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Risco de suicídio em uma amostra brasileira de minorias de gênero e sexuais

Suicide risk in a Brazilian sample of gender and sexual minorities

Riesgo de suicidio en una muestra brasileña de minorías sexuales y de género

RESUMO: Pessoas que fazem parte de grupos de minorias sexuais e de gênero apresentam maior risco de problemas de saúde mental. O presente estudo testou as relações entre congruência sexo/gênero, homofobia internalizada, conexão com a comunidade LGBTQIA+, depressão e risco de suicídio, com o objetivo de identificar fatores de risco para o suicídio, e examinou um modelo preditivo de risco de suicídio no qual a depressão foi considerada como mediadora. Responderam a um questionário on-line 411 adultos brasileiros que se identificaram como minorias sexuais ou de gênero. Um modelo composto por congruência sexo/gênero tipificada, congruência sexo/gênero mista, homofobia internalizada, depressão e risco de suicídio explicou aproximadamente 15% da variância da depressão e 40,3% da variância do risco de suicídio. Esses resultados sugerem que a depressão pode explicar o risco de suicídio de forma mais significativa do que variáveis relacionadas às minorias de gênero e sexuais. Discutem-se as implicações desses dados para a prevenção do suicídio na população brasileira.

Palavras-chave: Suicídio; Depressão; Minorias sexuais e de gênero.

ABSTRACT: People who are part of sexual and gender minority groups are at higher risk of mental health problems. The present study examined the relationships between sex/gender congruence, internalized homophobia, connectedness to the LGBTQIA+ community, depression, and suicide risk, with the aim of identifying risk factors for suicide, and tested a predictive mediation model in which depression was examined as a mediator of suicide risk. A total of 411 Brazilian adults who identified as sexual or gender minorities completed an online questionnaire. A model composed of typified sex/gender congruence, mixed sex/gender congruence, internalized homophobia, depression, and suicide risk explained approximately 15% of the variance in depression and 40.3% of the variance in suicide risk. These results suggest that depression may explain suicide risk more significantly than variables related to sexual and gender minorities. The implications of these findings for suicide prevention in the Brazilian population are discussed.

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Keywords: Suicide; Depression; Sexual and gender minorities.

RESUMEN: Las personas que forman parte de grupos de minorías sexuales y de género presentan un mayor riesgo de problemas de salud mental. El presente estudio examinó las relaciones entre la congruencia sexo/género, la homofobia internalizada, la conexión con la comunidad LGBTQIA+, la depresión y el riesgo de suicidio, con el objetivo de identificar factores de riesgo para el suicidio, y puso a prueba un modelo predictivo de el riesgo de suicidio en el cual la depresión fue examinada como mediadora. Un total de 411 adultos brasileños que se identificaron como minorías sexuales o de género respondieron a un cuestionario en línea. Un modelo compuesto por congruencia sexo/género tipificada, congruencia sexo/género mixta, homofobia internalizada, depresión y riesgo de suicidio explicó aproximadamente el 15% de la varianza de la depresión y el 40,3% de la varianza del riesgo de suicidio. Estos resultados sugieren que la depresión puede explicar el riesgo de suicidio de manera más significativa que las variables relacionadas con las minorías sexuales y de género. Se discuten las implicaciones de estos hallazgos para la prevención del suicidio en la población brasileña.

Palabras clave: Suicidio; Depresión; Minorías sexuales y de género.

Bullying, discrimination, prejudice, rejection, and lack of support are frequent experiences for gays, lesbians, transgender individuals, and other gender and sexual minorities. Non-heterosexual individuals often face heightened feelings of insecurity, sadness, and hopelessness, leading to a higher prevalence of suicide risk, self-injury, substance abuse, and other mental health challenges within the LGBTQIA+ population (e.g., Crane et al., 2020; Dickey, 2020; Francisco et al., 2020; Londero-Santos & Natividade, 2025; Starks et al., 2020).

Cognitive behavioral therapy has been shown to be effective in addressing suicidal ideation and suicide attempts in diverse populations and can be applied in both clinical and community settings (Wu et al., 2022). However, the effectiveness of suicide prevention and intervention strategies depends on a clear understanding of the specific risk factors that influence suicide risk in different social and cultural contexts. Despite growing international research, there is a lack of empirical studies examining suicide risk factors among sexual and gender minorities in Brazil (Domene et al., 2022; Londero-Santos & Natividade, 2025). Therefore, this study aimed to investigate suicide risk in a Brazilian sample of sexual and gender minorities.

