



**Project SPARK Two-Year Findings:  
A Longitudinal Study of Protective  
and Risk Factors in LGBTQ+ Youth  
Mental Health (2023-2026)**

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# Executive Summary

**Project SPARK** (*Studying Protective And Risk factors: A Longitudinal Mental Health and Experiences Study among LGBTQ+ Young People*) is an ongoing longitudinal study following 1,689 LGBTQ+ youth ages 13–24 across the United States (U.S.). This report presents two-year findings from the first five waves of data collection, with surveys administered every six months from September 2023 through March 2026. The study tracks the mental health, well-being, and lived experiences of LGBTQ+ young people over time, with the goal of understanding how risk and protective factors – including family support, access to care, and experiences of discrimination – shape mental health trajectories.

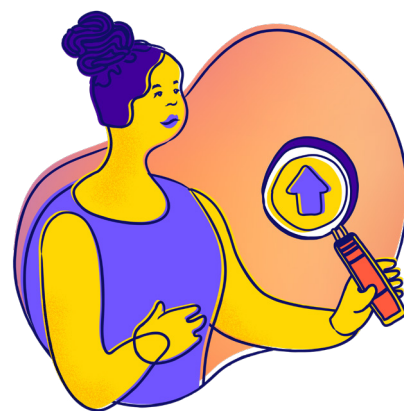
The sample is diverse across race/ethnicity, sexual orientation, and gender identity: 68% of participants were youth of color, and 53% were transgender, nonbinary, or gender-questioning. Participants reported a range of sexual orientations, including bisexual, pansexual, queer, and asexual identities.

This two-year report builds on [the interim one-year findings](#) by extending follow-up through the fifth survey wave, completed approximately two years after baseline. In this report, “baseline” refers to the initial survey completed by each participant.

In addition to tracking changes two years after baseline in respondents’ anxiety, depression, suicidal ideation, suicide attempts, discrimination, victimization, conversion therapy, economic insecurity, mental health care access, transgender health care access, affirming environments, family support, and gender euphoria, this report also includes findings related to self-harm, bathroom access among transgender and nonbinary (TGNB) participants, and online safety and social media use.

## Key Findings

- **Persistent mental health challenges:** Already high rates of anxiety and depression observed at baseline increased after two years of follow-up, while suicidal ideation stayed consistently high. At the same time, self-harm and suicide attempts decreased from baseline.
- **Continued stigma-related stressors:** From baseline through the two-year follow-up, more than half of participants reported discrimination based on sexual orientation or gender identity. Among TGNB participants, gender identity-based discrimination increased by the two-year follow-up. Reports of ever having been threatened with or exposed to conversion therapy also increased from baseline through the two-year follow-up, suggesting that these experiences continued to occur and accumulate during the study period.



# Executive Summary

- **Ongoing economic insecurity:** Past-year houselessness increased between one-year and two-year follow-ups. Unmet basic needs also remained high at both follow-ups relative to baseline.
- **A mix of progress and barriers in gender affirmation:** Among TGNB participants who wanted hormones, access increased substantially over time, and access to tools related to gender expression or transition – such as clothing, binders, or shapewear – also improved. However, many TGNB participants continued to report barriers, including bathroom access barriers and difficulty changing identification documents.
- **Growth in some protective factors:** LGBTQ+-affirming home environments increased by the two-year follow-up, gender euphoria increased steadily, and participants who received mental health care reported increasingly helpful care over time.
- **Barriers to care remained:** Although most participants who wanted mental health care were receiving it at the two-year follow-up, participants continued to report barriers including parent or caregiver permission, cost, fear of discussing mental health, fear of not being taken seriously, and concerns that providers would not understand their LGBTQ+ identities.
- **Decreases in online comfort and slightly fewer experiences of cyberbullying:** From the one-year to two-year follow-up period, LGBTQ+ young people became slightly less comfortable using social media for identity disclosure and exploration, and reported modest decreases in social media use to seek LGBTQ+-related information, support, and connection. At the same time, cyberbullying scores were low at both time points and participants reported slightly fewer LGBTQ+-related cyberbullying experiences in the two-year follow-up.
- **Peer support was central, crisis line support increased, but gaps in help-seeking remain:** Friends were the most common source of support during suicidal crises, and helpline use increased from baseline to the two-year follow-up. However, nearly one-third of participants who experienced suicidal thoughts reported seeking help from no one at every assessment.
- **Longitudinal models showed that risk and protective factors were linked to mental health over time:** Victimization, discrimination, conversion therapy, economic insecurity, and bathroom access barriers were associated with poorer mental health outcomes, self-harm, and suicidal ideation over time; while affirming home environments, family support, gender euphoria, and access to some gender-affirming resources were associated with better outcomes over time.

# Executive Summary

These findings point to the importance of addressing both the harms that place young people at risk and the supports that help them feel safe, affirmed, and connected. Reducing exposure to stigma, discrimination, conversion therapy, economic insecurity, and gender-based exclusion — while expanding affirming relationships, supportive homes, access to care, and gender-affirming resources — may be critical for improving mental health and reducing suicide risk among LGBTQ+ youth.

As Project SPARK continues, future waves will help show how LGBTQ+ young people's mental health, experiences, and sources of support change as they move through adolescence and young adulthood. Because the study is following participants during a period of significant social and political change for LGBTQ+ communities, continued follow-up will be especially important for understanding how these broader conditions shape young people's lives. Findings from this ongoing study can help guide policies, resources, and interventions that are grounded in what LGBTQ+ young people are experiencing and what they need to be healthy, safe, and supported.

## — The Trevor Project



# Background

## Study Rationale

LGBTQ+ young people face disproportionate mental health challenges, including elevated rates of poor mental health, suicidal thoughts, and suicide attempts compared to their cisgender heterosexual peers (Centers for Disease Control and Prevention [CDC], 2023; Veale et al., 2017). These disparities are not attributable to LGBTQ+ identity itself; rather, they result from chronic exposure to stigma, prejudice, and discrimination (Hatzenbuehler et al., 2010; Meyer, 2003). Although existing research has documented these disparities, much of the evidence comes from studies that capture young people's experiences at a single point in time (Real & Russell, 2025). This limits what is known about how mental health, risk exposure, and sources of support change as LGBTQ+ youth move through adolescence and early adulthood. These gaps are especially important for transgender, nonbinary, and gender-questioning youth, whose developmental experiences and needs for affirming mental health care, transgender health care, and other supports remain underexamined.

Project SPARK (***S**tudying **P**rotective **A**nd **R**is**K** factors: A Longitudinal Mental Health and Experiences Study among LGBTQ+ Young People*) was designed to address these gaps by following a large and diverse sample of LGBTQ+ young people over time. By collecting repeated data from the same participants, the study can examine how mental health trajectories unfold, which risk factors contribute to worsening outcomes, and which protective factors may support resilience and well-being. These findings can help inform evidence-based policies, resource allocation, clinical care, school-based supports, and community interventions for LGBTQ+ youth.

Throughout this report, the acronym “**TGNB**” is used to refer to participants who are transgender, nonbinary, or gender-questioning.

## Study Design Overview

Project SPARK is an ongoing longitudinal study following 1,689 LGBTQ+ young people ages 13 to 24 from across the U.S. Participants are surveyed every six months about their mental health and well-being, experiences of discrimination and victimization, family and peer support, access to mental health care and transgender health care, and other lived experiences. This report presents two-year findings based on data from the first five waves of the study, collected from September 2023 through March 2026.\*

*\*Note: This report reflects approximately two years of follow-up. Participants completed surveys every six months, but the exact calendar dates of participation varied depending on when each participant completed their baseline survey.*

# Background

## Methodology

**Participant recruitment and eligibility:** The study recruited U.S. residents ages 13 to 24 who self-identified as LGBTQ+ through paid social media advertisements. This occurred online during two recruitment windows: September 13 – December 12, 2023 and January 8 – February 17, 2024. Quota limits kept the baseline sample diverse by race/ethnicity and sex assigned at birth; once a quota was filled, additional entries from that group were closed. To be enrolled, respondents had to (1) provide electronic consent, (2) pass an honesty screen, and (3) submit unique email and phone information. Weekly reviews resolved possible duplicates or malicious responders, yielding a final analytic cohort of 1,689 participants.

**Survey administration:** To ensure accessibility and safety, data collection occurred via secure, confidential online surveys that included a maximum of 139 questions. All participant information was collected following strict ethical guidelines approved by an Institutional Review Board (IRB). Baseline and Wave 2 questionnaires were administered in the survey platform Qualtrics; Waves 3 to 5 were administered in the survey platform REDCap. Surveys were available in English and waves opened at six-month intervals.

**Data analysis:** This report of the two-year findings presents descriptive statistics and generalized linear mixed models. For descriptive results, “one-year follow-up” estimates summarize available data from Wave 2 and/or Wave 3, and “two-year follow-up” estimates summarize available data from Wave 4 and/or Wave 5. Specifically, for one-year follow-up estimates, we combined the 6-month recall windows used in the Wave 2 and Wave 3 surveys so that a “yes” response in either wave was indicative of exposure during the first 12-month follow-up period. For two-year follow-up estimates, we similarly combined available data from Waves 4 and 5 to summarize experiences across the second study year.

Descriptive results are presented only for participants with enough complete data across the study period for a given variable, including baseline data, data from at least one Wave 2 or Wave 3 survey to represent Year 1, and data from at least one Wave 4 or Wave 5 survey to represent Year 2. As a result, some baseline and one-year follow-up estimates in this two-year report may differ by a few percentage points from those presented in the interim one-year report published in October 2025, because the analytic sample for this report is restricted to participants with sufficient data across the two-year study period.



