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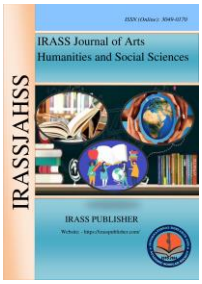

MINORITY STRESSORS AND SUICIDAL IDEATION AMONG GENDER AND SEXUAL MINORITIES IN CROSS RIVER STATE, NIGERIA: THE MEDIATING ROLE OF PERCEIVED

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Abstract: Gender and sexual minorities (GSM) face significant discrimination, stigma, and marginalization, which can lead to negative mental health outcomes, including suicidal ideation. This study examined the relationship between minority stressors (microaggressions, perceived stigma, and internalized homophobia) and suicidal ideation among gender and sexual minorities in Cross River State. Additionally, the moderating role of perceived family support on this relationship was investigated. A cross-sectional survey design was used to collect data from a sample of 129 gender and sexual minority individuals. Data were collected using the following instruments: the LGBTQ+ Microaggressions Scale (LMS), the Gender and Sexual Minority Stigma Scale (GSMSS), the Internalized Homophobia Scale (IHS), and the Beck Scale for Suicidal Ideation (BSS). Perceived family support was measured using a modified version of the Family Support Scale. Data were analyzed using hierarchical multiple regression analysis, with perceived family support entered as a moderator variable. The results showed that microaggressions did not significantly predict suicidal ideation (β = -.070; t = -.91; P >.05). However, perceived stigma (β =.17; t = 2.010, P <.05) and internalized homophobia (β =.17; t = 2.07, P <.05) were significant predictors of suicidal ideation. Furthermore, perceived family support was found to moderate the relationship between minority stressors and suicidal ideation, such that individuals with higher levels of perceived family support experienced lower levels of suicidal ideation in response to minority stressors. The findings indicate that tackling minority stressors and enhancing perceived family support could be crucial strategies for lowering suicidal ideation among gender and sexual minorities. The study's outcomes have significant implications for creating interventions and programs focused on improving the mental health and well-being of gender and sexual minorities.

Keywords: Minority stressors, Suicidal ideation, Gender and Sexual Minorities, Perceived family support.

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Introduction

Gender and sexual minorities (GSM), including lesbian, gay, bisexual, transgender, and other non-heteronormative individuals, experience discrimination and stigma across various societal domains. This marginalization contributes to significant mental health disparities, with GSM individuals facing a heightened risk of issues such as anxiety, depression, and suicidal ideation compared to their heterosexual and cisgender peers (Meyer, 2003; Russell & Fish, 2016).

Suicidal ideation is one of these outcomes that is particularly concerning because it has a significant effect on the mental health and general wellbeing of people with GSM (Russell & Fish, 2016). According to Silverman et al. (2007), suicidal ideation encompasses a range of thoughts and contemplations on taking one's own life, which might differ in frequency and intensity. It includes active planning, which entails determining a time and manner for attempting suicide, as well as passive ideas, such the wish to avoid waking up (Klonsky et al., 2016; Zeluf et al., 2016). Suicidal thoughts is a sign of extreme psychological suffering and is thought to be a major risk factor for suicide attempts (Nock et al., 2008; Plöderl & Tremblay, 2015). Suicidal ideation is frequently made worse in the setting of gender and sexual minorities (GSM) by minority stressors, such as internalized homophobia, stigma, and discrimination (Meyer, 2003). Compared

to heterosexual and cisgender people, these characteristics increase the likelihood of mental health problems and suicide ideation (Marshal et al., 2011; King et al., 2008). Studies show that the prevalence of suicide thoughts is much greater among GSM people because of common stressors that are specific to this population (Haas et al., 2011; Plöderl & Tremblay, 2015).