Sexual and gender minorities

People who identify as part of the LGBTQIA+ group constitute sexual or gender minorities (Reczek, 2020). While sex (e.g., male, female, intersex) is defined based on an individual's physical and biological traits, gender is defined based on sociocultural characteristics, including psychological and behavioral aspects (e.g., masculinity, femininity, nonbinary) (American Psychological Association, 2023a, b, c). People who constitute gender minorities have an identity that does not align with normative gender expectations (e.g., men or women). In contrast, sexual minorities are defined as people whose identity, attraction, or behavior does not conform to heterosexuality (e.g., gay, lesbian, bisexual, asexual, pansexual), and this minority status impacts the individual's access to resources and power (Reczek, 2020).

Sexual and gender minorities can face prejudice, discrimination, bullying, and rejection that are detrimental to mental health. In the Brazilian context, gay/lesbian and bisexual groups report higher levels of perceived prejudice and discrimination, reinforcing the relevance of these stressors for understanding mental health disparities among sexual minorities (Bastos et al., 2024). In a

transgender adult sample, Marquez-Velarde et al. (2023) found that 79% of the sample had suicidal ideation, and suicide probability increased from .35 for people who had no family rejection to .75 for people who experienced all five listed types of family rejection. Similarly, Enderwitz et al. (2024) found that parental rejection was positively associated with depression, anxiety, and stress in an adult sample. Additionally, Blais et al. (2014) found that homophobic bullying influences self-esteem, Freitas et al. (2015) found that unfair treatment is negatively associated with mental health, and Martell (2019) exposed how these minorities can face everyday stressors with unintentional microaggressions.

Consequently, LGBTQ+ adolescents tend to present poorer academic performance, less desire to finish school, and higher anxiety, depression, and suicidal thoughts (Chan et al., 2022), and sexual minorities have a higher prevalence of suicidal behavior when compared to heterosexual populations. Studies demonstrate that the prevalence of suicidal ideation in the LGBTQ+ population have been reported as 20.8%, while the prevalence of suicidal ideation has reached up to 67%, while in the general population, the variation was from 1.8% to 5.6% (Bacchi et al., 2024; Suen et al., 2018). In sum, sexual and gender minorities are a group at risk for the development of mental health issues.

Haas and Mortali (2020) have stated that numerous studies have found higher suicide attempt rates for sexual and gender minorities, and that explanations for these rates lie in Meyer's (2003) minority stress model. The individual is frequently exposed to stress, rejection expectations, and internalized stigma. Hence, throughout the world, sexual and gender minorities present high rates of self-harm and suicide attempts (Pantalone et al., 2019). Experiencing this prejudice can lead to the development of cognitive distortions, such as mind reading, personalization, and mental filter, which increase isolating and conflicting behaviors even in the context of no physical or mental integrity risk (Trujillo & Bertulino, 2024).

Along with suicide risk, stigma, discrimination, and early life adversity in sexual and gender minorities can increase depression symptoms (Chodzen et al., 2020), and minority stress can facilitate the development and maintenance of suicidality, self-harm, and borderline personality disorder symptoms (Pantalone et al., 2019). This means that these patients have specific contextual characteristics that must be taken into account during psychological care, as well as factors that directly interfere with the suicide risk of this population. Thus, practices such as cognitive behavioral therapy for social minorities and affirmative cognitive behavioral therapy are being considered (Paveltchuk et al., 2024; Rocha & Pucci, 2023).

Influence on suicide risk

Several factors can affect suicide risk, including gender, age, social context, marital status, occupation, trauma, drug use, and personality (Turecki et al., 2019). While some are considered risk factors, such as social isolation and workplace violence, others are considered protective factors, such as social support, self-esteem, and resilience (Hanson et al., 2023; Holman & Williams, 2020; Masango et al., 2008; McClelland et al., 2023; Newcomb & Mustanski, 2010). However, depression seems to be the most central risk factor for suicide risk (Holman & Williams, 2020). Multiple aspects that can increase suicide risk are hopelessness, pessimism, polarized thinking, and perceived burdensomeness (Holman & Williams, 2020; Masango et al., 2008; Ribeiro et al., 2018), which are depression symptoms (American Psychiatric Association, 2023; Matos & Oliveira, 2013).