# Background

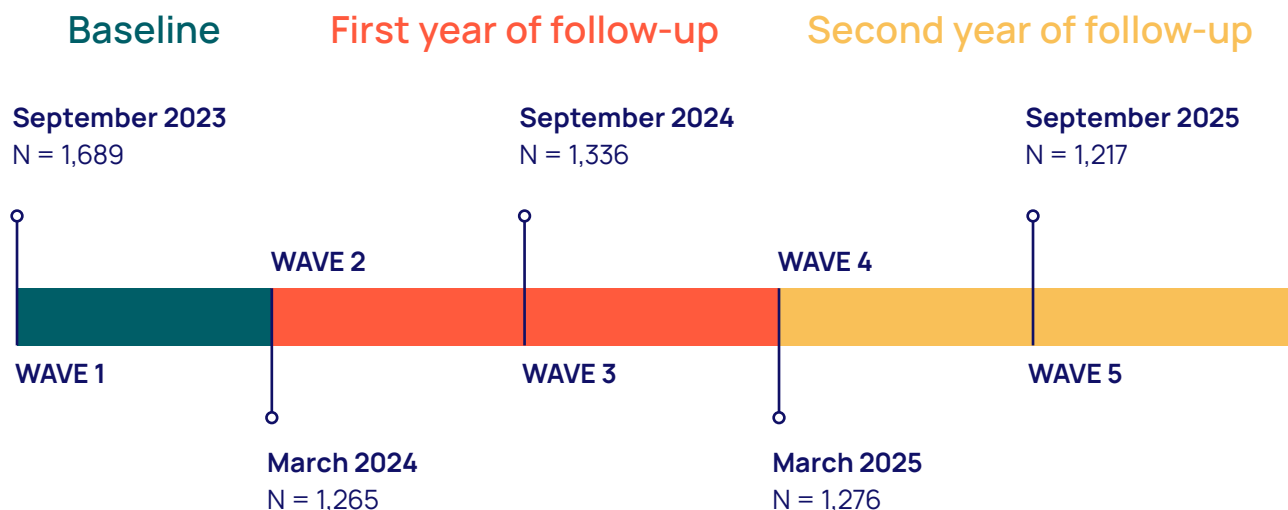
Because there was loss to follow-up across two years, observed changes could reflect attrition, meaning a change in the composition of the study population, rather than true change experienced by individual study participants. The most significant attrition occurred after the first wave; by Wave 5, 90% of study participants had completed at least one survey in each study year.

Generalized linear mixed models used data from all five available waves, controlling for the different recall window at baseline (i.e., 12 months), in order to examine the association of risk and protective factors on observed changes in anxiety, depression, suicidal ideation, self-harm, and suicide attempts. Models additionally controlled for age, sexual orientation, gender identity, and race/ethnicity. Because suicide attempts were relatively rare events during the first year of the study, statistical models examining changes in suicide attempts over time did not reliably converge and are not included in this report; we still report descriptive percentages for suicide attempts.

Unless otherwise noted, all analyses are statistically significant at  $p < 0.05$ , meaning results as extreme as those observed would be expected less than 5% of the time if there were no true difference (i.e., under the null hypothesis). Due to rounding, some presented percentages may not precisely add up to reported totals.

## Waves and Timeline

The following timeline summarizes the study's progress. Throughout this report, we refer to Wave 1 as baseline, Wave 3 as the one-year follow-up, and Wave 5 as the two-year follow-up.



# Key Domains Measured

To understand how well-being changed for LGBTQ+ young people over time, we tracked key areas spanning mental health, risk factors, and sources of support. Below is a summary of each domain assessed in Waves 1 to 5.

## Mental Health Outcomes

1. **Suicidal ideation:** Assessed with the Depressive Symptom Index–Suicidality Subscale (DSI-SS) (Joiner et al., 2002), which measures the frequency, intensity, and controllability of suicidal thoughts over the past two weeks.
2. **Attempted suicide:** Reports of past-year suicide attempts, based on items from the CDC's Youth Risk Behavior Survey (YRBS; CDC, 2023).
3. **Anxiety:** Anxiety symptoms captured using the Generalized Anxiety Disorder 2-item (GAD-2) screener (Plummer et al., 2016), which measures how often participants felt nervous or unable to control worrying over the past two weeks.
4. **Depression:** Depressive symptoms captured using the Patient Health Questionnaire 2-item (PHQ-2) screener (Richardson et al., 2010), which measures how often participants experienced low mood or loss of interest or pleasure over the past two weeks.
5. **Self-harm:** Reports of intentionally hurting oneself without wanting to die, based on an item from the Self-Injurious Thoughts and Behaviors Interview - Revised (Fox et al., 2020).

## Risk Factors

1. **Victimization:** Experiences of being physically threatened or abused based on one's sexual orientation or gender identity.
2. **Discrimination:** Experiences of being treated unfairly or excluded based on one's sexual orientation or gender identity.
3. **Conversion therapy:** Threats of or actual attempts to change one's sexual orientation or gender identity, reported separately. These include experiences with health care professionals and religious or spiritual leaders.
4. **Economic security:** Unstable housing and difficulty meeting basic needs like food, housing, and clothing.

# Key Domains Measured

5. **Bathroom access:** Among TGNB participants, experiences of being prevented or discouraged from using a bathroom that corresponded with their gender identity, assessed using an item adapted from the U.S. Trans Survey (James et al., 2016).
6. **Economic security:** Unstable housing and difficulty meeting basic needs like food, housing, and clothing.

## Protective Factors

1. **Access to mental health care:** Ability to obtain counseling or therapy when needed, perceived helpfulness of mental health care, and experiences with mental health-related hospitalization, as well as common barriers that prevent them from accessing desired care.
2. **Access to transgender health care:** Ability of TGNB youth to access the care and resources they wanted to support their gender identity – including clothing and binders, puberty blockers, hormones, surgeries, and/or updated identity documents.
3. **Family support and supportive environments:** Levels of acceptance and affirmation from family, peers, schools, and the broader community.
4. **Online safety and social media use:** Comfort disclosing personal information, communicating, and exploring or expressing gender and sexuality through social media, assessed using an online scale adapted from Lucero (2017); experiences of LGBTQ+-related cyberbullying, assessed using items adapted from Cooper and Blumenfeld (2012); and use of social media for LGBTQ+-related information, connection, and support (Ceglarek & Ward, 2016).
5. **Gender euphoria:** Degree of affirmation and comfort TGNB youth feel in expressing their gender and being seen as their gender, based on their agreement with statements from the Trans Youth CAN! Gender Positivity Scale (Bauer et al., 2021).
6. **Help-seeking behaviors:** Support sought by participants who seriously considered suicide in the past year – including from friends, family members, professionals, and crisis services.

# Results

## Demographics

### Baseline Characteristics

**Age:** At the start of the study, 41% of participants were ages 13 to 17 and 59% were ages 18 to 24; the median age was 18. By Wave 5, or two years later, the median age had risen to 21.

**Race/ethnicity:** Participants were racially and ethnically diverse; most (68%) were LGBTQ+ young people of color. Participants identified as White (32%), Multiracial (25%), Black or African American (17%), Hispanic/Latinx (15%), Asian American or Pacific Islander (8%), Native American/Indigenous (2%), and Middle Eastern or North African (1%). The distribution of race/ethnicity did not change significantly across the study.

**Sexual orientation:** At baseline, participants reported a range of sexual orientations, with a plurality identifying as bisexual (23%). The remainder of participants identified as lesbian (20%), gay (19%), pansexual (15%), queer (11%), asexual (8%), and heterosexual (1%). Three percent of participants indicated they were not sure of their sexual orientation. The majority of participants (72%) reported the same sexual orientation at Wave 5 as they did at baseline; changes in sexual orientation over time were not statistically significant when accounting for attrition across the study.

**Gender identity:** Nearly half of participants (48%) were cisgender – 21% cisgender boys/men and 27% cisgender girls/women. Nonbinary youth made up 30% of the sample, transgender youth made up 18% (11% transgender boys/men, 7% transgender girls/women), and 5% were questioning their gender identity. The majority (82%) reported the same gender identity at Wave 5 as they did at baseline; however, changes in gender identity over time were statistically significant when accounting for attrition across the study. These changes reflect both within-person changes in reported gender identity and differences in participant retention over time.



# Results

## Demographics

### Baseline Characteristics

#### By Age

- 41% 13 to 17
- 59% 18 to 24



#### By Race/Ethnicity

- 1% Middle Eastern/Northern African
- 2% Native/Indigenous
- 8% Asian American/Pacific Islander
- 17% Black/African American
- 15% Hispanic/Latinx
- 32% White
- 25% Multiracial



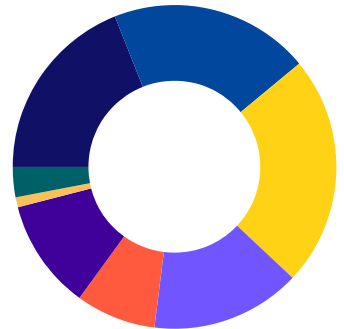
#### By Gender Identity

- 27% Cisgender Girl/Woman
- 21% Cisgender Boy/Man
- 30% Nonbinary
- 7% Transgender Girl/Woman
- 11% Transgender Boy/Man
- 5% Gender Questioning



#### By Sexual Orientation

- 19% Gay
- 20% Lesbian
- 23% Bisexual
- 15% Pansexual
- 8% Asexual
- 11% Queer
- 1% Heterosexual
- 3% Questioning



# Results

## Changes in Mental Health Outcomes Over Time

Across the first two years of Project SPARK, several mental health indicators worsened from baseline to the one-year follow-up and then remained elevated at the two-year follow-up:

### Recent Anxiety Among LGBTQ+ Young People:

Recent anxiety increased over the course of the study.

Baseline



One-year follow-up



Two-year follow-up



**Anxiety:** Recent symptoms of anxiety increased significantly from **54%** at baseline to **64%** one year later, and remained high at the two-year follow-up (**63%**). The overall change across the study period was statistically significant, while the change from the one-year to two-year follow-up was not statistically significant.

# Results

## Recent Depression Among LGBTQ+ Young People:

Recent depression increased over the course of the study.

Baseline



One-year follow-up



Two-year follow-up

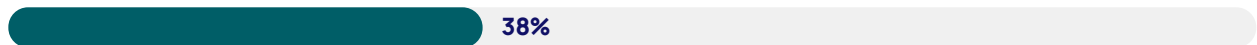


**Depression:** Recent symptoms of depression increased from **43%** at baseline to **49%** at the one-year follow-up, and remained elevated at the two-year follow-up (**51%**). The overall change across the study period was statistically significant, while the change from the one-year to two-year follow-up was not statistically significant.