According to minority stress theory, GSM people have particular stressors because they are marginalized, which may result in inequities in mental health (Meyer, 2003). Internalized homophobia, perceived stigma, and microaggressions are the three primary categories into which these stresses fall. According to Su et al. (2016Microaggressions are subtle, often unintentional, discriminating statements or behaviors that give persons with GSM a bad or derogatory impression. These behaviors might be environmental, verbal, or nonverbal slights that convey animosity or invalidation despite their seeming insignificance (Nadal et al., 2011). Being misgendered or hearing offensive jokes are examples of microaggressions, which are common and can happen in casual interactions. Over time, these incidents can cause psychological distress and accumulative stress (Nadal, 2013; Platt & Lenzen, 2013). Continuous exposure to microaggressions can contribute to feelings of alienation and marginalization, which negatively impact the mental health and well-being of GSM individuals (Nadal et al., 2016).

Perceived stigma refers to the awareness and anticipation of negative societal attitudes and discrimination based on one's sexual orientation or gender identity (Herek, 2009). This awareness can lead to chronic stress, as individuals anticipate and experience prejudice and rejection in various social contexts (Pachankis et al., 2015). Perceived stigma can create a hostile environment where GSM individuals feel constantly vigilant and unable to express their identities freely, impacting their psychological well-being (Baiocco et al., 2016; Schmitz et al., 2020). Internalized homophobia involves the internalization of negative societal attitudes and beliefs about one's own sexual orientation or gender identity, leading to self-stigma and psychological distress (Meyer, 1995). This internalization can manifest as self-hatred, shame, or denial of one's identity, contributing to negative mental health outcomes such as depression and anxiety (Szymanski et al., 2008; Newcomb & Mustanski, 2010). Internalized homophobia is particularly damaging as it perpetuates negative self-conceptions and inhibits the development of a positive self-identity, making it difficult for individuals to form healthy relationships and support networks (Kashubeck-West et al., 2017; Feinstein et al., 2019).

Research indicates that these minority stressors are linked to negative mental health outcomes, including anxiety, depression, and suicidal ideation (Bostwick et al., 2014; Russell & Fish, 2016). Suicidal ideation, the consideration or planning of suicide, is a particularly alarming outcome, as it reflects severe psychological distress and can lead to suicide attempts (Baams et al., 2015). Compared to their heterosexual and cisgender peers, GSM people are more likely to experience suicide thoughts (Marshal et al., 2011).

In Nigeria, gender and sexual minorities (GSM) face substantial challenges due to cultural and legal factors. The country's legal system criminalizes same-sex relationships, while societal attitudes often reflect deep-rooted homophobia and transphobia (Eze, 2020). These conditions exacerbate the minority stress experienced by GSM individuals, resulting in heightened levels of psychological distress and suicidal ideation (Okanlawon, 2018). Minority stressors, such as discrimination and stigma, create an environment where GSM individuals frequently encounter rejection and hostility, intensifying mental health challenges.

Family support is a crucial protective element that might lessen the detrimental impacts of minority stresses on mental health outcomes, according to research (Ryan et al., 2010; Chu et al., 2010). A person's sense of emotional and practical support from family members, which fosters a sense of acceptance and belonging, is known as perceived family support (Chu et al., 2010). Family support can be extremely important for GSM individuals in fostering psychological well-being and resilience while lessening the effects of stigma and prejudice (Snapp et al., 2015). However, the degree and efficacy of perceived family support might differ greatly, impacting its protective ability, in places like Nigeria, where social and familial acceptance of GSM users is frequently restricted.

Despite the critical impact of these factors on suicidal ideation, research is limited in addressing the specific mechanisms through which these stressors influence suicidal thoughts and behaviors. Furthermore, the moderating role of perceived family support in mitigating these effects remains underexplored. This study aims to bridge this gap by examining the relationships between minority stressors, suicidal ideation, and the potential buffering effect of family support.

Hypotheses

- **H_1:** Microaggression, perceived stigma, internalized homophobia, and family support will independently and jointly predict suicidal ideation among gender and sexual minorities in Cross River State.
- **H_2:** Family support will moderate the relationship between microaggression, perceived stigma, and internalized homophobia on suicidal ideation among gender and sexual minorities in Cross River State.

Theoretical Framework

A comprehensive framework for understanding the mental health challenges faced by gender and sexual minorities (GSM) is offered by Meyer's (1995) Minority Stress Theory. This concept states that due of their minority status, members of marginalized groups experience distinct pressures than the mainstream population (Meyer, 2003). These stressors include both exterior (such discrimination, microaggressions, and perceived stigma) and internal (like internalized homophobia) components (Meyer, 1995). The theory states that these stressors lead to increased psychological suffering and negative mental health consequences, such as thoughts of suicide.