Other factors that can influence suicide risk

can be specific to sexual and gender minorities. Internalized homophobia is one of these factors and can be defined as the process of directing societal homophobic attitudes toward oneself (Meyer, 2003). In previous studies, internalized transphobia predicted Generalized Anxiety Disorder symptoms (Chodzen et al., 2019). In addition, internalized homophobia was associated with depressive symptoms only for LGB adults in South Korea between 40 and 69 years old, but not for younger people between 19 and 29 years old (Lee et al., 2019), positively associated with anxiety and depression symptoms, and negatively with life satisfaction in a Chilean sample (Gómez et al., 2021), and positively correlated with depressive symptoms and suicidal ideation in Australian gay men and lesbian women, but not in bisexual women (McLaren, 2016).

Sex/gender congruence is another factor that can influence suicide risk. Gender orientation refers to a person's psychological sense of self in relation to their gender, influenced by biological and environmental factors (APA, 2023), such as women, non-binary, men, fluid gender, or agender. The sense of being a specific gender does not necessarily correspond to the sex assigned at birth. Hence, in this paper, sex/gender congruence can be defined as the convergence of gender identity with birth sex. It can range from extreme agreement with biological sex to extreme disagreement with it (Cotian et al., 2003; Natividade & Hutz, 2016). Thus, people can vary in the levels of the Typified factor (how much one agrees with one's birth sex) and the Mixed factor (how much one disagrees with one's birth sex). Previous studies have shown how appearance congruence with gender identity predicts symptoms of Major Depressive Disorder (Chodzen et al., 2019).

Finally, connectedness to the LGBTQIA+ community can also influence suicide risk. Previous studies have found connectedness to be a protective factor for suicide. For example, community connection was linked to personal growth (Szymanski et al., 2023), and participating in the LGBTQ community is associated with greater well-being (Toh et al., 2023).

Suicide evidence-based interventions typically increase protective factors and reduce risk factors for suicide. In this sense, enhancing protective factors such as problem-solving, conflict resolution, stress management, frustration tolerance, and social support, while reducing mental health difficulties, occupational stress, financial pressure, and relationship conflicts, is crucial (Ewing et al., 2020). Cognitive-behavioral therapy for suicide reduction uses thought records, behavioral experiments, and problem-solving training to target suicide-related cognitions and impulsivity, along with suicide event chain analysis, safety planning, and focused skills training (Tong et al., 2025). Third-wave cognitive-behavioral therapy approaches also incorporate techniques such as emotion regulation, interpersonal effectiveness, and mindfulness to support relapse prevention. Accordingly, incorporating the specific risk factors of the LGBTQIA+ population increases the effectiveness of these interventions.

Present study

The LGBTQIA+ population is at mental health risk (e.g., Chan et al., 2022; Meyer, 2003). Few quantitative studies have been made entirely with gender and sexual minorities in a Brazilian context, and exploring sexual and gender-related variables, in addition to depression, a prominent suicide risk factor, can provide helpful information about how being part of LBTQIA+ is related to suicide risk. In this sense, knowing the factors that most influence suicide risk can help formulate prevention interventions in specific target variables, where there is a lack in Global South countries (Silva et al., 2021).

Chodzen et al. (2020) highlight how much of what is known about depressive disorders in sexual and gender minorities has its origin in high-income countries, and countries in the Global South are susceptible to higher depression rates due to exposure to stressors such as hate speech and violence. Similarly, Dickey (2020) argued that understanding the mental health of people in the Global South is an urgent need, as we still do not know whether evidence-based treatment guidelines and approaches, largely formulated in Europe and North America, have the same effect in Latin America. In 2019, a total of 2,361 reports of human rights violations against LGBTQIA+ individuals were recorded in Brazil, including public humiliation, physical violence, and discrimination (Neivas & Baptista, 2022). Finally, Cerezo et al. (2020) recommend studying social factors related to resilience and positive mental health outcomes, including the community, in studies with sexual and gender health minorities from Latin America, and exposed how, although there are advances in antidiscrimination laws in Brazil, it is still the country with the highest rates of violence against sexual minorities.

It remains unclear which sexual and gender minority groups are at the greatest risk of suicide and how this risk varies according to demographic characteristics (Haas & Mortali, 2020). Given the critical role of research in advancing clinical care for sexual and gender minority populations (Hancock & Haldeman, 2020), investigating suicide risk among these populations is essential. Hence, the present study aimed to test relations between suicide risk, sex/gender congruence, depression, connectedness to the LGBTQIA+ community, and internalized homophobia. In addition, a predictive model of suicidal ideation among LGBTQIA+ individuals was tested, examining whether internalized homophobia and gender congruence predict suicidal ideation through the mediating role of depressive symptoms. It was expected that suicide risk would be associated negatively with (H1) the Typified factor and (H2) connection to the LGBTQIA+ community, and positively with (H3) the Mixed factor, (H4) depression, anxiety, and stress, and (H5) internalized homophobia.