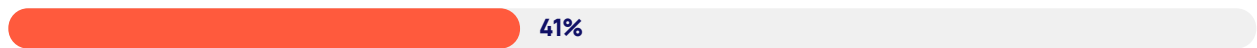
## Suicidal Ideation Among LGBTQ+ Young People:

Rates of suicidal ideation did not significantly change over the course of the study.

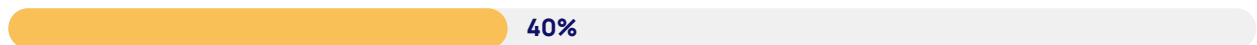
Baseline



One-year follow-up



Two-year follow-up



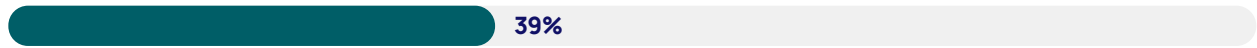
**Suicidal ideation:** Suicidal ideation remained consistently high across the two-year period but did not significantly change over time. At baseline, **38%** of participants reported suicidal ideation, compared to **41%** at the one-year follow-up and **40%** at the two-year follow-up.

# Results

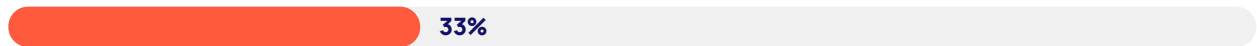
## Self-Harm Among LGBTQ+ Young People:

Rates of self-harm decreased from baseline to the one-year follow-up and then remained stable.

Baseline



One-year follow-up



Two-year follow-up

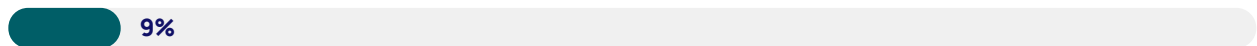


**Self-harm:** Rates of self-harm showed a different pattern. At baseline, **39%** of participants reported self-harm in the past year. This decreased significantly to **33%** one year later and remained at a similar level two years later (**34%**), with no statistically significant change between the one-year and two-year follow-ups.

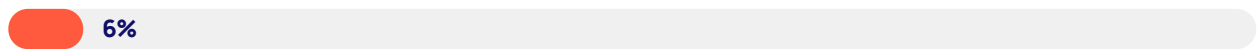
## Suicide Attempts Among LGBTQ+ Young People:

Rates of suicide attempts decreased over the course of the study.

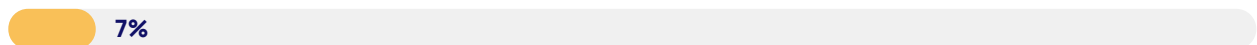
Baseline



One-year follow-up



Two-year follow-up



**Suicide attempts:** Suicide attempts changed significantly across the study period, decreasing from baseline to follow-up. At baseline, **9%** of participants reported a suicide attempt in the past year, compared to **6%** at the one-year follow-up and **7%** at the two-year follow-up. The change from the one-year to two-year follow-up was not statistically significant.

# Results

## Changes in Risk Factors Over Time

Risk factors are experiences that can negatively affect the health and well-being of LGBTQ+ young people. In this section, we track key risk exposures reported over the first two years of the study, including victimization, discrimination, exposure to or threats of conversion therapy, economic insecurity (such as houselessness or not being able to meet basic needs), and lack of bathroom access among TGNB respondents.

### Victimization

**Physical threats based on sexual orientation:** At baseline, 30% of participants reported being physically threatened because of their sexual orientation in the past year. This rate remained stable across the study period, with 30% reporting sexual orientation-based physical threats at the one-year follow-up and 31% reporting them at the two-year follow-up. These changes were not statistically significant.

**Physical threats based on gender identity:** Among TGNB participants, 38% reported being physically threatened because of their gender identity in the past year at baseline. This rate was essentially unchanged at the one-year follow-up (37%), but increased to 41% by the two-year follow-up. However, there was no significant change across the study period for gender identity-based physical threats among TGNB young people.

# Results

## Discrimination

Rates of discrimination were high across the two-year study period, with more than half of participants reporting discrimination based on sexual orientation or gender identity at each time point.

### Discrimination Based on Sexual Orientation:

Rates of discrimination based on sexual orientation decreased and then returned to near-baseline levels.

#### Baseline



#### One-year follow-up



#### Two-year follow-up



**Discrimination based on sexual orientation:** At baseline, **56%** of participants reported experiencing discrimination based on their sexual orientation in the past year. This decreased to **51%** at the one-year follow-up, then rose again to **55%** at the two-year follow-up. Overall, there was significant change across the study period; however, the two-year rate was not statistically different from baseline; sexual orientation-based discrimination returned to approximately its original level by the end of the second year.

# Results

## Discrimination based on gender identity:

Rates of discrimination based on gender identity increased over the course of the study.

### Baseline



### One-year follow-up



### Two-year follow-up



**Discrimination based on gender identity:** Among TGNB participants, **57%** reported experiencing discrimination based on their gender identity in the past year at baseline. This increased to **60%** at the one-year follow-up and **67%** at the two-year follow-up. Overall, there was significant change across the study period, with a statistically significant increase from the one-year to the two-year follow-up.

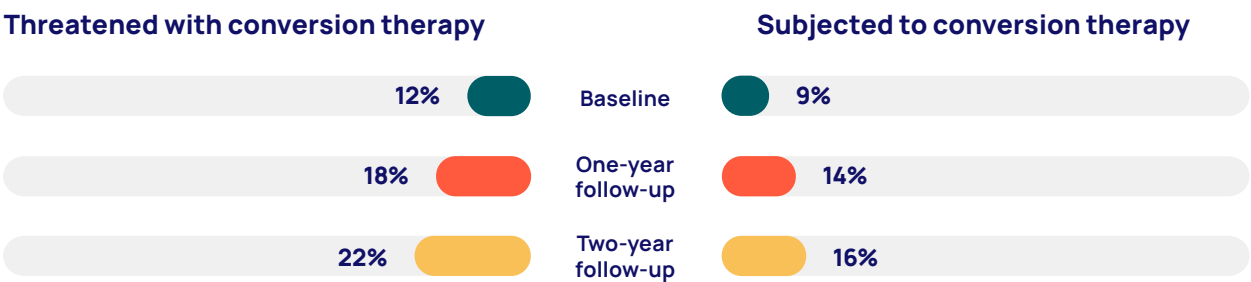
# Results

## Conversion Therapy

Conversion therapy refers to any threat or attempt to change a young person’s sexual orientation or gender identity.

### Rates of Being Threatened With or Subjected To Conversion Therapy:

Rates of both being threatened with and subjected to conversion therapy increased over the course of the study.



**Threats of conversion therapy:** At baseline, 12% of participants reported ever being threatened with conversion therapy. This increased to 18% at the one-year follow-up and 22% at the two-year follow-up. Overall, the proportion of participants who had ever been threatened with conversion therapy increased significantly across the study period, with the largest increase occurring during the first year.

**Exposure to conversion therapy:** At baseline, 9% of participants reported ever being subjected to conversion therapy. This increased to 14% at the one-year follow-up and 16% at the two-year follow-up. Overall, the proportion of participants who had ever been subjected to conversion therapy increased significantly across the study period, with the largest increase occurring during the first year.

Because these measures capture lifetime experiences, the increases indicate that threats of and exposure to conversion therapy continued to accumulate among participants over the two-year study period..

# Results

## Economic Security

Economic security — defined here as houselessness and difficulty meeting basic needs such as food, housing, or clothing — showed the following patterns.

### Houselessness

At baseline, **21%** of participants reported having **ever** experienced houselessness. Follow-up surveys assessed whether participants had experienced houselessness in the past year. Among these follow-up surveys, **past-year** houselessness increased significantly from **7%** at the one-year follow-up to **13%** at the two-year follow-up.

### Unmet basic needs

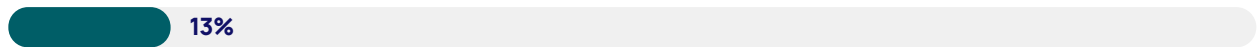
At baseline, **13%** of participants reported being unable to meet their basic needs. Follow-up surveys assessed whether participants had been unable to meet their basic needs in the past year. At the one-year follow-up, **18%** reported unmet basic needs in the past year, and at the two-year follow-up, **19%** reported unmet basic needs in the past year. Overall, reports of unmet basic needs changed significantly across the study period, with no statistically significant change from the one-year to two-year follow-up.

These findings indicate that economic insecurity remained a persistent concern across the two-year study period. The significant increase in past-year houselessness from the one-year to two-year follow-up is especially notable, suggesting that housing instability may have worsened for some participants during the second year of follow-up.

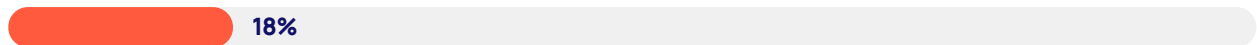
### LGBTQ+ Young People Unable to Meet Basic Needs:

Rates of being unable to meet basic needs increased between baseline and the one-year follow-up and then stabilized.

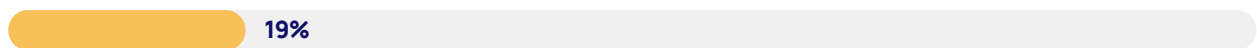
#### Baseline



#### One-year follow-up



#### Two-year follow-up



Note: Baseline reflects current unmet basic needs; one-year and two-year follow-up estimates reflect past-year unmet basic needs.

# Results

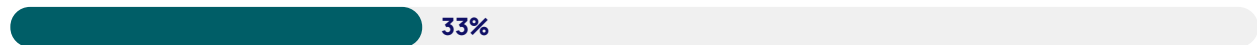
## Bathroom Access and Gender Identity

Among TGNB participants, reports of being prevented or discouraged from using a bathroom that corresponded with their gender identity were common across the study period. At baseline, **33%** of TGNB participants reported ever having experienced this. Follow-up surveys assessed whether participants had been prevented or discouraged from using a bathroom that corresponded with their gender identity in the past year: **35%** of TGNB participants reported being prevented or discouraged from using a bathroom that corresponded with their gender identity at the one-year follow-up, and **40%** reported this at the two-year follow-up. Although a higher proportion of TGNB participants reported past-year bathroom access barriers at the two-year follow-up than at the one-year follow-up, this change was not statistically significant.