Minority Stress Theory emphasizes that these stressors are chronic and cumulative, meaning that their effects build up over time, leading to increased vulnerability to mental health issues (Hatzenbuehler, 2009). This cumulative stress can exacerbate feelings of hopelessness and worthlessness, which are closely linked to suicidal ideation (Meyer, 2003; Nock et al., 2008). The theory also highlights the role of protective factors, such as perceived family support, which can buffer the impact of minority stressors on mental health outcomes (Ryan et al., 2010). Perceived family support provides emotional and practical resources that help individuals cope with stress and reduce the psychological impact of discrimination and stigma (Chu et al., 2010; Snapp et al., 2015). By integrating the concept of minority stress with the role of family

support, this theory helps explain how the interplay between stressors and support systems influences suicidal ideation among GSM individuals. It underscores the importance of addressing both minority stressors and enhancing supportive networks to mitigate their effects on mental health (Meyer, 2015; Hatzenbuehler & Pachankis, 2016).

Empirical Review

The relationship between minority stressors and suicide thoughts among GSM populations is supported by empirical research. McLemore (2015) demonstrated how daily experiences of prejudice can accumulate and cause significant suffering by finding that transgender people who experienced microaggressions were more likely to have mental health problems, including suicidal thoughts. Furthermore, Hatzenbuehler's (2009) study demonstrated that felt stigma was a major predictor of mental health problems like depression and suicidality among lesbian, gay, and bisexual individuals. Internalized homophobia, which happens when persons internalize unfavorable societal sentiments against their identity, is another important minority stressor linked to an increase in suicidal thoughts. A 2010 study by Newcomb and Mustanski found that suicide thoughts were more common among young sexual minorities who had higher levels of internalized homophobia. It has also been underlined how crucial family support is as a protective factor. Underscoring the importance of a supportive home environment in reducing the detrimental impacts of minority stresses, research by Ryan et al. (2010) revealed that GSM youth who believed they had high levels of family support were less likely to have depression and suicidal thoughts.

Methods

Research Design

The links between minority stressors (internalized homophobia, perceived stigma, and microaggressions), perceived family support, and suicidal ideation among gender and sexual minorities (GSM) in Cross River State were investigated in this study using a cross-sectional survey approach. Multiple variables and their relationships might be evaluated simultaneously at one moment in time thanks to the design.

Participants

The study included 129 gender and sexual minorities residing in Cross River State. Participants were recruited through community organizations, social media platforms, and local support groups. Inclusion criteria required participants to self-identify as part of the GSM community and to be 18 years or older.

Materials

Data were collected using five validated instruments, each designed to measure specific constructs relevant to the study:

- **LGBTQ+ Microaggressions Scale (LMS)**: This measure, which was created by Nadal et al. (2019), evaluates experiences of gender and sexual minority-specific microaggressions. It assesses different types of subtle discrimination and has 29 items. Strong test-retest reliability (r =.89) and internal consistency (α =.92) have been shown for the LMS (Nadal, 2013).
- **Experiences of Discrimination Scale:** To assess each participant's perceived stigma, the Experiences of Discrimination Scale (King et al., 2007) was administered to evaluate general stigma experiences (see Appendix C). Originally designed for individuals with mental health diagnoses, this scale showed a significant correlation with self-esteem ($r = .63$, $p < .001$). While various scales exist for assessing stigma, most target ethnic minorities. At the time of data collection, a well-established stigma scale for sexual minorities was unavailable. Given that mental illness, like sexual orientation, is not always visible, the Experiences of Discrimination Scale was selected for this study to capture relevant experiences.
- **Internalized Homophobia Scale (IHS)**: The Internalized Homophobia Scale, developed by Wagner et al (1994, 1996), measures negative attitudes internalized by gay men about their sexuality. It consists of 20 items, scored on a 5-point Likert scale, with higher scores indicating greater internalized homophobia. The scale demonstrates high reliability with a Cronbach's alpha of .92. Validity is shown through correlations with mental health issues like demoralization ($r = .49$) and depression ($r = .36$).
- **Beck Scale for Suicidal Ideation (BSS)**: The BSS, created by Beck et al. (1979), evaluates the existence and intensity of suicidal ideation and ideas. The 21-item scale is frequently used in academic and clinical contexts. High concurrent validity and internal consistency (α =.89) have been shown for the BSS (Beck et al., 1993).
- **Family Support Scale**: This modified version of the Family Support Scale, based on Dunst, et al (1986), measures perceived emotional and practical support from family members. It includes 15 items and evaluates various dimensions of family support. The scale exhibits good internal consistency ($\alpha = .88$) and reliable construct validity (Chu et al., 2010).