Method

Participants

Participants were 411 Brazilian adults, with a range of 18 to 71 years old and a mean age of 27.9 years old (*SD*=9.81). All participants identified as gender/sexual minorities. Participants were asked to declare their sex according to their birth certificates. 34.3% were from the masculine sex, and 65.7% were feminine. Descriptive data are shown in Table 1.

Tabela 1. *Sociodemographic Data.*

Education	
Complete college degree	15.1%
Complete high school	33.3%
Complete technical school	9.7%
Complete elementary school	0.7%
Race/Ethnicity	
White	66.7%
Brown	18.7%
Black	10.9%
Yellow	1.9%
Indigenous	0.5%

Prefer not to declare	1.2%
Sex	
Masculine	34.3%
Feminine	65.7%
Gender	
Men	33.8%
Women	51.1%
Non-binary	9.5%
Transgender men	7.3%
Queer gender	3.2%
Fluid gender	2.9%
Agender	2.7%
Transmasculine	2.7%
Transgender women	1.0%
Transfeminine	0.5%
Other	1.0%
Sexual orientation	
Bissexual	38.2%
Gay	23.0%
Lesbian	15.1%
Pansexual	12.9%
Queer	2.9%
Asexual	2.4%
Heterosexual	2.2%
Demisexual	1.9%
Other	1.5%
Country region	
Southeast	55.0%
South	22.9%
Northeast	10.7%
Center-West	4.6%
North	3.4%
Outside Brazil	3.4%

Instruments

The instrument comprised an online questionnaire featuring sociodemographic questions (e.g., gender identity, sex, age, and education) and the following scales:

Paykel Suicide Scale (PsS; Paykel et al., 1974). The scale comprises five items to assess suicide risk. Respondents must sign 1=Yes or 0=No to questions such as "Have you ever tried to take your own life?". Higher scores indicate higher suicide risk. Cronbach's alpha for the present sample was .83.

Sex/Gender Congruence Scale – ConGen (*omitted to preserve the author's identity*): Scale composed of 18 items utilized to assess the individual's identification with the sex declared when they were born. Higher scores in the Typified factor indicate higher proximity to the birth sex, while higher scores in the Mixed factor indicate less proximity to the birth sex. Respondents must sign from 1 to 7 how much they agree with each affirmative. Item examples are "Most of the people from my sex think a lot like me" and "I look more similar to the people from my opposite sex". Cronbach's alpha for the present sample = .93 for the Typified factor and .89 for the Mixed factor.

Depression, Anxiety, and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995, Vignola & Tucci, 2014): Scale composed of 21 items to check depression, stress and anxiety levels.

Respondents must sign from 0= Does not describe me in anything to 3= "Describes me perfectly well or most of the time, how much each affirmative describes them. Item examples are "I felt that life was meaningless" and "I was unable to become enthusiastic about anything." Cronbach's alpha for the present sample was .92 for depression, .89 for anxiety and .91 for stress.

Connectedness to the LGBT Community Scale (Frost & Meyer, 2012). Scale composed of eight items to evaluate the connectedness with the LGBTQIA+ community. The respondent must sign from 1 = Strongly Disagree to 4 = Strongly Agree how much they agree with each item, such as "You are proud of the LGBTQIA+ community" and "You feel a bond with other LGBTQIA+ people". Higher scores represent higher connectedness. Cronbach's alpha for the present sample was .87.

Internalized Homophobia (IHP; Martin & Dean, 1987). Scale composed of five items to assess internalized homophobia, such as "I tried to stop feeling attraction for people of the same gender as I am". Respondents must sign from 1 = Strongly Disagree to 5 = Strongly Agree. Cronbach's alpha for the present sample was .58.

Procedures

Data collection and ethical considerations

Participants answered an online questionnaire in the SurveyMonkey platform. Data was collected from June to September 2021. Participants were invited via email and social media. The invitations explained the research and provided the link to access the questionnaire. Furthermore, the research was requested to be disseminated among other potential participants (snowball procedure). The criteria for participation were being Brazilian, literate, 18 years old or older, and identifying as a sexual or gender minority.

After participants were informed about the research, they signed the Free and Informed Consent Form in accordance with the ethical guidelines for research involving human beings set forth in Resolution 510/16. The Comitê de Ética e Pesquisa - CEP UNISUAM also approved the research under protocol number CAAE: 46234921.7.0000.5235.

