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Mindfulness

ISSN 1868-8527

Mindfulness
DOI 10.1007/s12671-019-01294-5

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https://doi.org/10.1007/s12671-019-01294-5

ORIGINAL PAPER

Is Self-Compassion Protective Among Sexual- and Gender-Minority Adolescents Across Racial Groups?

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Abstract

Objectives Sexual- and/or gender-minority (SGM) youth report rates of suicidality, depression, and anxiety that are two to three times greater than those of their sexual- and gender-majority peers. Mounting evidence suggests that self-compassion can moderate the impact of stress on anxiety, depression, and suicidality. However, the potential limitations of self-compassion in overcoming adversity associated with minority status has not yet been investigated among youth with multiply marginalized identities (i.e., young people who find themselves at the intersection of more than one stigmatized group).

Methods Informed by the minority stress hypothesis and intersectionality theory and using models of moderated moderation as well as group mean and proportion comparisons, this secondary data analysis ($n = 1572$) compared buffering effects of self-compassion across youth experiencing varying degrees of marginalization.

Results In this study, although white sexual- and/or gender-minority adolescents reported higher rates of general peer victimization and anxiety than did counterparts of color, and to a moderate effect (Hedges' g = .31 and .30, respectively), results of the Pearson's chi-squared tests affirmed that sexual- and/or gender-minority students of color reported two to three times the frequency of exposure to structural discrimination. Results of the conditional process analysis suggest that the distinction across race within SGM status appeared in how self-compassion moderated the impact of identity on depressive symptoms compared with the reference group (i.e., white sexual- and gender-majority students). We did not find significant differences in how self-compassion moderated the relationship between sexual identity and depressive symptoms across racial groups.

Conclusions There is evidence to suggest that the relationship between self-compassion and mental health may differ according to degree of exposure to structural discrimination.

Keywords Sexual and gender minorities · Self-compassion · Peer victimization · Depression and suicidality

Although suicide is the second leading cause of death among 15–19-year-olds in the USA (Xu et al. 2018), the risk of suicide appears even higher for sexual- and/or gender-minority (SGM) youth. Overall, SGM youth report two to three times the rates of suicidality, depression, and anxiety as do their sexual- and gender-majority peers, although risk among SGM youth varies with gender, race, and ethnicity (Bostwick et al. 2014; King et al. 2008; Reisner et al. 2015b; Zaza et al. 2016). The psychological mediation framework (Hatzenbuehler 2009) of the minority stress hypothesis (Brooks 1981; Meyer 1995, 2003) suggests that vulnerability incurred from managing the onus of minority-targeted stressors, such as harassment, rejection, discrimination, and violence—cumulatively referred to as stigma—contributes to mental health disparities that disfavor minority group members (Hatzenbuehler and Pachankis 2016). Specifically, stigma theoretically "gets under the skin" partly via the internalization of rejection and a legitimizing mythology of deviance (for an explanation of legitimizing mythologies, see Sidanius and Pratto 2012).

Conversely, the same psychological mediation framework suggests that adaptive coping strategies and other protective

Electronic supplementary material The online version of this article (https://doi.org/10.1007/s12671-019-01294-5) contains supplementary material, which is available to authorized users.

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Published online: 07 January 2020

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resources may buffer the impact of minority stress on mental health. One coping strategy that may be protective is the practice of self-compassion. The emerging literature on self-compassion suggests that the tendency to offer oneself kindness and affectionate companionship when experiencing emotional distress is associated with lessened vulnerability to the negative outcomes associated with stress, including symptoms of depression and anxiety. However, just as experiences of depression, anxiety, and suicidality vary at the intersection of racial, sexual, and gender identities (Bostwick et al. 2014; Consolacion et al. 2004), so do experiences of dispositional self-compassion (Vigna et al. 2018). Accordingly, this investigation uses an intersectional lens and the minority stress hypothesis to view self-compassion as an individual-level resilience factor by asking: For whom and under what conditions does self-compassion buffer the relationship between stigmatized identities and mental health symptoms? Given that adolescence is an important period for the development of stress-management habits and identity formation and consolidation, insight into the relevance of potentially malleable qualities, such as self-compassion, is of particular consequence.

The concept of stigma includes broadly held, negatively valanced assumptions that serve, albeit erroneously, to legitimize personal and structural discrimination, status loss, and stereotyping of persons or groups with certain characteristics (Hatzenbuehler et al. 2013). Stigma is thought to serve as a fundamental driver of population-level health inequities by increasing stress and decreasing access to the personal and institutional resources needed to cope with it. The cumulative effect of exposure to stigma is the erosion of group members' physical and psychological well-being (Nadal et al. 2011; White Hughto et al. 2015). Stigma also appears to "get under the skin" via the exhaustion of adaptive emotion-regulation strategies and the adoption of maladaptive emotion-regulation strategies, including the internalization of stigma messages (Hatzenbuehler et al. 2008). Stigma messages and ideologies justify policies and practices designed to harass, exclude, and eliminate sexual- and/or gender-minority (SGM) individuals.

Although gender identity and sexuality are distinct identities, individuals who violate dominant expectations of one often violate both (Rieger and Savin-Williams 2012). Content analysis of the stigma messages and ideologies used to marginalize such individuals suggests that both sexual and gender minorities are targeted with the same stigma messages communicating an essentialist mythology that suggests nonheterosexuality or non-cisgender expressions as perversions of "normal" human development or expression (Gordon and Meyer 2008). This essentialist mythology asserts that the shape of one's anatomy dictates personality, preference, and purpose (Herek 2007; Schilt and Westbrook 2009; Worthen 2016). As such, stigma messages and practices designed to impute shame on those who violate expectations of hetero- and cis-normativity constitute a shared, but by no means equally experienced, source of stress that serves as a mechanism of health and mental health inequities found among SGM youth (Schilt and Westbrook 2009).

A number of investigations of inequities in mental health among SGM students compared with sexual- and gender-majority students support the internalization mechanism. For example, propensity-score-matched comparison of SGM and sexual- and gender-majority students on suicidality suggests that SGM students remain more vulnerable to the negative impacts of harassment at both ends of the harassment spectrum, even with control for contextual factors such as demographic characteristics, school attendance, harassment, and other risks for suicidality such as perceptions of parental love and support, parental physical abuse, being kicked out of the home, childhood sexual abuse, and dating violence (Robinson and Espelage 2012). The authors speculate that *some* variability in mental health concerns may be explained by the internalization of macro-level messages of hegemonic heteronormativity that persist in the absence of acute experiences of victimization (Mueller et al. 2015; Robinson and Espelage 2012). Furthermore, the strength of the relationship appears to be notable; a meta-analysis of existing data regarding found a significant link between the internalization of homophobia and depressive symptoms to a moderate effect (Newcomb and Mustanski 2010).