Data Collection Procedure

Data collection took place at two main centres: the Initiative for Health and Equality (IHE) and the Initiative for Improved Male Health (IIMH). Before beginning the study, the research team, led by a social mobilization expert who is a member of the GSM community, met with the leads of these centres to discuss the study's purpose and objectives. After receiving their approval, the centres permitted data collection on their premises. For one month, the research team visited the centres daily to administer the research instruments to individuals as they came to receive services. The centre coordinators assisted in ensuring that individuals did not participate more than once, preventing duplicate participation. In addition to collecting data at the centres, a snowball sampling method was used. Participants who visited the centres connected us to others in their network, allowing us to reach a broader group of GSM individuals. Data from these participants were collected at convenient locations of their choosing to ensure comfort and privacy. Furthermore, the social mobilizer guided the research team to hotspots—social venues where GSM individuals typically gather to relax. These locations were recommended by center officials as ideal places to engage with the community.

Data Analysis

Hierarchical multiple regression analysis was used to assess the associations between suicidal ideation and minority stressors,

such as internalized homophobia, perceived stigma, and microaggressions. First, the primary effects of minority stressors on suicidal ideation were evaluated. Next, the moderator variable of perceived familial support was examined to see how it affected the association between minority stressors and suicidal ideation. Additionally, the bivariate associations between minority stresses, perceived family support, and suicidal ideation were examined using Pearson product-moment correlation coefficients. These correlations helped identify the strength and direction of associations between the variables before and after accounting for the moderating effect of perceived family support.

Ethical Considerations

To protect participant privacy and safety, the study complied with ethical standards. All participants gave their informed consent after being made aware of their freedom to leave the study at any moment without incurring any repercussions. Data was securely kept and responses were anonymised to ensure confidentiality. Access to mental health resources, such as the contact details of nearby counseling services, was also provided to participants in case their participation in the survey caused them any difficulty.

Results

Table 1: Demographic Data of Respondents

Variable	Category	Frequency	Percentage
Age	18-29 years	104	80.6%
	30 years and above	25	19.4%
Educational Attainment	SSCE	45	34.9%
	Diploma	33	25.6%
	Higher Diploma/Bachelor	34	26.4%
	Post Graduate Degree	17	13.2%
Gender Identity	Cis Male	65	50.4%
	Cis Female	36	27.9%
	Non-Binary	6	4.7%
	Trans Male	7	5.4%
	Trans Female	8	6.2%
	Prefer not to say	7	5.4%
Sexual Orientation	Gay	52	40.3%
	Lesbian	22	17.1%
	Bisexual	35	27.1%
	Pansexual	14	10.9%
	Asexual	6	4.7%

The age distribution showed that the majority of participants, 104 (80.6%), were aged between 18 and 29 years, while 25 (19.4%) of the participants were aged 30 years and above. In terms of educational attainment, participants with a Senior Secondary Certificate Examination (SSCE) made up 45 (34.9%) of the sample, while 33 (25.6%) held a diploma. Additionally, 34 (26.4%) had achieved a higher diploma or bachelor's degree, and 17 (13.2%) had attained postgraduate degrees. Gender identity among the participants showed significant diversity. The largest group was cisgender males, accounting for 65 (50.4%) of the sample, followed by cisgender females at 36 (27.9%). Non-binary individuals represented 6 (4.7%) of the participants, while trans males and trans females accounted for 7 (5.4%) and 8 (6.2%), respectively. Additionally, 7 (5.4%) of participants preferred not to disclose their gender identity. Regarding sexual orientation, gay individuals constituted the largest group at 52 (40.3%), followed by bisexual individuals at 35 (27.1%). Lesbians accounted for 22 (17.1%) of the participants, while pansexuals and asexuals made up 14 (10.9%) and 6 (4.7%), respectively.

