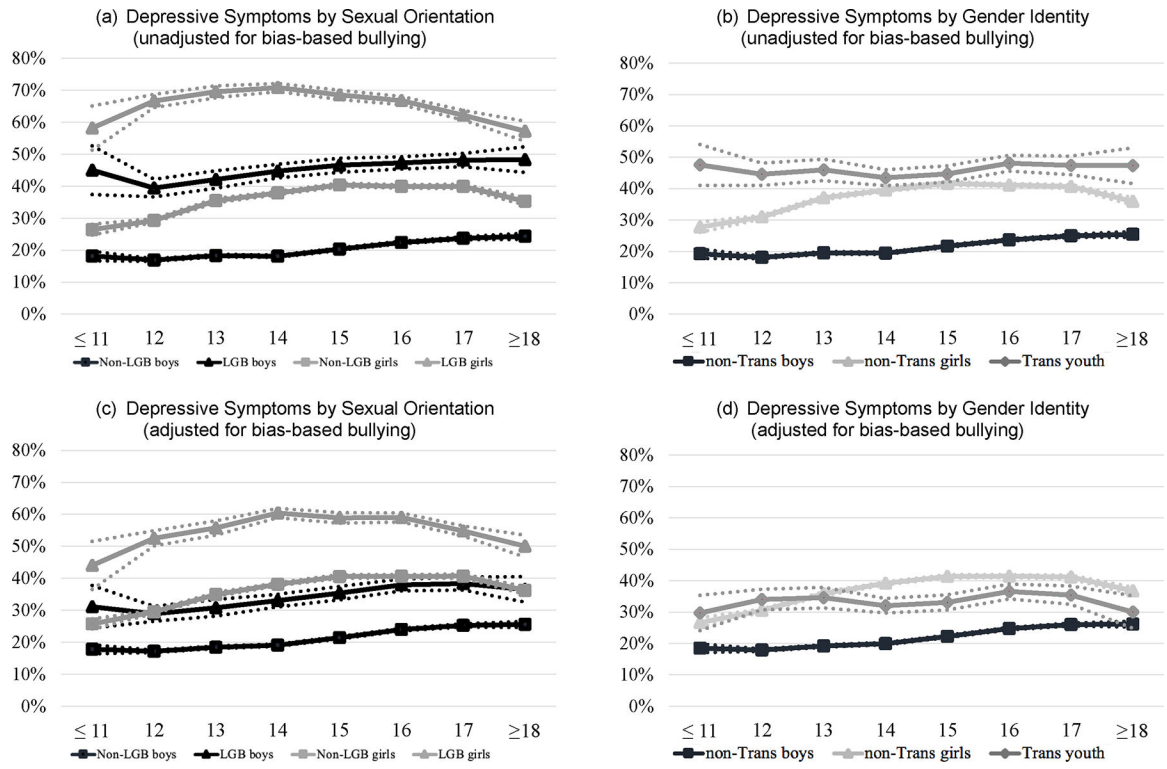

Figure 2.

Age-specific predicted probabilities of differences in depressive symptoms by sexual orientation and gender identity. California Healthy Kids survey (2013–2015). Left panels are predicted probabilities by sexual orientation. Panel a is the covariate adjusted model and panel c is the model adjusted for covariates and bias-based bullying. Right-hand panels are predicted probabilities by gender identity. Panel b is the covariate adjusted model and panel b is the model adjusted for covariates and bias-based bullying. All interactions are significant. Panel a: X^2= 55.07, p<.001. Panel b: X^2= 521.95, p<.001. Panel c: X^2= 16.62, p=.02. Panel d: X^2=470.18, p<.001.

Table 1.