Some SGM youth, however, possess additional stigmatized identities that interact to produce unique experiences of structural and interpersonal stigma, as well as access to unique resilience-promoting resources. As intersectionality theory posits, policies and practices that create social positioning in a dominance-based social hierarchy typically result in each member of that hierarchy benefiting from some relief from oppressive forces as well as navigating some negative impacts from the oppressive forces (Andersen and Collins 2010; Bowleg 2012; Crenshaw 1991; Collins 2000). In this way, intersectionality theory clarifies that being ascribed more than one stigmatized social position creates unique experiences of harm, and that social forces shaping one aspect of the self cannot be understood independently of any other facet of the self. Put another way, understanding how racism, heterosexism, and sexism function does not elucidate what it means to be ascribed the positionality of a black lesbian cisgender woman (Bowleg 2008). When it comes to assessing mechanisms of harm (i.e., risk factors) leveled at a certain aspect of the self, it is therefore essential to consider how unique aspects of the self interact with or otherwise modify those risks.

While the minority stress hypothesis proposes an additive effect on health—namely, that the more marginalized identities one manages, the worse one's health is likely to be—the data have not consistently supported this effect. Rather than observing an additive effect on mental health among multiply marginalized individuals, a number of studies have found

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either that there are no differences in mental health symptoms across racial groups among SGM youth (Button et al. 2012; Kertzner et al. 2009) or that white SGM youth are at a *higher* risk of experiencing mental health concerns due to bullying than are SGM students of color (SoC) (Consolacion et al. 2004; Mustanski et al. 2011; Vigna et al. 2018). An intersectional frame can help make sense of these contradictory findings by highlighting the complexity of lived experience at the convergence of marginalizing forces. For example, it is possible that racial-majority SGM youth are more vulnerable to the pernicious effects of stigma messaging than are racial-minority youth, since racial-minority youth are more likely to be embedded in a culture that has developed resilience in direct response to managing the burden of stigma levied at their racial identity (LeVasseur et al. 2013; Poteat et al. 2011). Conversely, racial-majority youth may have fewer enculturated counterresponses to summon when faced with stigma messaging and thus may be more prone to blame themselves or otherwise internalize such messages.

Over the last 15 years, the tendency to offer compassion to oneself has been identified as a healthy response to the experience of personal struggle. Higher levels of self-compassion (SC) involve responding to the self with kindness in lieu of criticism, a sense of connection-to-collective difficulty in lieu of self-isolation, and mindful acknowledgment of suffering in lieu of overidentification and rumination (Neff 2003). Thought to facilitate the acceptance of difficulty instead of avoiding processing the difficulty or of feeling somehow at fault for experiencing distress, SC has been negatively correlated with psychopathology, with a medium effect size in both adolescence and adulthood (MacBeth and Gumley 2012; Marsh et al. 2017). Experimental studies have shown that self-compassion buffers anxiety in the face of an ego threat in the laboratory (Neff et al. 2007), and intervention studies suggest that SC promotes psychological well-being among white adolescents (of unknown SGM status) (Bluth et al. 2016a, b; Bluth and Eisenlohr-Moul 2017).

Absence of self-compassion may be partly responsible for the emergence of health inequities (Yang and Mak 2016; Vigna et al. 2017). For example, multivariate analyses of data from a school-based sample reveal lower than average rates of SC among SGM youth than among sexual- and gender-majority youth, with a medium effect size (Vigna et al. 2018). Elsewhere, SC predicted more variation in mental health disparities than bias-based bullying, general victimization, and adverse childhood experiences combined, while inclusion of SC in the models dramatically attenuated the impact of stigma messages on mental health variability (Vigna et al. 2017).

Although SC is associated with resilience to adversity among SGM adolescents, it is also possible that an intraindividual resilience factor such as SC is insufficient for buffering the ill effects of compounded institutional disadvantages associated with holding *multiple* minority identities (Cyrus 2017). As resilience science has long argued, the greater the number of external risk factors, the less sufficient internal resilience factors will be for preserving adaptive functioning (Masten 2001). Evidence suggests that structural discrimination may be a stronger driver of mental health concerns among SGM SoC than the internalization of stigma. For example, one study found that higher rates of bias-based bullying were associated with a sharper decline in rates of SC among white youth than among youth of color, regardless of SGM identity (Vigna et al. 2018). Similarly, analysis of data collected from lesbian, gay, and bisexual (LGB) adults suggests that a stronger relationship exists between perceived and internalized stigma among white LGB adults than among racial-minority LGB adults (Moradi et al. 2010).

Elsewhere, it has been found that, whereas black SGM youth report the *same levels of increased risk* for mental health symptoms as do white SGM youth, black SGM youth appear to experience *less bias-based victimization* related to their sexual- and gender-minority status than do their white counterparts. The authors speculate that additional factors related to institutional-level stigma associated with racial identity may be more strongly implicated in risk for mental health symptoms (Mueller et al. 2015). In light of the finding that SGM students of color have higher rates of SC at matched rates of peer victimization, it follows that SoC may engage in broader resilience processes, such as being exposed to family-level or community-level resilience factors, likely related to coping with racism, which they can rely upon for managing other forms of stigma (e.g., sexuality- and/or gender-related stigma; Brondolo et al. 2005).

Although resilience research typically examines positive adaptation or competence in the presence of risk or adversity, it is also possible to examine the absence of negative outcomes in groups in which such negative outcomes (e.g., symptoms of depression and anxiety) are common (Poehlmann-Tynan and Eddy 2019). In this study, we aim to examine patterns in the relation between self-compassion and mental health concerns in youth across the intersectional or racial, sexual and gender identities. Informed by the Bi-dimensional Framework model of resilience (Johnson 2016), we conceptualize self-compassion as a psychological factor that can alter the association between risk (e.g., assumed stigma exposure based on group membership) and mental health concerns (e.g., depression and anxiety). In order to justify the convention of using identity groups as a proxy for exposure to structural-level stigma common among public health researchers (Ellison 2005; Klonoff and Landrine 2000), we conducted group mean comparisons of variables suggesting exposure to structural discrimination. Next, we examined the conditions in which self-compassion moderates the relationship between identity and mental health symptoms (see Online Resource 1 for the conceptual model). We expected

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that the relationship between self-compassion and mental health concerns for white SGM adolescents would differ from that for white sexual- and gender-majority adolescents and SGM adolescents who are also students of color. In light of potential resilience processes enculturated among historically marginalized racial-minority communities, we expected that white SGM students may need higher levels of SC to experience protective effects.

Method

Participants

Participants include $N = 1872$ high school students from two suburban high schools in a Midwestern county. Students completed the 2015 edition of the Dane County Youth Assessment (DCYA). The sample consisted of $n = 929$ males and $n = 943$ females. Roughly 58% identified themselves as "white" and 42% as students of color (SoC), with nearly a third (30%) of the SoC students identifying as "multiracial." Eighteen percent of the sample received free or reduced lunch. Schools returned surveys for 85–90% of their total student populations. See Table 1 for sample demographics.

Procedure

Midway through the school year, students at three Midwestern high schools were administered an online survey in the schools' computer labs during regular class time. Students were given the option to skip any question or decline to continue participation at any point during the survey. Students who declined to participate in the survey worked on homework in other classrooms. Computers were spaced several feet apart, with only a few questions displayed on the screens at one time, and at no point did the survey collect personal information. Each student received a directory of free resources for supporting them through personal, family, or academic struggles. The entire procedure took 40 min.