Table 2: Correlation Matrix for Demographic and Psychosocial Variables Related to Suicidal Ideation

Variable	1	2	3	4	5	6	7	8	9	Mean	Std. Deviation
1										27.51	5.94
2	0.11									2.05	1.49
3	0.04	0.10								2.18	1.06
4	0.10	0.43**	0.14							2.22	1.22
5	0.12	0.19	-0.03	-0.07						36.87	10.82
6	0.09	-0.05	-0.04	-0.097	0.294**					63.42	21.06
7	0.04	0.03	-0.05	-0.043	0.153	-0.09				93.85	33.79
8	0.15	-0.20*	-0.15	-0.109	-0.28**	-0.12	0.02			40.33	12.43
9	0.06	0.02	0.03	0.033	0.18*	0.24**	-0.18*	-0.32**		26.95	9.27

Key: 1 = Age, 2 = Gender Identity, 3 = Educational Attainment, 4 = Sexual Orientation, 5 = Microaggression, 6 = Perceived Stigma, 7 = Internalized Homophobia, 8 = Family Support, 9 = Suicidal Ideation

The following correlations between variables are shown by the results in Table 2: Gender Identity (r = 0.11), Educational Attainment (r = 0.04), and Sexual Orientation (r = 0.10) did not significantly correlate with age. Suicidal ideation (r = 0.01) was not positively correlated with it, although microaggression (r = 0.12) and family support (r = 0.15) were. Gender Identity was significantly positively correlated with Sexual Orientation (r = 0.43**), but not with Suicidal Ideation (r = 0.00), Perceived Stigma (r = -0.05), Internalized Homophobia (r = 0.03), Microaggression (r = 0.12), Educational Attainment (r = 0.10), or Family Support (r = -0.19*). Sexual orientation and educational attainment were positively correlated (r = 0.14*). It did not significantly correlate with Suicidal Ideation (r = 0.03), Internalized Homophobia (r = -0.05), Perceived Stigma (r = -0.03), Microaggression (r = -0.07), or Family Support (r = -0.15). Microaggression and sexual orientation were significantly positively correlated (r = 0.43**), while family support and sexual orientation were slightly positively correlated (r = -0.11). Suicidal ideation (r = 0.03), internalized homophobia (r = -0.11), and perceived stigma (r = -0.07) did not significantly correlate with it. Internalized homophobia (r = 0.15*) and perceived stigma (r = 0.29**) were significantly positively correlated with microaggression. Suicidal ideation (r = 0.18) and family support (r = -0.28**) did not significantly correlate with it. Suicidal ideation (r = 0.24**) and internalized homophobia (r = -0.09*) were significantly positively correlated with perceived stigma. Internalized homophobia did not significantly correlate with suicidal ideation (r = -0.18*), but it did have a substantial negative connection with family support (r = -0.32**). Suicidal Ideation and Family Support showed a significant negative connection (r = -0.32**), indicating that lesser suicidal thoughts are associated with greater family support.

Table 3: Multiple Regression Model Showing the Predictive Role of Minority Stressors and Family Support on Suicidal Ideation among GSM in Cross Rivers State

	R	***R²***	***F***	***P***	***β***	***t***	***P***
Predictors	*.417*	*.17*	*6.51*	*< .05*			
Microaggression					.08	-0.91	> .05
Perceived Stigma					.17	2.01	< .05
Internalized Homophobia					.17	2.08	< .05
Family Support					-.27	-3.17	> .05

Dependent Variable: Suicidal Ideation

Table 4 presents the results of the multiple regression analysis assessing the impact of minority stressors and family support on suicidal ideation among GSM individuals in Cross River State. The table shows that the predictors (microaggressions, perceived stigma, internalized homophobia, and family support) collectively predicted suicidal ideation ($R = 0.417$, $F(4, 124) = 6.51$, $p < 0.05$), explaining 17% of the variance in suicidal ideation ($R^2 = 0.17$).