Data analysis

Initially, the data was cleaned. Participants were excluded if they failed an attention check item (e.g., "Please select response option number three"), which was included to ensure data quality by identifying participants who were attentive to their responses. Participants were not excluded for incomplete questionnaires; therefore, completion of the full survey was not required for inclusion in the analyses. Next, Pearson correlation coefficients were calculated between the study variables (suicide risk, gender orientation, depression, anxiety, stress, connectedness and internalized homophobia). The Variance Inflation Factor (VIF) was inspected to verify the existence of multicollinearity.

A Structural Equation Modeling (SEM) was also performed to test the following model: three exogenous independent variables (typical gender orientation, mixed gender orientation, and internalized homophobia) that impact depression, the latter impacting the risk of suicide. The estimator used was the Weighted Least Squares Mean and Variance adjusted (WLSMV), given the ordinal nature of the variables. In this study, values above .95 are considered adequate for comparative fit index (CFI), Tucker-Lewis Index (TLI) (Hu & Bentler, 1999), while an Root Mean Square Error of Approximation (RMSEA) value below .06 indicates a good model fit (Xia & Yang, 2019).

Analyses were conducted in Jamovi version 2.3.26 (The jamovi project, 2023) and R version 4.6.0 (R Core Team, 2025) using the following packages: psych (Revelle, 2024) for descriptive statistics and reliability analyses, lavaan (Rosseel, 2012) for path analysis, and tidySEM (Van Lissa,

2023) for path model visualization. Data can be made available upon reasonable request.

Results

The correlation coefficients found between suicide risk, sex/gender congruence, depression, connectedness to LGBTQIA+ community, internalized homophobia, and age can be seen in Table 2. Suicide risk was negatively correlated with the typified factor of sex/gender congruence and age, and positively correlated with the mixed factor of sex/gender congruence, depression, and internalized homophobia.

Tabela 2. *Correlations between Suicide Risk, Gender Orientation, Depression, Anxiety, Stress, LGBTQIA+Connectedness, Internalized Homophobia and Age*

	1 *n*=356	2 *n*=263	3 *n*=264	4 *n*=356	5 *n*=356	6 *n*=356	7 *n*=351	8 *n*=356
1. Suicide Risk	-							
2. Typified Gender Orientation	-.23***	-						
3. Mixed Gender Orientation	.24***	-.62***	-					
4. Depression	.60***	-.19**	.17**	-				
5. Anxiety	.48***	-.11	.13*	.72***	-			
6. Stress	.45***	-.13*	.11	.70***	.82***	-		
7. Connectedness	-.07	-.12	.13*	-.12*	-.04	-.07	-	
8. Internalized Homophobia	.23***	-.03	.04	.33***	.25***	.25***	-.18***	-
9. Age	-.19***	.13*	-.08	-.18***	-.25***	-.19***	-.14*	-.09

Note. Connectedness = LGBTQIA+ Connectedness. *p < .05 **p < .01 ***p < .001

Based on the results of the correlation analysis, a structural equation modelling (SEM) was conducted to examine the direct and indirect effects of the variables on suicide risk. Given that the model was just-identified ($\chi^2(0, n = 260) = 0$, df = 0), fit indices indicated perfect fit by definition (CFI = 1.00, TLI = 1.00, RMSEA = .00, SRMR = .00) and are therefore not interpreted. Estimates from the tested model are shown in Figure 1. The model was able to explain approximately 15% of the variance in depression and 40.3% of the variance in suicide risk. The indirect effect of internalized homophobia on suicide risk via depression was significant (β = .19, 95% CI [.12, .26]), whereas the indirect effects of typified sex/gender congruence (β = −.07, 95% CI [−.16, .02]) and mixed sex/gender congruence (β = .05, 95% CI [−.03, .14]) were not significant, suggesting complete mediation of the internalized homophobia–suicide risk relationship through depression.