Measures

The DCYA surveys students on their opinions, concerns, attitudes, behaviors, and experiences. The 2015 edition of the survey consisted of 128 questions. Data were received by the primary investigator in de-identified form, and the University of Wisconsin–Madison Institutional Review Board approved a secondary analysis of the data.

Demographic Variables

Age, grade, race and ethnicity, biological sex assigned at birth, and free- or reduced-lunch status were elicited via forced-choice options to determine demographic characteristics (see Table 1 for full sample demographics).

Sexuality and Gender Status

Sexuality and gender status (SGmy) was assigned via analysis of responses to five items in the survey: (1) sexual identity; (2

Table 1 Sample demographics

Variable	Number (*n*)	Percent (%)	Variable	Number (*n*)	Percent (%)
Age	1571	99.9	Race/ethnicity	1572	100
14<	249	15.80	Asian (not Hmong)	35	2.3
15	453	28.8	Black or African Amer., not Hispanic	90	5.7
16	446	28.4	Hispanic or Latino	85	5.4
17	307	19.5	Hmong	47	3.0
18+	116	7.4	Middle Eastern/Arab American	3	.2
Missing	1		Native American	16	1
Grade	1569	99.8	White (not Hispanic)	1136	72.3
9th	499	31.7	Multi-racial	137	8.7
10th	474	30.2	Other	28	1.5
11th	343	21.8	BioSex	1572	100
12th	249	15.80	Assigned female	816	51.9
Missing	4		Assigned male	756	48.1
SGMy			SGMy		
White SGM	205	13	SGM SoC	121	7.7
White SGmaj	931	59.2	SGmaj SoC	315	20

SGMy sexual and gender minority/majority status, *SGM* sexual and/or gender minority, *SGmaj* sexual and gender majority, *BioSex* biological sex, *SoC* student of color

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and 3) sexual behavior (determined by responses to the item asking about biological sex and to the item asking about gender of sexual partners); (4) transgender identity (Q: "Do you identify yourself as transgender?" A: *Yes/No, or, I do not know what* transgender *means*); and (5) gender conformity (Q: "A person's appearance, style, dress, or the way they walk or talk may affect how people describe them. How do you think other people at school would describe you?" A: *(a) very feminine; (b) mostly feminine; (c) somewhat feminine; (d) equally feminine and masculine; (e) somewhat masculine; (f) mostly masculine, or (g) very masculine.*). Given the degree of conceptual overlap fueling cissexist, transphobic, and homophobic stigma, students were coded as SGM ($n = 326$) if indicating any of the following: (1) a nonheterosexual sexual identity, (2) nonheterosexual sexual behavior, (3) a transgender identity, or (4) a gender-nonconforming self-presentation. Everyone else was classified as sexual and gender majority ($n = 1246$). **S**tudents that indicated androgynous gender self-presentation (i.e., "equally feminine and masculine") were classified as SGM after a one-way ANOVA comparing rates of bias-based bullying found a significant difference in the means of bias-based bullying for being perceived to be L, G, B, or T between androgynous, gender-conforming, and gender-nonconforming students $F(2, 1569) = 36.37$, $p < .001$. Post hoc tests found that the only nonsignificant difference between groups was between the androgynous and gender-nonconforming students ($p = .08$), justifying the decision to include androgynous students in the gender- and sexual-minority category as they are subject to comparable amounts of harassment as are gender-nonconforming students. See Table 2 for a breakdown of sample size within each category.

Table 2 Table of frequency of factor that comprises the sexual and/or gender minority subsample ($n = 326$)

	Number (*n*)	Percent (%)
Sexual behavior		
Have had consensual sexual contact	167	42.5
Engaged in Same-sex or bi-sexual sexual contact	42	12.9
Affirmed minority identity		
Identify as L, G, B or "other"	151	46.3
Identify as "transgender"	12	.04
Gender performance		
Perceived by peers as gender nonconforming	92	28
Perceived by peers as androgynous	167	51.2

SGM sexual and or gender minority, "*L*" lesbian, "*G*" gay, "*B*" bisexual

Adverse Childhood Experiences

Eight items were collapsed into dichotomous variables and summed in order for us to assess cumulative exposure to adverse childhood experiences (ACEs) (Felitti et al. 1998): (1) forced sexual contact, (2) child abuse that leaves marks or causes injury, (3) a parent getting drunk at least once a week, (4) a parent getting high from marijuana at least once a week, (5) parents physically fighting with each other, (6) experiencing homelessness, (7) parental incarceration, and (8) a parent with mental health issues that worry the student. Higher scores indicate a greater number of ACEs. Although these items cover the range of adverse childhood experiences that have a demonstrated predictive correlation with lifetime mortality and morbidity, they have not been formally tested for external validity and internal reliability. This series of items demonstrated internal consistency reliability of .67. Elsewhere, research examining a variety of measures of ACEs has found that, despite important variation, a cumulative risk score is discriminating and predictive of outcomes assessed, such as having an emotional, behavioral, or mental health condition (see Bethell et al. 2017).

Distrust of Police

Distrust of police was assessed by a negative response to a single item: "I can count on police if I need them." Response options were in the form of a 4-point Likert scale ranging from 1 (*strongly agree*) to 4 (st*rongly disagree*) and were collapsed into a dichotomous variable to reflect *yes* or *no*. In this sample, 15.5% of students indicated that they felt they could not count on police if they needed them ($n = 244$).

Economic Hardship

Economic hardship was assessed through a single item that inquired about food insecurity: "Do you receive free or reduced lunch?" In this sample, 17% of students indicated receiving free or reduced lunch ($n = 272$).

Exclusionary Discipline

Experiences with exclusionary discipline were assessed through a single item: "During this school year, how many times have you received either an in-school or out-of-school suspension?" Response options ranged from 0 to 3 or more times and were collapsed to reflect the absence or presence of experiences of exclusionary discipline. In this sample, 7% of students indicated receiving a suspension in the past year ($n = 102$).

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Parental Incarceration

Incarceration of a parent was assessed by a positive response to a single item: "My parent has been in jail or prison." Response options were *yes*, *no*, and *I do not know* and were collapsed into *yes no*, or, *missing*. In this sample, 10% of students affirmed that one of their parents had been incarcerated ($n = 162$).

Individualized Education Plan

Students were asked to indicate whether they "currently receive an individualized education plan." Possible response options were *yes*, *no*, and *I do not know* and were collapsed into *yes no*, or, *missing*. In this sample, 6.5% of students indicated receiving an IEP (individualized education plan) ($n = 101$).

General Peer Victimization

Students were asked to use the University of Illinois Victimization Scale (Espelage and Holt 2001) to indicate how often the following incidents had happened to them in the previous 30 days: "Other students called me names"; "Other students made fun of me"; "Other students picked on me"; "I got hit and pushed by other students." Response options included: 0 *(never)*, 1 *(1 or 2 times)*, 2 *(3 or 4 times)*, 3 *(5 or 6 times)*, and 4 *(7 or more times)*. Responses were averaged into an index of general victimization wherein higher scores indicated more self-reported victimization. In this sample, scores ranged from 0 to 3 (M = .31, SD = .53), and internal reliability was on par with that of other samples ($\alpha = .87$) (Espelage et al. 2008; Espelage and Holt 2001; Poteat et al. 2011).