Subsequent investigation indicates that internalized homophobia ($\beta = 0.17$; $t = 2.08$; $p < 0.05$) and perceived stigma ($\beta = 0.17$; $t = 2.01$; $p < 0.05$) both significantly improved suicidal thoughts on their own. This suggests that heightened suicide thoughts is linked to higher levels of internalized homophobia and perceived stigma. Additionally, the research demonstrated that in this model, family support ($\beta = -0.27$; $t = -3.17$; $p > 0.05$) and microaggressions ($\beta = 0.08$; $t = 0.91$; $p > 0.05$) were not statistically significant predictors of suicidal thoughts. Therefore, there was only partial evidence for the hypothesis that these variables have an impact on suicidal ideation.

Table 4: Moderated Regression Model Showing the Moderating Effect of Family Support on the Relationship Between Minority Stressors and Suicidal Ideation Among Gender and Sexual Minorities in Cross River State

Model	**R**	**R²**	**R² Change**	**F**	**p**	**Predictor**	**β**	**t**	**p**
1	0.244	0.059	-	8.021	0.005	Perceived Stigma	0.107	2.832	<.05
2	0.378	0.143	0.084	12.292	0.001	Perceived Stigma	0.092	2.532	<.05
						Family Support	-0.217	-3.506	<.05
3	0.417	0.174	0.031	8.559	0.005	Perceived Stigma	0.092	2.532	<.05
						Family Support	-0.217	-3.506	<.05
						Microaggression	0.070	0.913	>.05
						Internalized Homophobia	0.04	2.08	<.05

Dependent Variable: Suicidal Ideation

Table 4 presents the results of the moderated regression analysis examining how family support moderates the relationship between minority stressors and suicidal ideation among the sample.

Model 1 included only the centered predictor variable, perceived stigma. This model showed that perceived stigma accounted for a significant amount of variance in suicidal ideation ($R^2 = 0.059$, $F(1, 127) = 8.021$, $p = 0.005$). Suicidal ideation was positively impacted by perceived stigma ($\beta = 0.107$, $t = 2.832$, $p = 0.005$), suggesting that higher perceived stigma levels are linked to more suicidal thoughts.

Model 2 added family support to the model along with perceived stigma. This model revealed a significant improvement

in explaining the variance in suicidal ideation (R^2 = 0.143, F(2, 126) = 12.292, p = 0.001). The association between perceived stigma and suicidal ideation was significantly attenuated by the addition of family support (β = -0.217, t = -3.506, p = 0.001), suggesting that suicidal ideation is less common when family support is higher. The substantial interaction term indicates that the detrimental effects of stigma are successfully buffered by family support, which moderates the influence of perceived stigma on suicidal thoughts.

Model 3 introduced additional variables, microaggressions, and internalized homophobia, into the model. The inclusion of these predictors resulted in a further significant increase in the explained variance (R^2 = 0.174, F (4, 124) = 8.559, p = 0.005). The effects of perceived stigma (β = 0.092, t = 2.532, p = <.05) and family support (β = -0.217, t = -3.506, p = <.05) remained significant. However, microaggressions (β = 0.070, t = 0.913, p > 0.05) did not significantly predict suicidal ideation, suggesting that while they contribute to the overall model, they are not directly moderated by family support. Conversely, internalized homophobia demonstrated a significant positive effect on suicidal ideation (β = 0.040, t = 2.08, p < 0.05), with family support serving as a moderator that mitigates its impact. These results indicate that family support plays a crucial moderating role in the relationship between minority stressors (perceived stigma and internalized homophobia) and suicidal ideation. Although family support did not have a significant independent prediction on suicidal ideation, it effectively moderated the relationship between these stressors and suicidal ideation. Specifically, increased family support helps mitigate the negative impact of perceived stigma and internalized homophobia on suicidal ideation, while microaggressions contribute to the overall model without being significantly moderated by family support. Therefore, the hypothesis stated in this regard was partially supported.