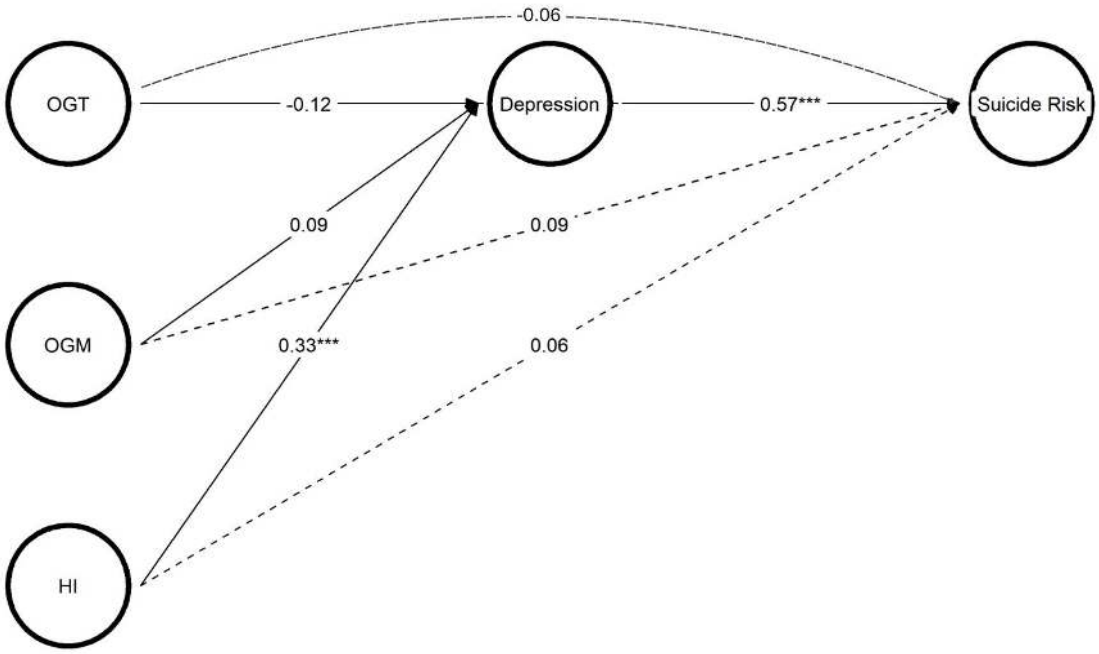
Discussion

The present study aimed to test relations between suicide risk, sex/gender congruence, depression, connectedness to the LGBTQIA+ community, and internalized homophobia, to acknowledge more about suicide risk among sexual and gender minorities. We tested a structural equation model of suicidal ideation among LGBTQIA+ individuals, examining whether internalized homophobia and gender congruence predict suicidal ideation through depressive symptoms.

First, our results show that suicide risk is positively correlated with depression. This result is aligned with previous studies that underlined depression as a suicide risk factor (e.g., Holman & Williams, 2020; Lew et al., 2019; Pimentel et al.,

2020). Additionally, suicide risk was also significantly correlated with factors related to sexual and gender minorities. Specifically, internalized homophobia and mixed sex/gender congruence were positively correlated with suicide risk, while typified sex/gender congruence was negatively correlated. Hence, higher internalized homophobia and higher disagreement with the birth sex are associated with a higher suicide risk. Although results tend to vary depending on the minority group studied, previous studies have shown internalized homophobia associated with numerous mental health symptoms, such as anxiety and depression, as well as negative relation with life satisfaction, an important component of well-being (Gómez et al., 2021; Lee et al., 2019; McLaren, 2016; Newcomb & Mustanski, 2010; Wang et al., 2021; Yolaç & Meriç, 2020), and these findings are replicated for internalized transphobia (Chodzen et al., 2019; Scandurra et al., 2018). This means that internalized prejudice can have severe consequences for sexual and gender minorities.

Figure 1. Structural Model for Predicting Suicide Risk



Note. Standardized estimates using the WLSMV estimator. OGT = Typified gender orientation; OGM = Mixed gender orientation; HI = internalized homophobia. *** $p < .001$.

The correlations regarding higher incongruence with the biological sex, positively associated with suicide risk, indicate how gender minorities can be at a higher risk for suicide attempts or ideation. This corroborates previous studies that found gender minorities have higher rates of suicidal ideation and attempted suicide compared to cisgender people (Horwitz et al., 2020). One possible explanation for the higher risk in this group is that people whose gender does not correspond to their sex at birth or who must reveal and assume their gender identity, once it is not considered natural or obvious, have to look closely at themselves and reflect on their own identity. Thus, greater introspection could relate to depression and suicide. Moreover, less congruence with the biological sex can generate a sense of inadequacy or as if something is wrong with the individual,

especially in cases where there are prejudices, stigma, and a lack of support. Qualitative studies could investigate these possible explanations in future research.

Connectedness to the LGBTQIA+ community was not related to suicide risk. We expected a negative association (H2), as identification with and support from the LGBTQIA+ community could potentially serve as protective factors against suicide risk and show a buffer effect. However, the present findings did not support this hypothesis. Thus, being proud of the LGBT community, being active, and feeling a part of it were not associated with lower or higher suicide risk. Previous studies found LBTQIA+ community connectedness positively associated with well-being (Roberts & Christens, 2020), but other studies also found no correlation between connectedness to the LGBTQIA+ community and suicide ideation (Rogers et al., 2021). The relationship between community connectedness and suicide risk may operate through other mediators, such as identity affirmation (Parmenter et al., 2025), sense of belonging (Penfold et al., 2025), and the consumption of cultural and news media featuring LGBTQIA+ representation (Wootton et al., 2024). Future research can test this and further understand this relationship.