Bias-Based Bullying

Three items assessed the frequency of bias-bullying victimization. Items included: "In the past 12 months have you ever been bullied, threatened, or harassed (a) by others thinking you're gay, lesbian or bisexual, or transgender; (b) about your race or ethnic background; or (c) about how you look?" Response options included: (0) *Never*, (1) *Rarely*, (2) *Sometimes*, (3) *Often*, and (4) *Very Often*. Scores in this sample ranged from 0 to 3 (M = .22, SD = .43), with higher scores indicating greater frequencies of bias-based bullying. The item regarding harassment based on perceived LGBT identity has been used in other school-climate surveys and is associated with lower perceived school safety and higher depression (O'Shaughnessy et al. 2004). Internal reliability for the composite in this sample is .64.

Self-Compassion

The short form of the Self-Compassion Scale has been found to be a valid and reliable alternative to the long-form self-compassion scale and, due to space constraints, was used to assess dispositional self-compassion (SCS-SF; Raes et al. 2011). The SCS-SF is composed of twelve items assessing the six facets (three positive and three negative) of the construct. Negatively worded items were reversed, scored, and averaged into one overall measure of SC. Sample items included: "When I'm feeling down, I tend to obsess and fixate on everything that's wrong" and "When I'm going through a very hard time, I give myself the caring and tenderness I need." Response options are presented on a Likert-type scale ranging from 1 (*Almost Never*) to 5 (*Almost Always*). Higher scores indicate greater SC ($\alpha = .80$). In this sample, scores ranged from 1 to 5, while the mean score for SC was 3.06 (SD = .73).

Depression and Suicidality Symptoms

A composite score indicating the frequency of depressive and suicidal thoughts and behaviors was created by standardizing and summing the following items: (1) "During the past 12 months, have you thought seriously about killing yourself?"; (2) "During the past 12 months, how many times did you do something to hurt yourself on purpose, without wanting to die, such as cutting or burning?"; and (3) "During the past 12 months, did you ever feel so sad or hopeless almost every day for at least two weeks in a row that you stopped doing some usual activities?" These items are used by the Centers for Disease Control and Prevention in their national Youth Risk Behavior Surveillance survey and have excellent test-retest reliability, although they have not undergone psychometric validation (Brener et al. 2002). Items were standardized and summed. Higher scores indicate more frequent reports of symptoms of depression and suicidality. In this sample, standardized scores ranged from − 1.63 to 15.65, with median score at − 1.63 (M = 0.01, SD = 3.18; $\alpha = .78$).

Anxiety Symptoms

The frequencies at which students reported experiencing the following symptoms of anxiety over the previous 30 days were averaged into a composite anxiety score: (a) "Felt nervous, anxious, or on edge;" (b) "Not been able to stop or control worrying;" and (c) "Felt problems were piling up so high that you could not handle them." Response options included 0 (*Not at all*), 1 (*Always*), 2 (*Sometimes*), and 3 (*Often*). Higher scores indicated greater anxiety. In this sample, scores ranged from 0 to 9 (M = 3.40, SD = 2.66). The first two items came from the psychometrically validated and normed Generalized Anxiety Disorder Screener, known by the abbreviation GAD-2 (Kroenke et al. 2007, 2009; Löwe et al. 2010).

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The GAD-2 has been supported by intercorrelations with other self-report scales for anxiety and with demographic risk factors for anxiety. These two items assess the two core criteria for generalized anxiety disorder and have been shown to be effective items in screening for panic, social anxiety, and post-traumatic stress disorders in clinical samples (Kroenke et al. 2007). The third item was sourced from the four-item Perceived Stress Scale (Cohen et al. 1983). Summing all three items for a composite anxiety score has demonstrated acceptable reliability elsewhere (Espelage et al. 2016), with $\alpha = .97$ in this sample.

Validity Check

Students who did not indicate biological sex, racial identity, or SGmy ($n = 4$) were removed. Data were screened for "mischievous responders" (Robinson-Cimpian 2014). Students who indicated either implausible weight ($\leq$ 70 lbs or $\geq$ 400 lbs) or height ($\geq$ 7 ft) and two of eight low-frequency response items selected to be theoretically unrelated to variables of interest (i.e., drinking 4+ sodas daily) were excluded from analyses, in keeping with previously used screening techniques (see Robinson and Espelage 2012; Robinson-Cimpian 2014). In total, 47 students were identified as mischievous responders, reducing the available analytic sample to $n = 1817$.

Data Analyses

After constructing multicategorical independent variables representing the intersectional identities of race by SGM status (Johnson 2016; Johnson et al. 2017), we conducted group comparisons on variables representing structural discrimination in order to justify the use of identity as a proxy for discrimination. Pearson's chi-squared tests were conducted on categorical variables across the four groups, while a one-way ANOVA was performed on continuous variables to examine mean differences across intersectional statuses with Games-Howell post hoc tests selected to accommodate violations to homogeneity of variances due to different group sizes. Hedges' g effect sizes were calculated for the continuous variables and Cramer's V for the categorical variables. Effects were characterized as small ($r = .10$), moderate ($r = .30$), or large ($r = .50$) using Cohen's benchmarks (Cohen 1988; Hedges and Okin 1985).

Next, we conducted moderation analyses and conditional-means comparisons. This strategy was informed by the Bi-dimensional Framework for resilience research, which asserts that resilience arises from the interaction between risk and resilience factors such that resilience factors moderate or buffer the impact of risk factors on outcomes. First, data were screened for regression assumptions, and the composite variable assessing bias-based bullying was log-transformed to improve normality. Potential covariates were identified through the identification of significant, zero-order correlations known to be causal mechanisms of the outcome variables. Statistically significant correlations ($p < .05$) of medium effect size using Cohen's benchmarks for effect sizes ($r > .30$) were subsequently controlled for in the models of the moderation effect of self-compassion on the relationship between identity and mental health symptoms (Cohen 1988).

Identity variables used as proxies for intersectional experiences of discrimination were constructed by creating nominal multicategorical predictor variables representing the four potential intersections of social positioning identities provided by the data (i.e., SGM white, sexual- and gender-majority white, SGM SoC, and sexual- and gender-majority SoC). Using the Omnibus Groups Regions of Significance (OGRS) macro (version 1.2) for SPSS, we then examined whether each identity group held significant group by SC interaction effects with each outcome variable (Hayes and Montoya 2017). OGRS iteratively searches the continuum of the moderator to discern the point at which the effect of a multicategorical X on Y transitions into or out of significance at a specified alpha level.