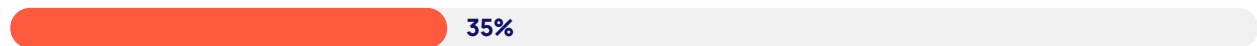
### Bathroom Access Among TGNB Young People:

Rates of being denied bathroom access increased over the course of the study.

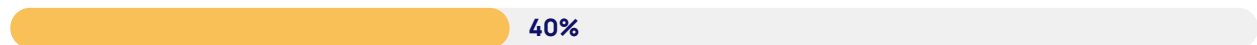
#### Baseline



#### One-year follow-up



#### Two-year follow-up



Note: Baseline reflects lifetime experience of being prevented or discouraged from using a bathroom that corresponded with one's gender identity; one-year and two-year follow-up estimates reflect past-year experiences.

# Results

## Changes in Protective Factors Over Time

Protective factors are the resources and supports that buffer minority stress and promote LGBTQ+ young people's well-being. In this section, we examine how key protective factors changed over two years of Project SPARK, including access to mental health care; medical, legal, and social supports for gender transition (such as transgender health care and document updates); affirming environments (at home and in school); online safety; gender euphoria; and help-seeking behaviors.

### Access to Mental Health Care

#### Access to Desired Mental Health Care

At the time of the baseline survey, among participants who wanted mental health care, **80%** reported that they were receiving it. At the one-year follow-up, **61%** reported receiving the mental health care they wanted in the past year. By the two-year follow-up, **80%** reported receiving the mental health care they wanted in the past year. Overall, receipt of desired mental health care changed significantly across the study period; the follow-up estimates suggest that receipt of desired mental health care improved between the first and second years of follow-up, with the two-year follow-up estimate similar to the percentage reporting current receipt of care at baseline.

#### Access to Desired Mental Health Care Among LGBTQ+ Young People:

Rates of access to mental health care dropped from baseline to the one-year follow-up but returned to similar rates by the two-year follow-up.

##### Baseline



##### One-year follow-up



##### Two-year follow-up



Note: Baseline reflects whether participants were receiving desired mental health care at the time of the survey; one-year and two-year follow-up estimates reflect receipt of desired mental health care in the past year.

# Results

## Helpfulness of Received Mental Health Care

Among participants who received mental health care, most reported that the care was helpful. At baseline, **64%** of participants who were currently receiving mental health care reported that it was helpful. At the one-year follow-up, **80%** of participants who received mental health care in the past year reported that it was helpful. By the two-year follow-up, **91%** of participants who received mental health care in the past year reported that it was helpful. Overall, perceived helpfulness of received mental health care changed significantly across the study period, suggesting that participants who received care reported helpful care at increasingly higher rates over time.



“ I would love mental health support as well as gender affirming care. It would help me to feel less depressed and anxious all the time if I was able to express myself in a way I want to. ”

“ Therapy has been one of the most helpful things in my life, period. It is the best medical care I have ever received in my life and saved my life. I used to struggle with obsessive and intrusive thoughts and suicidal ideation. I have managed to cope and adapt with the help of therapy. I am also working on processing the trauma from my childhood and upbringing. ”



# Results

## Mental Health-Related Hospitalization

At baseline, **22%** of participants reported ever having been hospitalized for mental health-related reasons. Follow-up surveys assessed past-year hospitalization. At the one-year follow-up, **5%** of participants reported a mental health-related hospitalization in the past year, compared to **6%** at the two-year follow-up. Rates of past-year hospitalization remained relatively low at both follow-up points and did not significantly change from the one-year to two-year follow-up.

## Barriers to Care

**Baseline characteristics:** At the start of the study, the most common reasons for being unable to access desired mental health care in the past were:

1. Inability to afford it (43%)
2. Fear of not being taken seriously (35%)
3. Fear of involuntary hospitalization (32%)
4. Fear of talking about mental health with someone else (31%)
5. Previous negative experiences with a therapist (30%)

**Changes over time:** Two years later, three of the five most common barriers reported at baseline remained among the top reasons for not accessing care:

1. Not wanting to have to get a parent/caregiver's permission (49%)
2. Inability to afford care (27%)
3. Fear of talking about mental health with someone else (16%)
4. Fear of not being taken seriously (14%)
5. Feeling that provider would not understand their LGBTQ+ identity (13%)

# Results

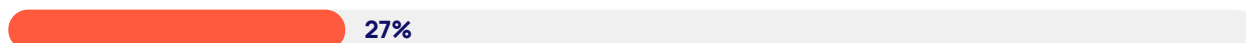
## Barriers to Mental Health Care Among LGBTQ+ Young People:

The top 5 barriers to mental health care at the two-year follow-up.

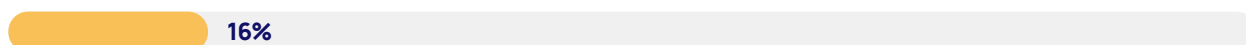
Didn't want to get parents permission



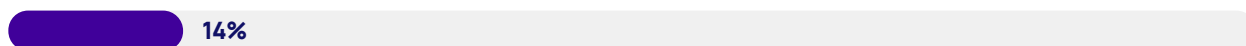
Couldn't afford it



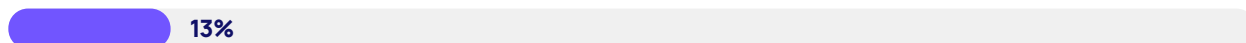
Afraid to talk about mental health concerns with someone else



Afraid I wouldn't be taken seriously



Didn't feel they would understand my LGBTQ+ identity



“ It's been really difficult to find a therapist or mental health support that holds all my intersecting identities as Asian, trans/LGBTQ, an immigrant, a high-functioning person who struggles behind the scenes. ”

# Results

## Access to Transgender Health Care

### Access to Puberty Blockers

Use of puberty blockers remained low across the two-year study period. At baseline, **2%** of TGNB participants reported having ever used puberty blockers or using them at the time of the survey. At the one-year follow-up, **4%** reported using puberty blockers during the past year; this remained at **4%** at the two-year follow-up. Overall, reported puberty blocker use did not change significantly over the two-year follow-up period.

“ Transgender health care has helped me finally live the life I was supposed to be living. I truly don't know where I'd be without it. ”



# Results

## Access to Hormones

TGNB participants were asked whether they wanted gender-affirming hormones – also referred to as hormone replacement therapy – which typically include testosterone or estrogen used to support gender-related physical changes. The proportion of TGNB participants **who wanted hormones** increased significantly over the study period, from **59%** at baseline to **67%** at the one-year follow-up and **71%** at the two-year follow-up. The increase from the one-year to two-year follow-up was not statistically significant.

### Desire for Gender-Affirming Hormones Among TGNB Young People:

The number of TGNB young people who desired gender-affirming hormones increased over the course of the study.

#### Baseline



#### One-year follow-up



#### Two-year follow-up



**Access to desired hormones** also increased significantly across the two-year study period. Among TGNB participants who wanted hormones, **34%** reported access at baseline, compared to **49%** at the one-year follow-up and **62%** at the two-year follow-up.

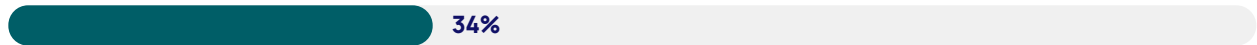
# Results

Because participants aged over the course of the study, age at follow-up is an important context for interpreting access to desired hormones. At the two-year follow-up, among TGNB participants who wanted hormones, **73% of those ages 18 and older** had access to them, compared to **33% of those under age 18**. Among TGNB participants who wanted hormones but did not have access at baseline, **37% had access by the end of the second study year**. Among those who already had access to hormones at baseline, 97% maintained access by the two-year follow-up.

## Access to Gender-Affirming Hormones Among TGNB Young People:

Access to desired gender-affirming hormones increased across the course of the study.

Baseline



One-year follow-up



Two-year follow-up



“ The happiness I felt when the hormones started changing my body is indescribable. Nothing else has done more to convince me that I'm actually transgender and it's not all in my head. ”

# Results

## Access to Gender-Related Surgeries to Support Gender Transition

In the U.S., gender-related surgeries – when pursued – are undertaken after careful clinical evaluation and informed consent with qualified medical professionals, in line with applicable standards of care and laws. Availability and eligibility vary by age, state, and insurance. As with all findings in this report, these results are based on a convenience (non-probability) sample and are not nationally representative population estimates.

Among TGNB participants, reports of having had surgery in the past year increased from **2%** at the one-year follow-up to **8%** at the two-year follow-up; this change was statistically significant. Because participants aged over the course of the study, age at follow-up is an important context for interpreting the proportion of participants who reported having gender-related surgery in the past year. Nearly all participants who reported having surgery in the past year were ages 18 or older at the time of the survey. Among those who reported surgery during the second year of the study, the median age was 23 years old.

# Results

## Access to Tools Related to Gender Expression or Transition

TGNB youth were asked whether they were able to access tools – such as clothing, binders, or shapewear – that support their gender expression or transition. Among TGNB participants who expressed interest in tools related to gender expression or transition, access increased significantly over the study period. At baseline, **62%** reported being able to access tools they wanted. At the one-year follow-up, **68%** reported having access to desired tools, increasing to **75%** at the two-year follow-up.

Access increased for both younger and older TGNB participants, though older participants reported higher levels of access overall. Among participants ages **18 and older** at the time of the survey, access increased from 69% at baseline to 77% at the two-year follow-up. Among participants **under age 18** at the time of the survey, access increased from 51% at baseline to 67% at the two-year follow-up, representing a larger increase among younger participants.

### Gender-Affirming Tools Among TGNB Young People:

There was an increase in access to gender-affirming tools over the two year study period.

#### Baseline



#### One-year follow-up



#### Two-year follow-up



“ Receiving HRT and top surgery has eliminated almost all of my dysphoria and greatly lessened related problems like social anxiety, disordered eating behaviors etc. I am much happier and healthier than I've ever been in my life. ”

# Results

## Ability to Change Identification Documents

TGNB participants were asked whether they wanted to change their identification documents, such as a driver's license or passport, to match their gender identity, and whether they were able to do so. The proportion of TGNB participants **who wanted to change** their identification documents remained stable at about two-thirds across the study period (69% at baseline, 68% at the one-year and two-year follow-ups). Among those who wanted to change their documents, **55%** reported **being able to do so** at baseline, compared to **58%** at the one-year follow-up and **53%** at the two-year follow-up.