In addition, in the Brazilian context, Pereira (2019) describes how the LGBTQ movement emerged in São Paulo in the late 1970s, initially composed primarily of gay men. Over time, other sexual and gender minority groups joined the movement. However, when some members felt underrepresented, new groups and organizations emerged, contributing to the diversification of the broader LGBTQ movement. As a result, the Brazilian LGBTQ movement is characterized by multiple organizations, agendas, and forms of leadership rather than a single unified national structure. Furthermore, the movement has historically sought to promote public dialogue and advocate for the human rights of sexual and gender minorities. These characteristics may help explain the present findings. For example, it is unclear whether all LGBTQIA+ individuals feel equally represented by or connected to the broader community. Consequently, community connectedness may vary substantially across individuals and groups.

Nevertheless, structural equation modeling indicated that sex/gender congruence did not significantly predict suicide risk, either directly or indirectly through depression. Hence, simply being a gender minority is not, by itself, a suicide risk factor. For this reason, health professionals should be aware of the elevated rates of mental health issues among sexual and gender minorities. However, the notion that they should be especially attentive to suicide risk when treating gender minorities may unintentionally reinforce stigma and prejudice against these groups.

Data from this study indicate that depression is a stronger predictor of suicide risk than specific sexual and gender minority–related variables. Our findings show that the association between suicide risk and internalized homophobia is fully mediated by depressive symptoms, whereas the indirect effects of sex/gender congruence on suicide risk via depression were not significant. These results suggest that the interplay between depression and internalized homophobia, a key minority stress process, provides a more comprehensive explanation of suicide risk than minority status indicators such as sex/gender congruence alone. In addition, internalized homophobia was the only significant predictor of depression among the variables examined ($\beta = .33$, $p < .001$), whereas sex/gender congruence did not significantly predict depression. Taken together, these results underscore the central role of depression as a proximal and modifiable risk factor,

highlighting the importance of depression-centered interventions that can be empirically tested in future studies and implemented in clinical settings to reduce suicide risk among sexual and gender minority individuals.

Screening for depression has been widely recommended across age groups (Barry et al., 2023; Viswanathan et al., 2022). However, evidence remains insufficient to conclude that universal suicide risk screening yields benefits that consistently outweigh potential harms. Given that approximately 800,000 people die by suicide each year worldwide (World Health Organization, 2019), the development of effective assessment strategies remains a critical clinical priority (Masango et al., 2008). In line with cognitive-behavioral models, our findings suggest that, among sexual and gender minority adults, depressive symptoms constitute a more central indicator of suicide risk than sexual and gender minority–related variables alone, although internalized homophobia provides additional clinically relevant information. From a cognitive behavioral therapy perspective, internalized homophobia can be conceptualized as a maladaptive cognitive schema that contributes to depressive symptomatology and, indirectly, to suicide risk. While some authors argue that suicide risk screening may identify individuals not detected through depression measures alone (Kemper et al., 2021), our results support the inclusion of internalized homophobia measures alongside standardized depression instruments to inform case formulation and intervention planning. This approach aligns with core cognitive behavioral therapy principles by targeting modifiable cognitive processes and offers a clear pathway for designing and testing depression-centered interventions aimed at reducing suicide risk in clinical settings. In contrast, connectedness to the LGBTQIA+ community and sex/gender congruence measures do not seem to be effective in assessing suicide risk, and future studies can confirm these findings.

Martell (2019) suggested that being prepared to provide care with the greatest efficacy is the first step of affirmative therapy with sexual and gender minorities. The author highlights how therapists must be aware of biases, therapists' own privilege, limitations in their ability to respect, and recognize that diversity is part of human identity and behavior. Besides, it can be beneficial for therapists treating sexual and gender minorities at risk of suicide to help patients develop protective factors that buffer negative health issues, such as positive identity, coping skills, peer and community support, and emotional regulation skills (Dickey, 2020; Haas & Mortali, 2020; Pantalone et al., 2019). Intending to increase efficacy in Brazilian sexual and gender minority treatment, our data suggest that interventions to minimize internal homophobia and utilize guidelines for depression treatment can help decrease suicide risk. Future experimental and treatment studies can test these hypotheses more effectively.