For significant omnibus tests, we ran a simple moderation model in PROCESS with our multicategorical X to generate graphs of the interactions and estimate conditional means for each group. PROCESS was also use to conduct pairwise inference tests by dummy coding each intersectional identity group into unique variables, calculating the products of each group with SC and then running simple moderation analyses using the Johnson-Neyman technique for identifying the exact points at which effects transition into and out of significance for each comparison of interest (see Online Resource 2 statistical model). First, with SGM/white coded as the reference group, we modeled sexual- and gender-majority/white as the predictor variable and SC as the moderator variable and included the other identity groups and the products of the other group with SC as covariates in the model, in addition to relevant covariates detailed below. We repeated this process three times, each time exchanging the reference group to test all relevant contrasts.

The PROCESS macro mean centers continuous variables used in the construction of interaction terms and generates 10,000 bootstrapped samples to calculate 95% bias-corrected confidence intervals. Because of suspected violations of the assumption of homoscedasticity of residuals, heteroscedasticity-consistent standard errors were estimated using the HC3 estimator (Darlington and Hayes 2017). Models were estimated using the PROCESS macro (version 3), executed in SPSS v. 25 (SPSS 2016). In this investigation, the interpretation of resilience will be assessed when mental health symptoms are observed either at below-

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average rates or below the baseline rates of white sexual- and gender-majority youth. All models will control for biological sex assigned at birth, ACEs, bias-based bullying, and general victimization. These covariates were selected because they hold a significant, moderate correlation ($r \geq .5$) with the outcome variables, and a one-way ANOVA found significant between-group differences.

Missing Data

Level of missingness in the data ranged from 0% at the beginning of the survey to 11.8% at the end, with 82% of cases providing complete data. Between 5.7 and 11.8% of the items of interest were missing data. The last three items of the SCS-SF had the highest rates of missingness (11.5 to 11.8% missing), likely due to their placement at the end of a 128-item survey. SCS-SF scores were calculated only for respondents who answered 10 of 12 items. Results of Little's MCAR test to determine if missing values were related to values of other variables were not significant (χ 2 = 3276.74, d = 4741, p = 1.00), and thus we failed to reject the null hypothesis that data were Missing Completely at Random (MCAR).

Because the macro used for the analyses reported in this manuscript is unable to process a pooled, multiply imputed dataset in SPSS, we also conducted sensitivity analyses to ensure our results were not sensitive to using listwise deletion to manage missingness. After a categorical variable demonstrating completeness or incompleteness for items from each variable of interest was created, a one-way ANOVA testing predictors of completeness of variables included in this investigation was conducted. While age was significantly negatively correlated with the likelihood of completing the entire DCYA, social positionality at the intersection of sexuality and gender status and racial grouping did not significantly predict completion of the survey and the SCS-SF. These sensitivity analyses suggest that using listwise deletion would not be sensitive to missingness.

A power analysis was conducted using Cohen's (2013) effect size standards. Without multiple imputation, listwise deletion was used for managing missing data. With all variables included in the model, our final sample size was reduced from 1817 to 1572. As such, our power was 1.0 to detect large, medium, and small effect sizes for simple group difference models. Given that the subgroups were highly unequal in size (see Table 1), power to examine the intersectionality hypotheses (i.e., 2- or 3-way interactions) was lower, and the sample size was adequate to detect large group differences only (.80–1.0), with power to detect small effect sizes at .10–.65 for multiple subgroup analyses. Thus, we were able to detect only large effects with adequate power in the current study. Because of this limitation, failing to reject the null hypothesis could reflect either (a) that the null hypothesis is true, or (b) that the null hypothesis is false but we failed to reject it because of low statistical power (i.e., a type II error) (Aberson 2002).

Results

Differences in Structural Discrimination

The results of the one-way ANOVA comparisons across racial grouping with sexual- and gender-identity grouping indicate that while sexual- and gender-*majority* SoC report higher rates of both ACEs and bias-based bullying than do their white sexual- and gender-*majority* counterparts and to a moderate effect (Hedges' g = .30 and .35, respectively), white SGM report higher rates of general peer victimization and anxiety than do their SGM SoC counterparts and to a moderate effect (Hedges' g = .31 and .30, respectively); see Table 3 for details. Similarly, results of the Pearson's chi-squared tests affirmed

Table 3 Results of group differences ANOVAs of mean scores by SGMy × Racial Category with effect sizes

	SGM (n = 326)				g	Sexual and gender majority (n = 1246)				g
	SoC (n = 121)		White (n = 205)			SoC (n = 315)		White (n = 931)		
	M	SD	M	SD		M	SD	M	SD	
ACEs	.72	1.09	.64	.97	.08	.56	1.02	.32	.73	.30*
Gen. Peer Vic.	.31	.52	.50	.67	− 0.31*	.24	.45	.27	.51	− 0.06
Bias-Based B.	.39	.65	.40	.52	− 0.02	.26	.45	.14	.30	.35*
Anxiety	4.04	2.89	4.87	2.76	− 0.30*	3.10	2.62	3.20	2.52	− 0.04
Dep. & Suic.	.78	2.75	1.27	3.36	− 0.16	0.25	2.07	− 0.39	2.07	.07
SCS	2.93	.73	2.75	.68	.27*	3.17	.70	3.12	.74	.07

***p < .001. *ACEs* adverse childhood experiences, *Gen*. general, *Vic*. victimization, *B*. bullying, *Dep*. depressive symptoms, *Suic*. suicidality, *SCS* self-compassion scale. Depression and suicidality scores reported in standardized format. Sample size variability reflects variability in survey completion. Hedges' g calculated due to account for unequal group sizes

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Table 4 Results of the Pearson's chi-squared tests of statistical difference in experiences of structural discrimination across intersectional identity

	SGM ($n = 326$)				Sexual and gender majority ($n = 1246$)						
	SoC ($n = 121$)		White ($n = 205$)		SoC ($n = 315$)		White ($n = 931$)				
	%	*n*	%	*n*	%	*n*	%	*n*	x^2	df	v
Par. Incarcerated	23.6	25	12.6	24	17.9	52	6.8	61	48.92	3	.18***
Exclusionary Disc.	16.5	20	7.3	15	6.7	21	3.8	35	33.84	3	.15***
IEP	20	24	8.8	18	9.2	29	3.4	32	55.37	3	.19***
Econ. Hardship	47.9	58	15.6	32	34.9	110	7.7	72	257.41	6	.29***
Police not trust.	35.5	43	19.5	40	22.6	71	9.7	90	75.03	3	.22***

Par. parent, *Disc.* discipline, *IEP* individualized education plan, *Econ.* economic—measured by rates of receiving free or reduced lunch, *trust.* trustworthy, *SoC* students of color, *SGM* sexual and/or gender minority; *** $p < .001$

that SGM SoC reported two to three times the frequency of exposure to structural discrimination as did white SGM students; see Table 4 for details.

Conditional Relationships between Sexuality and Gender Status and Mental Health Symptoms

The results of the regression model providing the omnibus test of group differences in depressive symptoms were significant [$F(10, 1561) = 92.89$, $p < .001$], accounting for 37% of the variance. All predictors and covariates were significant, including their interaction terms, and the results of the Johnson-Neyman technique suggest, with 95% confidence based on 10,000 bias-corrected bootstrapped samples, that a significant difference in the conditional means of depressive symptoms exists across intersectional identity groups when SC is less than 3.18 and above 4.32.