Sample Demographic Characteristics, California Healthy Kids Survey (2013–2015)

	Overall Sample		Sexual Orientation Comparison Sample				Gender Identity Comparison Sample		
			non-LGB boys	LGB boys	non-LGB girls	LGB girls	non-Trans boys	non-Trans girls	Trans youth
	n	%	%	%	%	%	%	%	%
Age									
11 years old or younger	7,021	0.96	0.95%	1.39%	0.98%	0.76%	0.94%	0.94%	3.18%
12 Years Old	129,675	17.81	17.06%	9.40%	19.54%	8.84%	16.87%	18.82%	11.43%
13 years old	87,345	11.99	12.80%	9.43%	11.56%	8.67%	12.71%	11.35%	10.66%
14 years old	143,193	19.66	18.87%	17.81%	20.43%	20.71%	18.83%	20.46%	19.15%
15 years old	105,894	14.54	15.14%	16.81%	13.60%	17.99%	15.17%	13.90%	16.97%
16 years old	142,110	19.52	18.74%	22.94%	19.84%	23.60%	18.86%	20.11%	20.59%
17 years old	93,415	12.83	13.49%	17.58%	11.77%	15.87%	13.62%	12.06%	14.01%
18 or older	19,551	2.68	2.96%	4.64%	2.28%	3.57%	3.00%	2.36%	4.01%
Sex			-			-			
Male	353,969	48.61	-	-	-	-	-	-	61.17%
Female	374,235	51.39	-	-	-	-	-	-	38.83%
Gender Identity									
Non-Transgender	720,721	98.97	99.42%	79.50%	99.61%	94.26%	-	-	-
Transgender	7,483	1.03	0.58%	20.50%	0.39%	5.74%	-	-	-
Sexual Orientation									
Non-LGB	688,636	94.57	-	-	-	-	97.11%	93.18%	44.62%
LGB	39,568	5.43	-	-	-	-	2.89%	6.82%	55.38%
Race/Ethnicity									
American Indian/ Alaska Native	25,348	3.48	3.77%	3.90%	3.17%	3.63%	3.77%	3.20%	4.05%
Asian/Asian American	88,793	12.19	12.48%	10.97%	12.32%	7.57%	12.44%	11.99%	11.21%
Black/African American	32,759	4.50	4.82%	6.33%	3.99%	6.07%	4.81%	4.11%	9.10%
Native Hawaiian/ Pacific Islander	14,973	2.06	2.20%	2.62%	1.90%	1.94%	2.21%	1.90%	2.67%
White	200,657	27.56	27.37%	28.48%	27.87%	25.34%	27.39%	27.68%	28.72%
Two or more races	265,048	36.40	35.93%	36.54%	36.32%	43.30%	35.97%	36.81%	35.72%
unreported	100,626	13.82	13.43%	11.16%	14.43%	12.14%	13.41%	14.31%	8.53%
Hispanic/Latinx									
No	355,677	48.84	49.91%	51.09%	47.90%	46.50%	49.88%	47.79%	52.71%
Yes	372,527	51.16	50.09%	48.91%	52.10%	53.50%	50.12%	52.21%	47.29%
Parent Education									
Some high school	104,569	14.36	12.60%	15.11%	15.73%	18.64%	12.66%	15.92%	16.06%
Finished high school	118,743	16.31	16.22%	16.25%	16.23%	18.52%	16.25%	16.39%	14.75%
Some College	91,254	12.53	11.55%	13.17%	13.21%	15.88%	11.60%	13.40%	12.86%

	Overall Sample		Sexual Orientation Comparison Sample				Gender Identity Comparison Sample		
			non-LGB boys	LGB boys	non-LGB girls	LGB girls	non-Trans boys	non-Trans girls	Trans youth
	n	%	%	%	%	%	%	%	%
Graduated college	272,114	37.37	38.39%	38.46%	36.84%	30.67%	38.38%	36.41%	37.48%
Don't Know	141,524	19.43	21.23%	17.00%	18.00%	16.29%	21.11%	17.87%	18.84%
Past Year Homophobic Bullying									
No	668,233	91.76	93.36%	54.39%	94.26%	57.01%	92.28%	91.83%	64.71%
Yes	59,971	8.24	6.64%	45.61%	5.74%	42.99%	7.72%	8.17%	35.29%
Past Year Gender-Based Bullying									
No	674,735	92.66	95.87%	82.08%	91.06%	77.47%	95.66%	90.28%	70.20%
Yes	53,469	7.34	4.13%	17.92%	8.94%	22.53%	4.34%	9.72%	29.80%
Past Year Sadness									
No	508,100	69.77	80.08%	53.69%	63.15%	32.09%	79.33%	61.07%	55.63%
Yes	220,104	30.23	19.92%	46.31%	36.85%	67.91%	20.67%	38.93%	44.37%