For the development of public health policies, the findings of this study suggest strengthening depression screening strategies and implementing preventive actions aimed at reducing stigma and discrimination, particularly to decrease internalized homophobia. In this regard, training healthcare professionals to administer open-access depression screening instruments within the population may be a powerful tool. Meanwhile, interventions specifically targeted at the LGBTQIA+ population may focus on reducing internalized homophobia, for example, by promoting greater acceptance of emotional experiences, cognitive defusion, self-compassion, and self-kindness (Wu et al., 2026), sexual strategies explanation (Gao et al., 2023), and support (Dawes et al., 2024).

For professional training, it is important to reinforce the need to consider the patient's

sociocultural context (American Psychological Association, Presidential Task Force on Evidenced-Based Practice, 2006) while avoiding stigmatization or reducing all experiences to this aspect alone. In courses on suicide prevention and management, it may be valuable to train professionals to assess minority stressors and screen for depressive symptoms, in addition to learning evidence-based approaches to suicide risk management. Healthcare professionals should also remain attentive to their own biases and strive to use non-pathologizing language.

It is important that suicide-focused interventions are conducted in a respectful manner, without reinforcing stigmas or stereotypes about the LGBTQIA+ community, and that they address multiple factors influencing suicide. Here, we highlight the role of depression and internalized homophobia in a model explaining suicide risk. These findings suggest that, in cases of suicide, health professionals should assess depression and internalized homophobia, and that evidence-based cognitive-behavioral techniques for depression, such as behavioral activation and cognitive restructuring, may be applied (Hundt et al., 2013). Future studies could also examine how incorporating psychoeducation based on the minority stress model may help reduce internalized homophobia, as well as the use of affirmative or minority-focused therapy for the same purpose.

This study has limitations. It is a correlational and cross-sectional study, with only self-report measures. Hence, we cannot affirm causality between the variables. Additionally, most of the sample identified as white and came from the Southeast and South regions of Brazil. Therefore, the findings can only be generalized to samples with similar characteristics. For example, rates of homophobic violence vary across regions of Brazil, and this variation may reflect other demographic characteristics, such as regional human development indices (Mendes & Silva, 2020) and access to healthcare services, which provide treatment for suicide risk, is also unequal across regions, with more limited access in rural areas (Magalhães et al., 2022). Therefore, greater representation from other regions could influence the findings. Furthermore, we did not control for the presence of comorbidities or other mental disorders, which may act as confounding variables in the observed relationships.

A limitation of this study concerns the internal consistency of the internalized homophobia measure. The five-item Internalized Homophobia Scale (Martin & Dean, 1987) yielded a Cronbach's alpha of .58, below the recommended threshold of .70 (Nunnally, 1978). This scale was originally developed with cisgender gay men (Herek et al., 2009), which may limit its applicability to the diverse sample included here, encompassing bisexual, pansexual, transgender, and non-binary individuals. Indeed, currently available measures of internalized homophobia may not accurately capture this construct among transgender and nonbinary individuals (Huynh et al., 2025). Future studies should consider instruments validated specifically for diverse gender and sexual minority populations.

Future studies could further include protective factors, such as social support and resilience. Longitudinal studies are encouraged, as well as the use of implicit measures (e.g., Carvalho et al., 2023), especially because self-report assessments may be affected by social desirability, self-image management, and limited awareness of socially undesirable characteristics. Also, important variables were not included, such as prejudice and discrimination experiences and perceptions (Bastos et al., 2024), internalized transphobia, and personality factors (e.g., neuroticism), which could be included as future additional mediators to explain differences in suicide risk of sexual and gender minorities. Still, this study was able to advance in promoting data about the sexual and gender

minorities' suicide risk in a Brazilian sample and the effects of depression and sexual and gender-specific variables. This study draws attention to the treatment of minorities aimed at depression and internal homophobia instead of treatments that reinforce stigma or have no scientific evidence.

Declaração de Contribuição de Autoria CRediT

José Candido Pereira Neto - Conceptualization, Data curation, Methodology.

Daniela Zibenberg- Writing original draft.

Miriã Barbosa Tebas - Formal analysis, writing original draft.

Amanda Londero-Santos - Formal analysis

Jean Carlos Natividade- Conceptualization, Methodology, Supervision.

Declaração de Conflito de Interesses

Authors José Candido Pereira Neto, Daniela Zibenberg, Miriã Barbosa Tebas, Amanda Londero-Santos and Jean Carlos Natividade declare no conflict of interest.

Nota dos autores:

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