Moderation analyses comparing different groups examined the distinctions in conditions of the moderating effect self-compassion has on stigma exposure (estimated by identity group) on depressive symptoms. As expected, all SGM students demonstrated higher rates of depressive symptoms than did sexual- and gender-majority students when SC was at average or below-average rates. White sexual- and gender-majority students reported significantly lower rates of depressive symptoms than did white SGM students (reference group) when SC levels were less than 3.08 (effects = − 2.59 to − .38, SEs = .71 to .20). Yet, when SC ≥ 4.41, white sexual- and gender-majority students reported *higher* levels of depressive symptoms (effects = 1.02–1.65, SE = .52–.71). However,

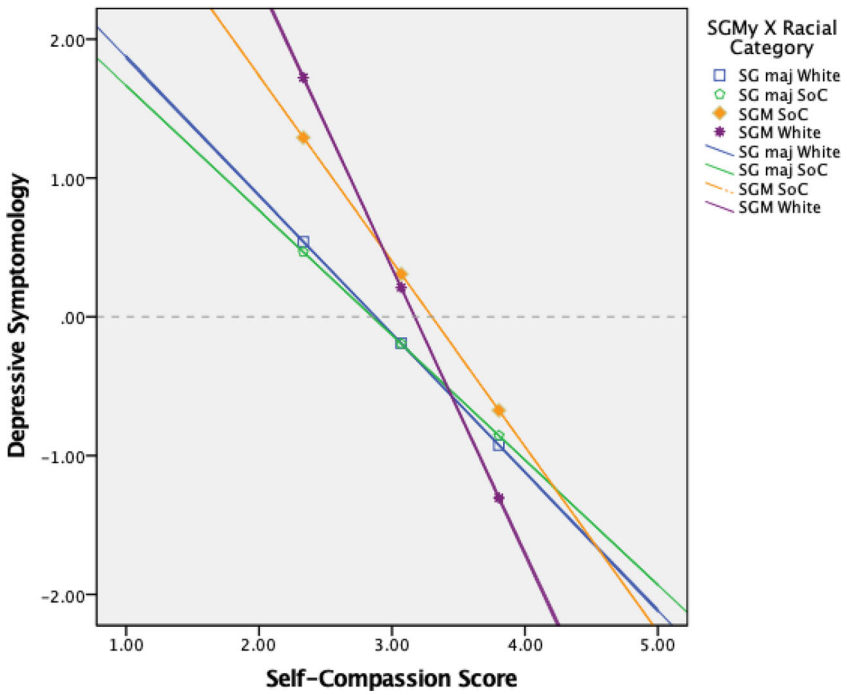

Fig. 1 Graph of the relation between intersectional identity and depression symptoms at different rates of self-compassion. SGMy sexual and gender grouping category, SGM sexual and/or gender minority, SGmaj sexual and gender majority, SoC student of color. Reference line set to sample mean for Anxiety symptoms

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the SEs of the effects estimated at the extremes of SC are high, raising concerns about potential inflation of type I error. Similar to their white counterparts, SGM SoC had higher rates of depressive symptoms than did sexual- and gender-majority SoC at all rates of SC. Nonetheless, in this set of pairwise contrasts, the interaction term was not significant, suggesting that, regardless of sexual and gender identity group, we were unable to detect differences in how SC buffered the identity to symptom link for SoC—either because there are no differences or because of type II error.

The graph of the simple slopes of each group appears to suggest that rates of SC most strongly moderate depressive symptomology for white SGM students (see Fig. 1). However, when pairwise contrasts were conducted using heteroscedastic consistent standard errors, the interaction term for SGM SoC found in the initial omnibus test was no longer statistically significant. Contrary to our hypothesis that white SGM youth would fare worse than SGM SoC, in this sample, we did not detect significant differences in the estimated conditional means of depressive symptoms between white SGM and SGM SoC. Thus, the distinction across race within SGM status appeared in how SC moderated the impact of identity on depressive symptoms compared with the reference group (i.e., white sexual- and gender-majority students).

White sexual- and gender-majority students were chosen to serve as the baseline group for pairwise comparisons as membership in both majority categories ostensibly affords these students the benefits of privileged sexual- and gender-identity status and privileged racial status. Results of pairwise comparisons of white SGM and white sexual- and gender-majority students (cited above) suggest that differences among white students exist when SC is below average or more than one standard deviation above the average. Conversely, results probing conditionality of identity to depressive symptoms found that SGM SoC significantly differed from white sexual- and gender-majority youth when SC rates were between 2.02 and 3.46 (effects = .87–.38, SEs = .39–.18). Put another way, at average rates of SC, we were unable to detect differences in white students' rates of depressive symptoms compared with their sexual-majority racial counterparts. At average rates of SC, however, multiply marginalized students (i.e., SGM SoC) reported significantly higher levels of depressive symptoms than did students reporting doubly privileged identities.

Interestingly, according to pairwise comparisons, SC appears to moderate the link between identity and depressive symptoms between white SGM and sexual- and/or gender-majority SoC in a similar manner as it does between white students across sexual and/or gender status [$F(11, 1560) = 48.77$, $p < .001$]. White SGM students reported *higher* levels of depressive symptoms than did sexual- and gender-majority SoC when SC rates were at 3.05 or lower (effects = 2.8–.43, SEs = .77–.49). At very high rates of SC ($\geq$ 4.25), white SGM students reported *lower* rates of depressive symptoms than did sexual- and gender-majority SoC (effects = − .96 to − 1.83, SEs = .49 to .75). No significant differences were found in how SC moderated exposure to stigma on

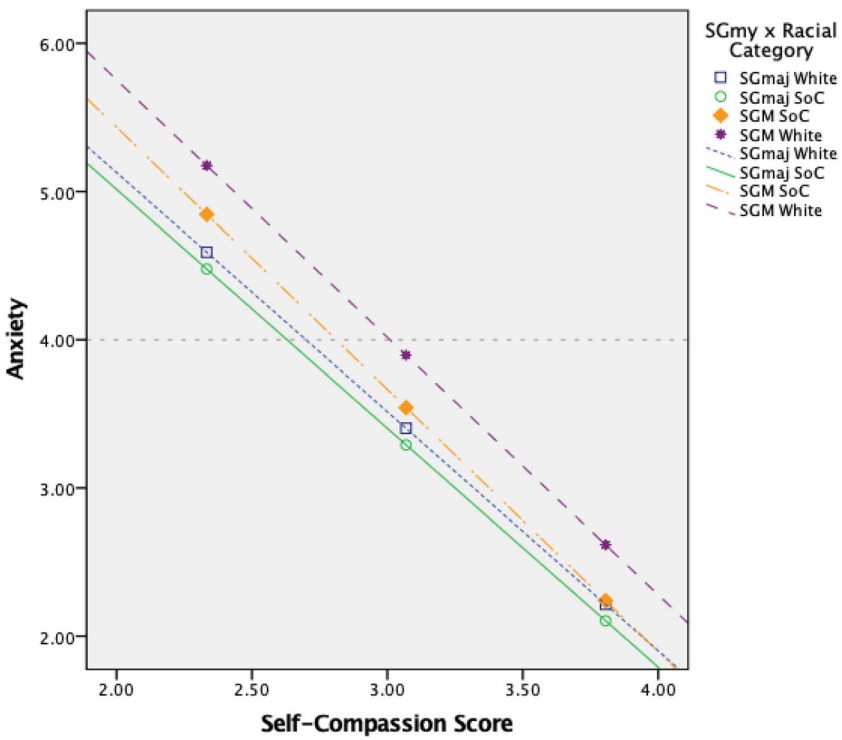

Fig. 2 Graph of the relation between intersectional identity and anxiety symptoms at different rates of self-compassion. SGMy sexual and gender grouping category, SGM sexual and/or gender minority, SGmaj sexual and gender majority, SoC student of color. Reference line set to sample mean for Anxiety symptoms

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depressive symptoms across racial status among sexual- and gender-majority students.