Neither the proportion of TGNB participants who wanted to change their identification documents nor the proportion of those interested who were able to do so changed significantly across the two-year study period.

# Results

## Affirming Spaces

### Access to Affirming Schools

Among participants who were in school, **54%** reported that their school was LGBTQ+-affirming at baseline. At the one-year follow-up, **61%** reported having an LGBTQ+-affirming school environment, suggesting an increase in reported school affirmation during the first year. At the two-year follow-up, the percentage reporting an affirming school environment decreased to **51%**. The distribution of reported affirming school environments differed significantly across the study period.

#### Affirming School Environments Among LGBTQ+ Participants:

Rates of attending an affirming school rate fluctuated over the course of the study.

##### Baseline



##### One-year follow-up



##### Two-year follow-up



“ I would have appreciated more open discussions about diverse identities in school, as it would have made me feel more seen and accepted. ”

# Results

## Access to Affirming Home Environments

The percentage of LGBTQ+ young people who reported living in an LGBTQ+-affirming home environment increased over the two-year study period. At baseline, **53%** of participants reported that their home was LGBTQ+-affirming. At the one-year follow-up, this remained similar, with **53%** reporting an affirming home environment. At the two-year follow-up, this increased to **61%**. Overall, the change across the study period was statistically significant, driven by the increase from the one-year to the two-year follow-up. These findings suggest that home environments became more affirming for some participants over time, particularly during the second year of follow-up.

### Affirming Home Environments Among LGBTQ+ Participants:

Rates of living in an affirming home increased between the one-year and two-year follow-up.

Baseline



One-year follow-up



Two-year follow-up



“ I would like more motivational support from people around me especially from my family members cause I really need their acceptance but I've received so much help from my friends in the LGBTQ+ community which keeps me going and I'm very grateful for their love and support. ”

# Results

## Types of Support Received by Family

LGBTQ+ youth answered 12 questions about specific family supportive actions (e.g., “Supported your gender expression,” “Talked with you respectfully about your LGBTQ+ identity”). Responses were on a 4-point scale (1 = no family members engaged in the action and 4 = all of the family members engaged in the action). Scores were summed to create a total score of supportive actions taken by the family.

Mean family supportive action scores changed significantly over the two-year study period. At baseline, when participants reported whether family members had ever engaged in each supportive action, the average score was **1.97** (standard deviation [SD] = 0.64, range: 1–4). At the one-year follow-up, when participants reported family supportive actions in the past year, the average score decreased to **1.87** (SD = 0.67). At the two-year follow-up, the average score increased slightly to **1.92** (SD = 0.76), though the change from the one-year to two-year follow-up was not statistically significant. Across all three time points, average scores remained close to 2 on the 1–4 scale, indicating that, on average, **participants reported that some family members engaged in supportive actions across the study period.**

## Online Safety and Social Media Use

Measures of online safety and social media use were added at the one-year follow-up; therefore, changes are presented from the one-year to two-year follow-up only. On the Comfort Online Scale (Lucero, 2017), measured on a 1–5 scale where higher scores indicate **greater comfort using social media** to disclose personal information and explore or express gender and sexuality, the average score **decreased** from 3.53 (SD = 0.89) at the one-year follow-up to 3.43 (SD = 1.01) at the two-year follow-up. This modest decrease suggests that participants became slightly less comfortable using social media for personal disclosure and identity exploration during the second year of follow-up.

**LGBTQ+-related cyberbullying** was assessed using an adaptation of the Experiences and Frequency of Cyberbullying Subscale from the Cyberbullying and Face-to-Face Bullying Scale (Cooper & Blumenfeld, 2012). Scores ranged from 1 to 4, with higher scores indicating more

# Results

frequent online harassment, exclusion, or harmful messages because a participant is LGBTQ+. The average LGBTQ+-cyberbullying scores at both time points were **low**, and **decreased** from 1.39 (SD = 0.60) at the one-year follow-up to 1.34 (SD = 0.56) at the two-year follow-up. This slight decrease suggests that participants reported marginally fewer LGBTQ+-related cyberbullying experiences during the second year of follow-up.

Participants were also asked about **LGBTQ+-related social media behaviors** in the past 30 days. From the one-year to two-year follow-up, participants reported **modest decreases** in LGBTQ+-related information-seeking, support-seeking, and connection on social media, including looking for information about sexual orientation or gender identity they would not ask about offline (47% to 45%), seeking LGBTQ+-related support (43% to 41%), and receiving affirming support online (38% to 33%).

## Gender Euphoria

Gender euphoria captures how affirmed and comfortable young people feel in expressing their gender and being recognized for who they are. Following the Trans Youth CAN! Guide (Bauer et al., 2021), each participant's score was calculated as the average of 10 items rated 1–5, yielding a 1–5 scale in which higher values indicate greater gender positivity.

Gender euphoria scores increased significantly over the two-year study period. Among all LGBTQ+ participants, the average gender positivity score increased from 3.09 (SD = 0.82) at baseline to 3.24 (SD = 0.85) at the one-year follow-up and 3.33 (SD = 0.85) at the two-year follow-up. This represents a 0.24-point increase from baseline to the two-year follow-up.

**Among TGNB participants, the average score increased from 3.07 (SD = 0.83) at baseline to 3.23 (SD = 0.85) at the one-year follow-up and 3.37 (SD = 0.85) at the two-year follow-up. This represents a 0.30-point increase from baseline to the two-year follow-up.**

Both increases were statistically significant.

These findings indicate that, on average, **participants reported feeling somewhat more affirmed and comfortable in their gender over time**. Although the increases were modest in magnitude, they suggest a **consistent upward pattern in gender positivity** across the first two years of the study, including among TGNB participants.

# Results

## Help-seeking behaviors during suicidal crises

Participants who experienced suicidal thoughts were asked whether they sought help from different sources during those suicidal crises. Across the two-year study period, **friends were the most commonly reported source of support**, followed by mental health professionals and intimate partners. Helplines were the only source of support that changed significantly across the study period.

**Friends:** Friends were the most common source of support across all time points. At baseline, 44% of participants who experienced suicidal thoughts reported seeking help from a friend, compared to 46% at the one-year follow-up and 42% at the two-year follow-up.

**Mental health professionals:** Help-seeking from a mental health professional remained relatively stable, reported by 35% at baseline, 38% at the one-year follow-up, and 37% at the two-year follow-up.

**Intimate partners:** Help-seeking from an intimate partner was reported by 31% at baseline, 37% at the one-year follow-up, and 32% at the two-year follow-up.

**Helplines:** Help-seeking from a helpline increased from 22% at baseline to 30% at the one-year follow-up and remained at 30% at the two-year follow-up. This was the only source of support that changed significantly across the study period.

**Parents/caregivers and other family members:** Help-seeking from a parent or caregiver was reported by 15% at baseline, 17% at the one-year follow-up, and 17% at the two-year follow-up. Help-seeking from another relative or family member was reported by 11% at baseline, 14% at the one-year follow-up, and 10% at the two-year follow-up.

**Doctors/general practitioners:** Help-seeking from a doctor or general practitioner remained low, reported by 6% at baseline, 4% at the one-year follow-up, and 5% at the two-year follow-up.

**Religious leaders:** Help-seeking from a minister or religious leader was rare across all time points, reported by 1% at baseline and less than 1% at both follow-ups.

**No one:** The proportion of participants who reported seeking help from no one when experiencing suicidal thoughts was 29% at baseline, 31% at the one-year follow-up, and 32% at the two-year follow-up.

# Results

## Help-Seeking Behaviors During Suicidal Crises:

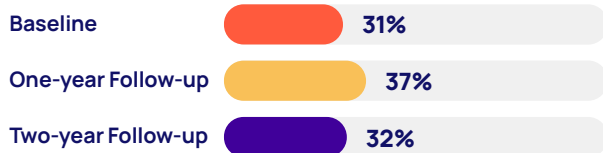
### Friend



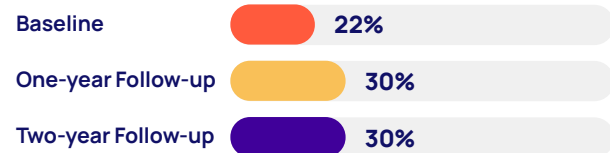
### Mental Health Professional



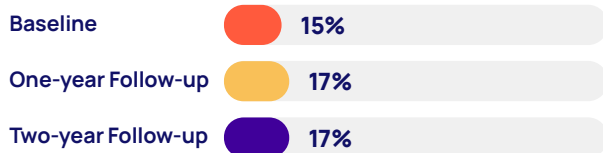
### Intimate Partner



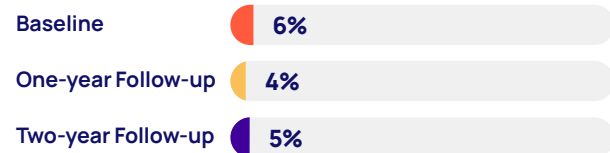
### Helpline



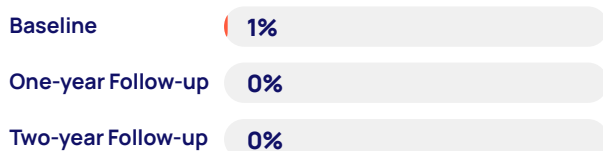
### Parent / Caregiver



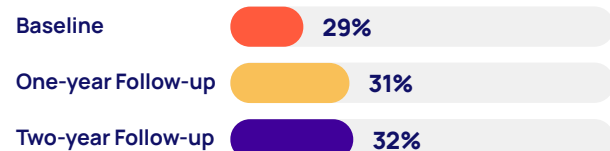
### Doctor/General Practitioner



### Minister / Religious Leader



### No One



# Results

## Temporal Relationships

Risk and protective factors were associated with changes in participants' likelihood of experiencing recent symptoms of anxiety, recent symptoms of depression, self-harm, and suicidal ideation over time. All models accounted for the nested nature of the data, in which multiple observations from the same participant were collected across waves. Models also controlled for age, sexual orientation, gender identity, and race/ethnicity.