Discussion of Findings

According to the study's findings, internalized homophobia and perceived stigma significantly influence suicidal thoughts among GSM individuals in Cross River State, Nigeria. This is consistent with earlier studies that have consistently demonstrated that suicidal thoughts is a significant problem for those with GSM. Suicidal thoughts are more common among GSM people than among heterosexual and cisgender people, as is well documented, and our results demonstrate the substantial impact of minority pressures on mental health (Haas et al., 2011; Plöderl & Tremblay, 2015).

In the current study, microaggressions did not significantly affect suicidal ideation. Even though earlier studies have highlighted the negative effects of microaggressions on mental health, including suicidal ideation (Su et al., 2016; Nadal et al., 2016), our findings imply that, in this particular situation, microaggressions might not be a direct cause of suicidal ideation. Numerous reasons, such as Nigeria's distinct cultural and social dynamics, where other types of minority stressors may be more prevalent, could be to blame for this.

Suicidal ideation was found to be significantly predicted by perceived stigma. This finding corroborates Meyer's (2003) minority stress theory, which posits that the anticipation and awareness of societal discrimination create chronic stress, impacting mental health. The heightened awareness of societal attitudes and discrimination reinforces feelings of vulnerability and rejection (Pachankis et al., 2015), leading to increased suicidal ideation among GSM individuals.

Internalized homophobia was also found to be a significant predictor of suicidal ideation in the current study. This confirms earlier findings that significant psychological discomfort can result from internalized negative cultural attitudes (Meyer, 1995; Newcomb & Mustanski, 2010). Self-hatred or shame are common manifestations of internalized homophobia, which can lead to detrimental mental health consequences like depression and suicidal thoughts (Kashubeck-West et al., 2017; Feinstein et al., 2019). In order to improve mental health outcomes for GSM individuals, focused interventions addressing internalized stigma are necessary, as the results of the current study demonstrate the continued relevance of internalized homophobia as a key predictor of suicidal thoughts.

Additionally, a major moderating element in the association between minority stresses and suicide thoughts was shown to be family support. The protective function of supporting social networks in reducing the negative impacts of minority stresses is highlighted by this nuanced conclusion. Family support was acknowledged for its function in mitigating the adverse effects of stressors, even though it did not independently predict suicidal ideation in other studies (Baiocco et al., 2016; Schmitz et al., 2020). This knowledge is expanded by the current study, which shows that family support both independently predicts suicidal ideation and moderates the association between minority stressors and suicidal ideation. This emphasizes how crucial supportive family dynamics are in affecting mental health outcomes, especially in Nigeria, where social and cultural issues may affect how family support is experienced and how effective it is.

Conclusion

Drawing from the findings of this study, we concluded that minority stressors, particularly perceived stigma and internalized homophobia, significantly contribute to suicidal ideation among gender and sexual minorities in Cross River State. These stressors emphasized the profound mental health challenges faced by GSM individuals. Furthermore, family support emerged as a critical factor, moderating the impact of these stressors. By comprehending the challenges faced by gender and sexual minorities (GSM), such as discrimination, stigma, and marginalization, tailored intervention strategies that effectively address their unique needs can be designed. These interventions could reduce mental health disparities and foster overall well-being within the GSM community, ensuring that they receive the support and resources necessary to thrive.

Recommendations

Mental health professionals should develop targeted interventions that address perceived stigma and internalized homophobia, focusing on cognitive-behavioral strategies to foster resilience and positive identity formation. Additionally, family-based therapy programs should be implemented to strengthen family support networks and enhance their protective role against suicidal ideation. Community organizations can facilitate support groups and workshops for GSM individuals and their families, creating safe spaces for sharing experiences and building community resilience. They should collaborate with local leaders to promote awareness and understanding of GSM issues, reducing stigma and fostering a more inclusive environment. Policymakers are encouraged to advocate for policies that protect GSM

individuals from discrimination and promote equal rights, reducing the systemic stressors that contribute to mental health challenges. Supporting funding for research and mental health services focused on GSM populations will ensure accessible and culturally competent care. Educational institutions should incorporate diversity and inclusion training into curricula to educate students about GSM issues and promote empathy and acceptance.

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