The omnibus test for anxiety symptoms did not show any significant interaction terms nor did the Johnson-Neyman technique locate any regions of significance. As can be seen in Fig. 2, the simple slopes of every identity group are roughly parallel, with white SGM students demonstrating elevated rates of anxiety symptoms at all levels of SC. Pairwise inference tests confirmed that white SGM students had significantly higher rates of anxiety symptoms when SC = 2.34 ($\hat{y}$ = 5.19) and when SC = 3.07 ($\hat{y}$ = 3.95) compared with white sexual- and gender-majority students ($\hat{y}$ = 4.61 and 3.42, p's = .002–.005) and sexual- and gender-majority SoC ($\hat{y}$ = 4.44 and 3.29, p's = .004–.002). However, at no point did the conditional means of anxiety symptoms among white SGM students differ significantly from those of SGM SoC, meaning that either the conditional means were similar or the differences were too small to be detected based on the subgroup sample size.

All reported models were reevaluated without covariates included. Inclusion of covariates did not alter the pattern of results. However, the covariate-free models had more statistically significant interactions. Given the extant research linking the covariates with depression and suicidality, the authors chose to report the more conservative model with covariates included.

Discussion

Adolescence is a critically important period in the consolidation of a positive self-view and in the development of stress-management habits that either lay the groundwork for preserving mental well-being or steadily erode it over time. As such, insight into the relevance of potentially malleable self-management practices, such as self-compassion, is of particular consequence. However, the experience of adolescence and exposure to stressors varies considerably in accordance with positionality in a social hierarchy. Although the evidence that self-compassion may preserve well-being across adolescence is mounting, it remains to be seen whether it functions similarly across social positionality. By assessing the conditionality of a proposed protective factor (e.g., self-compassion) across groups with varying exposure to known risk factors for mental health concerns (e.g., groups that experience interpersonal and structural discrimination), this investigation explored the possibility that the relationship between self-compassion and mental health outcomes may vary depending upon the degree of adversity one faces.

With rates of bias-based bullying, general peer victimization, sex assigned at birth, and ACEs held constant, all identity groups experienced lower rates of mental health concerns when they reported higher self-compassion. Furthermore, intersectional identity grouping—our proxy for variability in exposure to stigma—no longer predicted variability in depressive symptoms when students reported above-average rates of self-compassion. However, we also found evidence to suggest that the effects of self-compassion on depression and suicidality were conditional. For example, whereas average rates of SC were associated with below-average rates of anxiety for all identity groups, SC was associated with below-average rates of depression and suicidality symptoms only for sexual- and gender-majority youth who reported average or above-average rates of SC. In contrast, for SGM students SC was at least one standard deviation above average before we observed below-average rates of depression and suicidality.

Contrary to our hypothesis, our analyses were unable to detect evidence that self-compassion significantly varied in how it related to depressive symptoms in SGM students from different racial groups, although the subgroup analyses were underpowered. However, we found that both racial-minority and racial-majority SGM students varied significantly from white sexual- and gender-majority students, albeit in slightly different ways that raise several possible interpretations. For instance, when SC was in the average range, white SGM students reported similar rates of depressive symptoms compared with their white sexual- and gender-majority counterparts. However, we found that SGM SoC fared worse than white sexual- and gender-majority students at average rates of self-compassion. Put another way, these findings suggest that only when self-compassion levels are well above average do multiply marginalized youth (i.e., SGM SoC) report below-average rates of depression and suicidality. We also found that in comparison with sexual- and gender-majority youth of both racial groupings, white SGM students experienced *higher* rates of depressive symptoms when SC was just below the sample average, but they fared better when SC levels were exceptionally high. However, SGM SoC were not significantly different from either racial group of sexual- and gender-majority students in rates of depressive symptoms at extremely high SC.

Although we cannot infer causality based upon the analyses in this study and we are underpowered with respect to the subgroup analyses, if we interpret our findings in light of the extant experimental literature that suggests changes in self-compassion result in changes in mental health (Breines et al. 2015; Diedrich et al. 2014; Diedrich et al. 2016; Galla 2016), our findings raise a number of speculative interpretations.

First, if self-compassion does indeed interrupt the internalization of stigma messages and discrimination, as the minority stress theory suggests, our findings regarding variance in significant moderation effects across intersectional identities could indicate that one's tendency to hold the suffering self with compassion and a sense of common humanity rather than ruminate in a belief of personal fallibility needs to be exceptionally robust when one encounters higher levels of adversity, as we presume in this study that SGM SoC do. Whereas, since

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white SGM youth are managing discrimination for only one aspect of their identity and otherwise enjoy a supremacy narrative regarding their racial group, it may be that only a modest level of self-compassion is needed to preserve mental health at this presumed lower exposure to adversity, if each student's ACEs score and experiences of peer victimization are controlled for (i.e., general victimization).

In support of this hypothesis, an analysis of survey data collected from African American adolescents suggests that the belief that racial discrimination reflects a shared reality defined by a collective struggle within a dominance-based social system buffers the relationship between daily experiences of discrimination and depression (Sellers et al. 2006). In other words, the belief that stigma experiences are *not* a reflection of personal fallibility but a *collective* experience produced by a system of inequity may facilitate resilience processes regarding the harm that discrimination can cause. Whereas the belief that the world is fair and thus suffering is deserved was associated with declines in well-being for African American adolescents (Godfrey et al. 2017). Similarly, an analysis of African American adults found that trait mindfulness, or the tendency to observe suffering but not identify with it as an essential facet of the self, buffered the impact of discrimination on mental health symptoms (Shallcross and Spruill 2017). Other researchers have found the transition point between a sense of personal suffering and collective struggle to be the point of resilient coping for racial-majority LGBT youth (DiFulvio 2011; Wexler et al. 2009).