## Risk Factors

Several risk factors were consistently associated with higher likelihood of adverse mental health outcomes, self-harm, and suicidal ideation. The **largest observed associations** included:

- Participants who had been threatened with or subjected to conversion therapy had nearly three times the odds of suicidal ideation over time (aOR = 2.86, 95% CI = 2.28–3.60).
- Participants who experienced homelessness had more than twice the odds of self-harm (aOR = 2.29, 95% CI = 1.75–2.98) and suicidal ideation (aOR = 2.33, 95% CI = 1.85–2.95).
- Among TGNB participants, victimization based on gender identity was associated with more than twice the odds of self-harm (aOR = 2.21, 95% CI = 1.80–2.72) and suicidal ideation (aOR = 2.42, 95% CI = 1.96–2.98).
- Recent mental health-related hospitalization showed the strongest association with self-harm (aOR = 5.90, 95% CI = 3.85–9.03).

The full set of associations for each of the risk factors is presented below.

**Victimization based on sexual orientation** was associated with higher likelihood of anxiety symptoms (adjusted odds ratio [aOR] = 1.24, 95% confidence interval [CI] = 1.10–1.46), depressive symptoms (aOR = 1.42, 95% CI = 1.21–1.66), self-harm (aOR = 1.71, 95% CI = 1.41–2.07), and suicidal ideation over time (aOR = 1.73, 95% CI = 1.45–2.06).

**Victimization based on gender identity** was associated with higher likelihood of anxiety symptoms (aOR = 1.77, 95% CI = 1.44–2.18), depressive symptoms (aOR = 1.52, 95% CI = 1.25–1.85), self-harm (aOR = 2.21, 95% CI = 1.80–2.72), and suicidal ideation over time (aOR = 2.42, 95% CI = 1.96–2.98).

# Results

**Discrimination based on sexual orientation** was associated with higher likelihood of depressive symptoms (aOR = 1.42, 95% CI = 1.23–1.65), self-harm (aOR = 1.28, 95% CI = 1.08–1.51), and suicidal ideation over time (aOR = 1.50, 95% CI = 1.28–1.77).

**Discrimination based on gender identity** was associated with higher likelihood of anxiety symptoms (aOR = 1.47, 95% CI = 1.22–1.77), depressive symptoms (aOR = 1.48, 95% CI = 1.24–1.78), self-harm (aOR = 1.46, 95% CI = 1.21–1.77), and suicidal ideation over time (aOR = 1.48, 95% CI = 1.22–1.79).

Having been **threatened with or subjected to conversion therapy** was associated with higher likelihood of anxiety symptoms (aOR = 1.28, 95% CI = 1.04–1.58), depressive symptoms (aOR = 1.59, 95% CI = 1.30–1.95), self-harm (aOR = 1.80, 95% CI = 1.39–2.31), and suicidal ideation over time (aOR = 2.86, 95% CI = 2.28–3.60).

**Houselessness** was associated with higher likelihood of anxiety symptoms (aOR = 1.32, 95% CI = 1.06–1.65), depressive symptoms (aOR = 1.41, 95% CI = 1.14–1.75), self-harm (aOR = 2.29, 95% CI = 1.75–2.98), and suicidal ideation over time (aOR = 2.33, 95% CI = 1.85–2.95).

**Being unable to meet basic needs** was associated with higher likelihood of anxiety symptoms (aOR = 1.60, 95% CI = 1.30–1.97), depressive symptoms (aOR = 1.82, 95% CI = 1.50–2.23), self-harm (aOR = 1.74, 95% CI = 1.39–2.16), and suicidal ideation over time (aOR = 1.65, 95% CI = 1.33–2.03).

Among TGNB participants, being **prevented from using a bathroom** that corresponded with their gender identity was associated with higher likelihood of anxiety symptoms (aOR = 1.33, 95% CI = 1.07–1.66), depressive symptoms (aOR = 1.55, 95% CI = 1.26–1.91), self-harm (aOR = 1.77, 95% CI = 1.42–2.21), and suicidal ideation over time (aOR = 1.47, 95% CI = 1.18–1.84).

Recent **mental health-related hospitalization** was associated with higher likelihood of anxiety symptoms (aOR = 1.57, 95% CI = 1.10–2.22), self-harm (aOR = 5.90, 95% CI = 3.85–9.03), and suicidal ideation over time (aOR = 1.43, 95% CI = 1.02–1.99).

# Results

## Protective Factors

Several protective factors were associated with lower likelihood of adverse mental health outcomes, self-harm, and suicidal ideation. **Some protective associations were also especially notable**, including:

- Higher family support was associated with 45% lower odds of suicidal ideation (aOR = 0.55, 95% CI = 0.48–0.64) and 42% lower odds of self-harm (aOR = 0.58, 95% CI = 0.50–0.67).
- Higher gender euphoria was associated with 50% lower odds of suicidal ideation (aOR = 0.50, 95% CI = 0.44–0.57) and 49% lower odds of depressive symptoms (aOR = 0.51, 95% CI = 0.45–0.58).
- Among TGNB participants, being able to change identification documents to match one's gender identity was associated with 45% lower odds of suicidal ideation (aOR = 0.55, 95% CI = 0.43–0.72), and access to desired hormones was associated with 38% lower odds of depressive symptoms (aOR = 0.62, 95% CI = 0.46–0.85).

The full set of associations for each of the protective factors is presented below.

Among TGNB participants, **being able to change identification documents** to match one's gender identity was associated with lower likelihood of anxiety symptoms (aOR = 0.69, 95% CI = 0.53–0.89), depressive symptoms (aOR = 0.69, 95% CI = 0.54–0.89), and suicidal ideation over time (aOR = 0.55, 95% CI = 0.43–0.72).

Among TGNB participants, **access to desired hormones** was associated with lower likelihood of depressive symptoms (aOR = 0.62, 95% CI = 0.46–0.85) and suicidal ideation over time (aOR = 0.65, 95% CI = 0.47–0.91).

# Results

Living in an **LGBTQ+-affirming home** was associated with lower likelihood of anxiety symptoms (aOR = 0.78, 95% CI = 0.67–0.90), depressive symptoms (aOR = 0.63, 95% CI = 0.55–0.73), self-harm (aOR = 0.70, 95% CI = 0.59–0.82), and suicidal ideation over time (aOR = 0.76, 95% CI = 0.65–0.89).

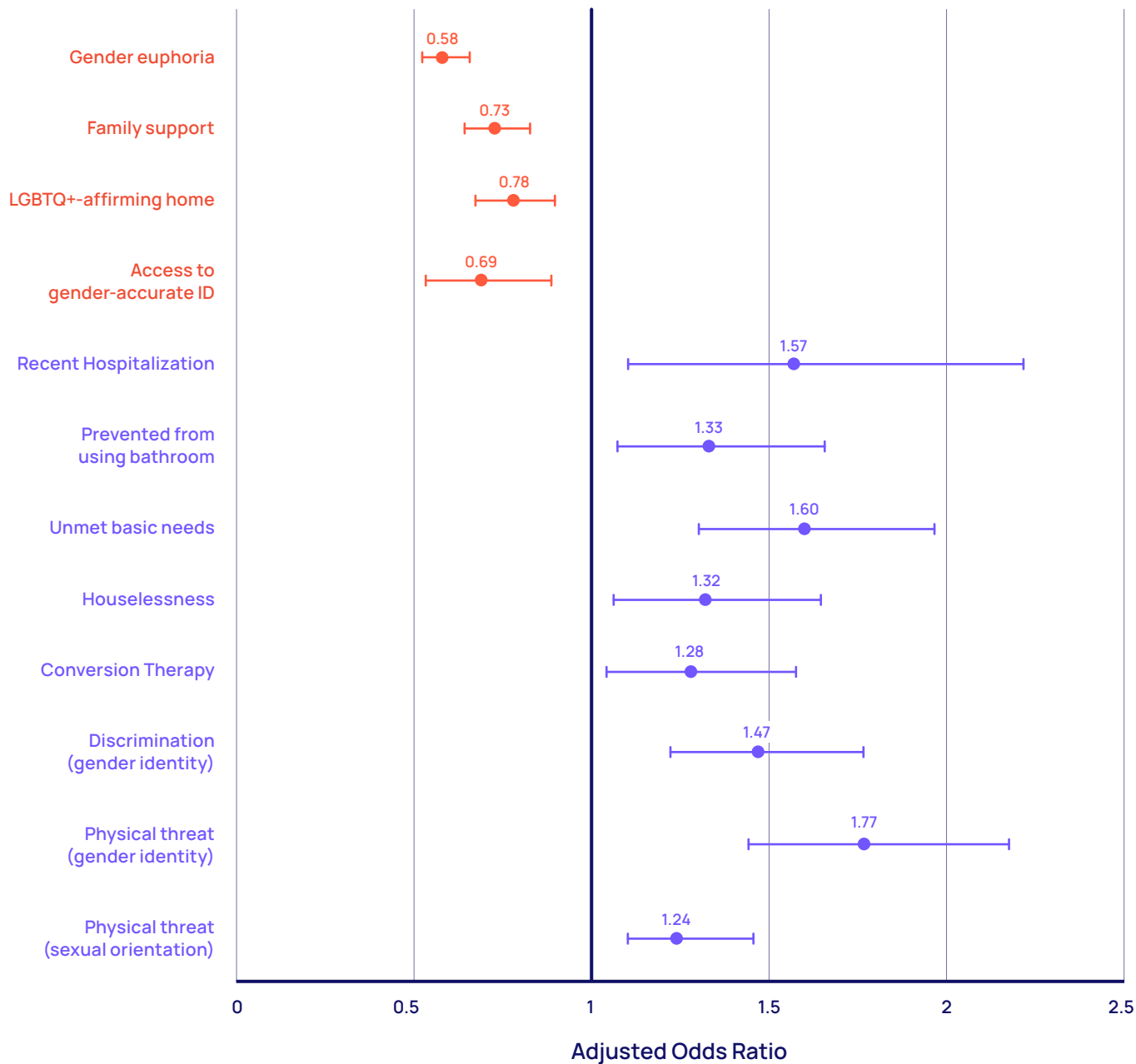
**Family support** was associated with lower likelihood of anxiety symptoms (aOR = 0.73, 95% CI = 0.64–0.83), depressive symptoms (aOR = 0.59, 95% CI = 0.52–0.68), self-harm (aOR = 0.58, 95% CI = 0.50–0.67), and suicidal ideation over time (aOR = 0.55, 95% CI = 0.48–0.64).