Conversely, the finding that white youth had lower self-compassion and higher rates of depressive symptoms than their SoC counterparts could suggest that some facet(s) of white culture may serve as a risk factor for conditioning lower levels of trait self-compassion and consequently high rates of mental health concerns. Notably, in this sample, while rates of mental health symptoms across racial status among SGM students did not significantly differ, SoC reported higher than average rates of self-compassion than did their white SGM counterparts (see Table 3). Some facets of white culture that would be likely to induce lower rates of trait self-compassion are a focus on the individual over the collective, a preference for competition over cooperation, and a reliance upon system-justifying ideologies such as the "bootstrap" framework for understanding the social-dominance hierarchy (Jost et al. 2004; Malat et al. 2018; Okun n.d.). Relational culture theory is one framework that might shed light on this dynamic (Miller and Stiver 1997). According to relational culture theory, resilience is born from growth-fostering relationships characterized by empathy, authenticity, mutuality, and empowerment. The extreme focus on individuality, independence, competition, and blame that characterizes white culture may serve to dampen opportunities to build growth-fostering relationships that are more readily available in the countercultures that have emerged, or been strengthened, in response to white culture. Other research has found support for the role that growth-fostering relationships can play in reducing the association between internalized homophobia and psychological distress among sexual minorities (Mereish and Poteat 2015).

Alternatively, it is possible that the remaining variance in the regression focusing on intersectional identity and mental health symptoms is accounted for by other factors both internal and external, such as genetic predisposition for anxiety or depression, degree of parental acceptance, presence of supportive adults, acceptance by peers, and factors in the wider community. It is important to emphasize that our interpretations are purely speculative since we did not directly include rates of discrimination in the model nor did we attempt to manipulate self-compassion.

Limitations and Future Directions

The most significant limitation of this study is its cross-sectional design; the study did not permit examination of self-compassion, bias-based bullying, and mental health concerns as dynamic processes over time and thus does not permit conclusions of causality. Longitudinal data collection would permit examination of changes and interrelationships over time. In addition, experimental trials of SC interventions with this population would provide the strongest test of the role of SC as a protective factor against bias-based bullying and peer victimization.

Second, the school-based nature of the study means that students who missed school on the day the survey was administered, either for random reasons (e.g., one-day illness or other brief absence) or reasons reflecting existing inequities (e.g., homelessness, fear of peer violence, exclusionary discipline, parental incarceration, and juvenile detention) were not included. Given that SGM youth are disproportionately represented in the latter groups (Irvine and Canfield 2016; Mitchum and Moodie-Mills 2014; Zaza et al. 2016), the absence of some of the most vulnerable youth might change the results of the study, including impacting the power to detect actual relations between the variables.

Third, a relatively small number of racial-minority students also identified as sexual and/or gender minorities (i.e., Hmong, Native American, Latinx, or African American *and* sexual- or gender-minority status). Had the composition of SGM students included more gender-nonconforming and/or transgender-identified students, the variability in rates of self-reported anxiety, depression, and suicidality symptoms would have likely been higher, as these subpopulations are increasingly recognized as experiencing higher rates of harassment, discrimination, and mental health concerns (O'Shaughnessy et al. 2004; Reisner et al. 2015a, b). As a result of this limitation, the study was able to detect only large effect sizes in these subgroups. To conduct a truly intersectional analysis and assess patterns among the relevant identity groups that

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are targeted with stigma messages, it will be necessary to analyze data from larger and more racially/ethnically diverse samples. Perhaps more importantly, although our measure of identity encompassed variables of self-perceived social assessment in addition to affirmed identities, relying upon these as proxies for experiencing intersecting mechanisms of marginalization is problematic. Future investigations would benefit from including variables that directly measure experiences of structural discrimination (e.g., exclusionary discipline).

Fourth, due to space limits in the DCYA, the short form of the original SC scale was used, precluding examination of the potential mediational role of SC subscales—for example, that a sense of common humanity or tendency to overidentify with suffering may play a role in explaining relationships between identity and mental health symptoms.

Fifth, reliance upon existing survey questions to construct variables of interest is not optimal, as some items have not undergone rigorous psychometric evaluation. Although some of the items utilized in the mental health variables are either similar or identical to items used elsewhere, they have not been validated in this group, so conclusions drawn about relationships with mental health are provisional. Most of the scales demonstrated acceptable internal consistency reliability, but that is only one index of a measure's utility. Future work would benefit from using measures previously determined to be reliable and valid in SGM and multiply marginalized youth.

Additionally, while extant literature suggests that stigma delivered via peer victimization may play a causal role in the development of mental health symptoms in adolescents (Mustanski et al. 2016), we cannot make causal inferences with this data set. Furthermore, since the data in this study are cross-sectional and self-reported, they are subject to bias because of shared method variance, which may lead to results being confounded by report biases such as social desirability (Podsakoff et al. 2003).

Finally, future research designed to generate insight into how youth cope with stigma via self-compassion and the degree to which they appraise difficulties as a collective struggle would allow for further exploration of our hypotheses. More importantly, although our findings raise interesting concerns about vulnerability associated with the social construction of whiteness, it cannot be overstated that mental health is not the only measure of health that warrants the attention and concern of the research community. For example, although youth of color in this sample demonstrated relatively robust mental health, they are nonetheless living in a state with the highest rate of black infant mortality in the nation and some of the worst disparities in incarceration, academic achievement, and poverty (Wisconsin Council on Children and Families 2013). Indeed, several investigations have demonstrated the profound protective effects of structural resources for individuals—such as supportive parental relationships (Ryan et al. 2010; van Beusekom et al. 2015), inclusive curricula, visible SGM adults, and explicit nondiscrimination laws and policies (Hatzenbuehler 2011; O'Shaughnessy et al. 2004; Poteat et al. 2012). While information on intraindividual factors associated with resilience is valuable in the development of interventions that support individuals who are coping with adverse circumstances, investigations into intraindividual factors run the risk of inadvertently perpetuating harmful "pull yourself up by your bootstraps" rhetoric. Specifically, the dominant trope of individualism that prevails in Western psychology is often interpreted as suggesting that resilience to adverse contexts is the individual's responsibility rather than a function of the context or interactions with the environment (Fergus and Zimmerman 2005; Toomey et al. 2012; Ungar 2003).

Although our focus is on the conditionality of self-compassion, we hope to emphasize how a sense of shared humanity might play an important role in transforming adverse contexts, whether via internal transformation or external change. Indeed, it is critical for society to transform contexts from discriminatory to affirmative, with an accompanying shift in the distribution of power (Braveman et al. 2011; Cook et al. 2014; Holley et al. 2012), thus helping vulnerable youth. However, recent evidence suggests that among SGM individuals with elevated rates of internalized stigma, high levels of engagement in collective action aimed at transforming contexts of discrimination can actually exacerbate individual psychological distress (Breslow et al. 2015). As such, in addition to mobilizing societal-change efforts, identifying emotion-regulation practices that can be strengthened through intervention—such as the practice of self-compassion—remains a priority to support long-term structural-change efforts.

Author Contributions AV designed and executed the study, conducted the data analyses, and wrote the paper. JPT collaborated with the design, consulted on the data analysis, and contributed to the writing and editing of the paper. BK brokered the relationship to secure the data.

Compliance with Ethical Standards This article does not contain any studies with human participants or animals performed by any of the authors. Secondary analysis of existing data was approved by the University of Wisconsin–Madison Institutional Review Board.

Conflict of Interest The authors declare that they have no conflict of interest.

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