**Gender euphoria** was associated with lower likelihood of anxiety symptoms (aOR = 0.58, 95% CI = 0.52–0.66), depressive symptoms (aOR = 0.51, 95% CI = 0.45–0.58), self-harm (aOR = 0.70, 95% CI = 0.62–0.79), and suicidal ideation over time (aOR = 0.50, 95% CI = 0.44–0.57).

Taken together, the models show that experiences of victimization, discrimination, conversion therapy, economic insecurity, bathroom access barriers, and recent hospitalization were associated with greater likelihood of adverse mental health outcomes, self-harm, and suicidal ideation over time. In contrast, affirming home environments, family support, and gender euphoria were consistently associated with lower likelihood of anxiety, depression, self-harm, and suicidal ideation, while access to gender-affirming resources — including accurate identification documents and desired hormones — was associated with lower likelihood of anxiety, depression, and/or suicidal ideation among TGNB participants.

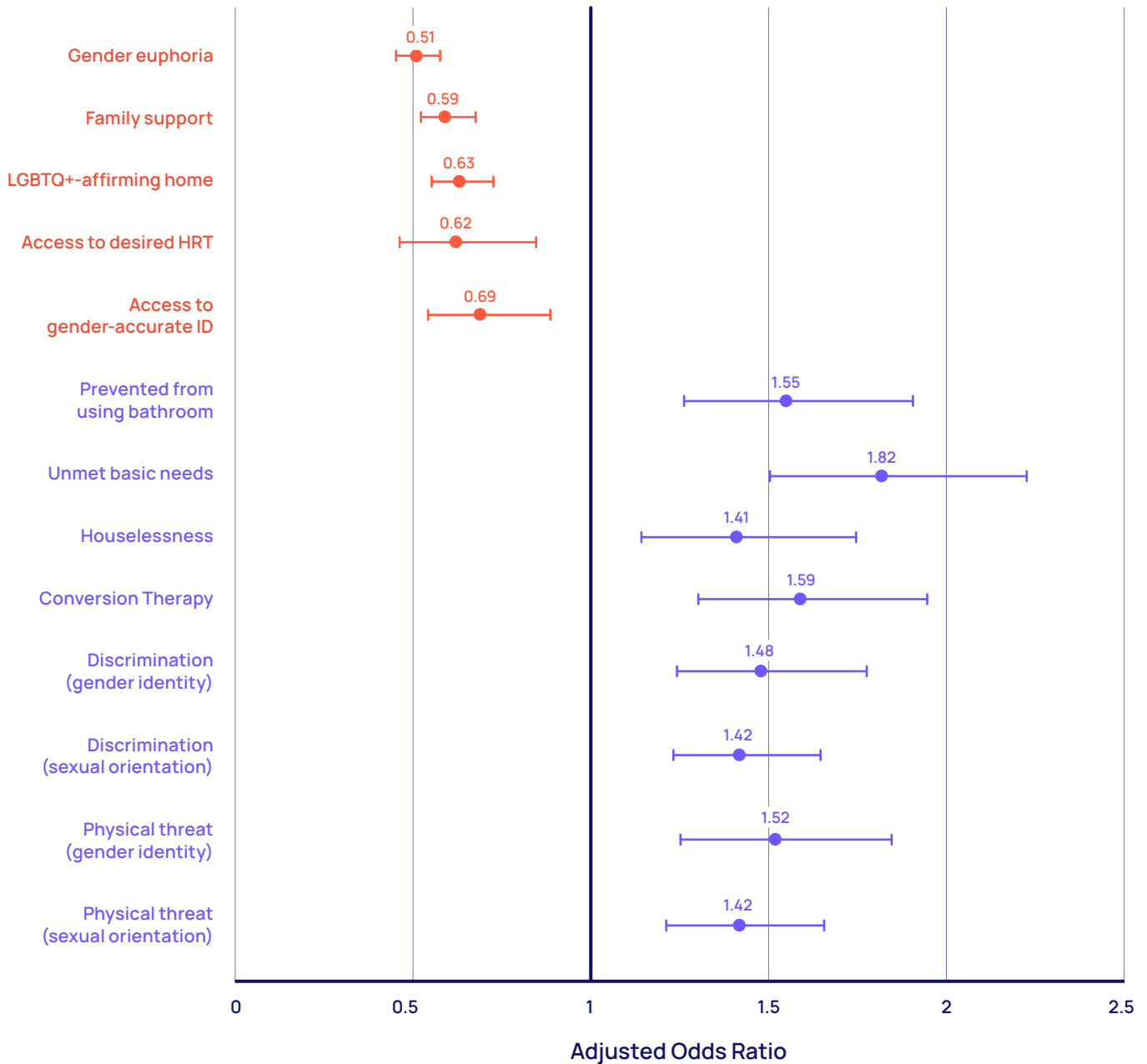
# Results

## Factors Associated with Changes in Anxiety among LGBTQ+ Young People



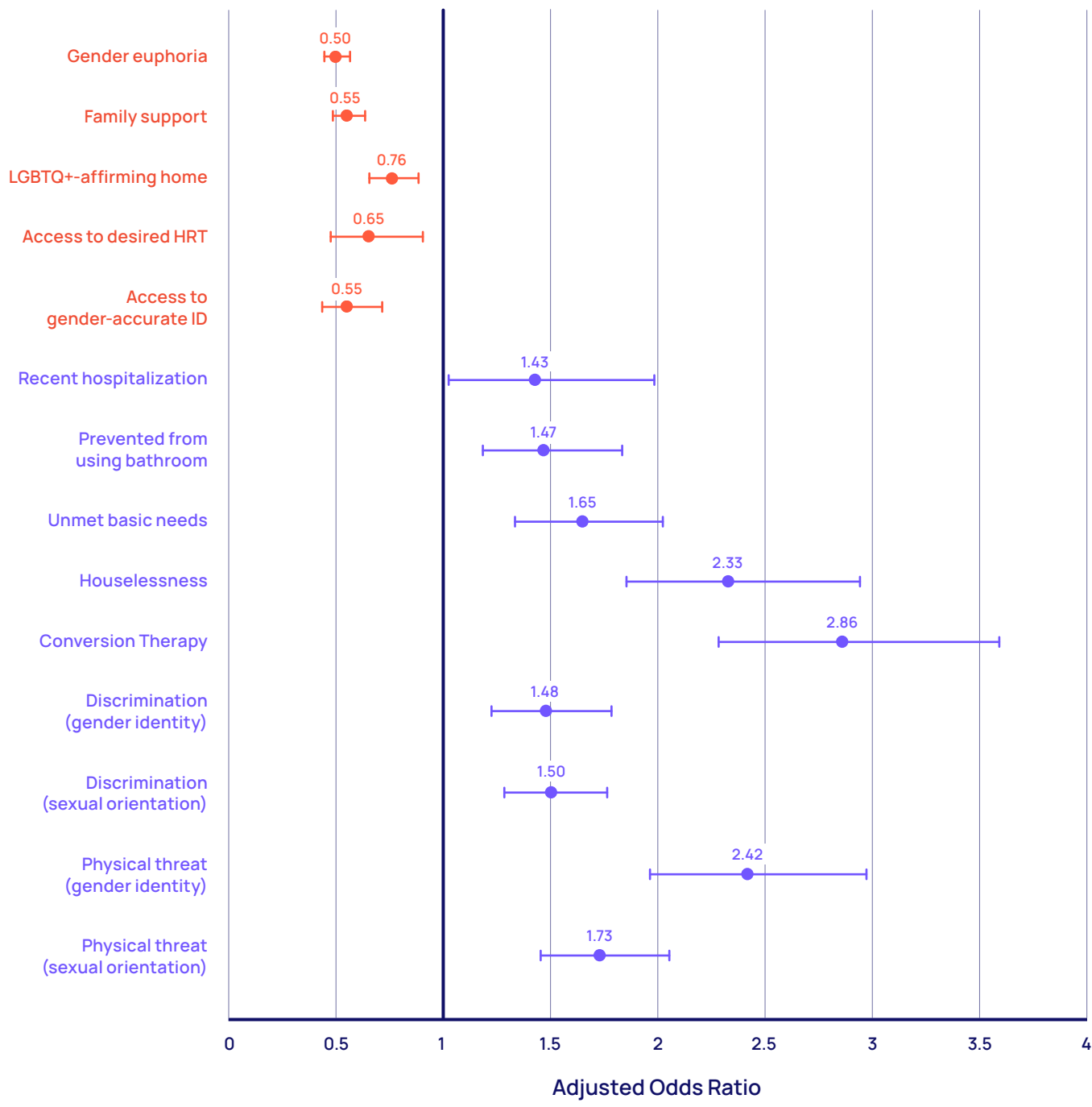
# Results

## Factors Associated with Changes in Depression among LGBTQ+ Young People



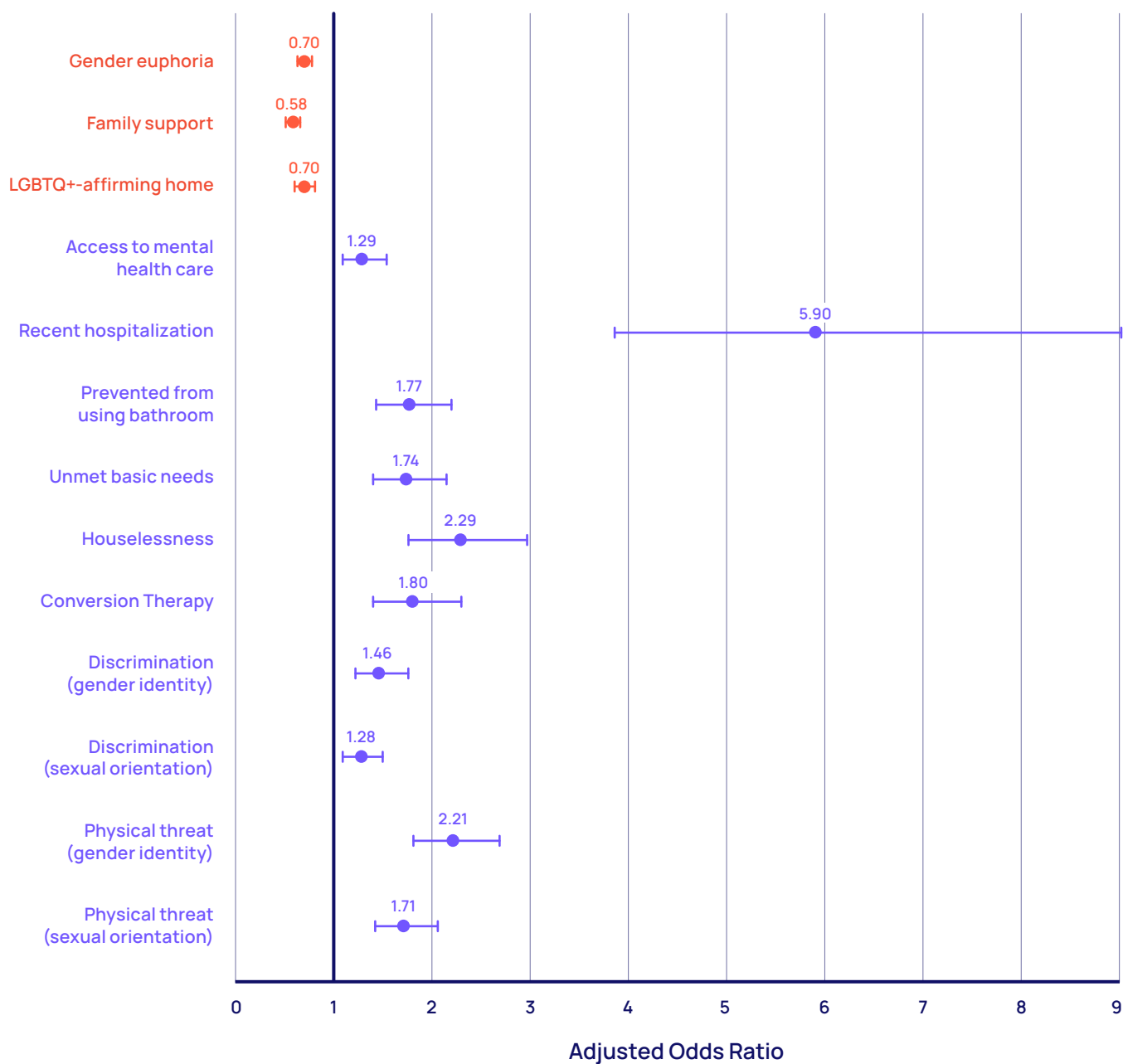
# Results

## Factors Associated with Changes in Suicidal Ideation among LGBTQ+ Young People



# Results

## Factors Associated with Changes in Self-Harm among LGBTQ+ Young People



# Interpretations and Implications

The two-year Project SPARK findings show that LGBTQ+ young people continued to experience substantial and persistent mental health challenges across the study period. Anxiety and depression increased from baseline to follow-up and remained elevated, while suicidal ideation stayed consistently high, indicating that overall mental health concerns did not improve over the two-year study period. At the same time, self-harm and suicide attempts decreased from baseline. This contrast may be attributable to the fact that protective factors helped some participants manage periods of acute risk more safely, even as chronic distress remained high. Indeed, the study's longitudinal models show that **family support, affirming home environments, and gender euphoria were each associated with lower likelihood of self-harm over time**. Several protective factors — including perceived helpfulness of mental health care, gender euphoria, and helpline use during suicidal crises — also strengthened during the first year of the study, the same period in which self-harm and suicide attempts declined. This interpretation is consistent with research showing that social support, family support, and affirming environments can buffer suicide-related risk among LGBTQ+ youth, even in the context of ongoing mental health challenges (DeFerro et al., 2024; Russell & Fish, 2016; Ryan et al., 2010). Because the study experienced attrition over time, changes in self-harm and suicide attempts may also partly reflect changes in the composition of the analytic sample.

The divergence between sustained suicidal ideation and declining self-harm and attempts is itself noteworthy. Research within the "ideation-to-action" framework indicates that the factors driving suicidal ideation often differ from those governing the progression from ideation to suicidal behavior (Klonsky & May, 2015; Klonsky et al., 2016). It suggests that the pathway from suicidal thoughts to suicidal behavior may be where protective factors and supports exerted the most influence during the study period, and it reinforces that ideation-focused measures alone do not capture the full picture of risk.

## Stigma-Related Stressors

One likely reason that anxiety, depression, and suicidal ideation remained high is that many **participants continued to face stigma-related stressors throughout the study**. More than half of participants reported discrimination based on sexual orientation or gender identity at every time point, showing how persistent these experiences were across the two years. Sexual orientation-based discrimination changed significantly over time, while physical threats based on sexual orientation remained stable. Among TGNCB participants, gender identity-based discrimination increased significantly, while physical

# Interpretations and Implications

threats based on gender identity did not change significantly. Overall, the clearest worsening was in gender identity-based discrimination among TGNB young people. In addition, threats of and exposure to conversion therapy continued to accumulate over the study period, indicating that some participants continued to face direct attempts to change, suppress, or invalidate their sexual orientation or gender identity. This is especially concerning given evidence that conversion therapy and related sexual orientation or gender identity change efforts are associated with serious mental health harms, including suicidal thoughts and behaviors among LGBTQ+ young people (Forsythe et al., 2022; Green et al., 2020). These findings suggest that stigma, exclusion, threats to safety, and identity-based invalidation remained common and consequential experiences for many LGBTQ+ young people, particularly TGNB youth.

## Economic Insecurity

Economic insecurity remained a concern across the study period. Past-year houselessness increased significantly from the one-year to the two-year follow-up, while unmet basic needs remained high at both follow-up points. This increase may reflect, in part, participants aging into more independent living situations, and losing access to family housing – a transition that carries particular risk for LGBTQ+ young people, who experience disproportionate rates of family rejection and housing instability (DeChants et al., 2021). These findings underscore that mental health is closely tied to the conditions of young people's daily lives, including whether they have stable housing, enough food, and access to basic resources. Improving mental health for LGBTQ+ young people therefore requires attention not only to clinical care, but also to the social and economic conditions that shape their safety and well-being.

## Gender Affirmation: Progress and Barriers

The findings related to transgender health care and gender affirmation show both progress and ongoing barriers. Among TGNB participants, desire for hormones increased over the study period, and access to desired hormones also increased substantially. This increase should be interpreted in the context of participants aging over the course of the study. As participants moved from adolescence into young adulthood, some may have gained more control over health care decisions, had fewer consent-related barriers, or become better positioned to find and navigate transgender health care. The wide gap

# Interpretations and Implications

in access at the two-year follow-up between participants ages 18 and older (73%) and those under 18 (33%) is consistent with this interpretation, and also reflects the **restrictive legal landscape governing transgender health care for minors in many states**. Prior research has similarly identified caregiver involvement, provider availability, long wait times, and lack of affirming or knowledgeable care as key barriers to transgender health care for TGNB youth (Gridley et al., 2016; Pullen Sansfaçon et al., 2019; Sequeira et al., 2023). Reports of gender-related surgery also occurred primarily among older participants: nearly all participants who reported surgery in the past year were ages 18 or older at the time of the survey, and among those who reported surgery during the second year of the study, the median age was 23. This pattern is consistent with prior evidence that gender-related surgeries are uncommon in adolescence and, when they do occur among TGNB young people, they more often take place in young adulthood (Fazal et al., 2023).

Beyond medical care, access to tools related to gender expression or transition also increased, particularly among younger participants, suggesting some gains in social and practical forms of gender affirmation. At the same time, many TGNB participants continued to report barriers to gender affirmation, including bathroom access barriers and difficulty changing identification documents. This distinction is critical: some forms of gender affirmation became more accessible as participants gained autonomy with age, including hormones and tools related to gender expression. Other forms of gender affirmation that were tied to **laws and policies**, such as updating identification documents and accessing bathrooms that aligned with their genders, did not show progress over time.

## Affirming Environments and Relationships

Affirming environments and supportive relationships showed encouraging but uneven patterns. LGBTQ+-affirming home environments increased by the two-year follow-up, suggesting that some participants may have experienced greater acceptance, support, or safety in their immediate living environments over time. This increase may also reflect participants gaining greater control over their living situations as they aged into adulthood, including moving into homes of their own choosing.

Gender euphoria also increased steadily among both the full sample and TGNB participants. The increase in gender euphoria is especially important because it highlights positive identity-related experiences — not only distress, dysphoria, or risk — as a meaningful dimension of LGBTQ+ youth well-being (Bauer et al., 2021).

# Interpretations and Implications

**The concurrent rise in gender euphoria alongside worsening gender identity-based discrimination is striking:** even in a more hostile external climate, TGNB participants reported growing comfort and affirmation in their gender, which may reflect gains in access to hormones, gender-expression tools, and affirming homes.

In contrast, affirming school environments increased at the one-year follow-up before decreasing by the two-year follow-up. This fluctuation may reflect **changes in the composition of the in-school subsample as participants aged** – by the two-year follow-up the median age was 21, so fewer participants remained in school and those who did were disproportionately in college and university settings – as well as school transitions, differences in school climate across settings, or changes in the broader social and policy environment affecting LGBTQ+ students.

There were mixed findings related to participants' online behaviors and experiences. LGBTQ-related cyberbullying was low at both the one-year and two-year follow-ups, and LGBTQ+ young people reported slightly fewer cyberbullying experiences at the two-year follow-up. At the same time, at the two-year follow-up, participants reported lower comfort using social media for identity exploration and disclosure, and lower use of social media to seek LGBTQ+-related support and connection. However, these findings demonstrated that many LGBTQ+ young people consistently used social media – through all stages of the study – for information, support, and connection. Ultimately, these results suggest that **online spaces play an important role in helping young people find understanding and belonging, while at the same time, respondents have become somewhat less comfortable using social media** as a source of identity-related support during the second year.

## Mental Health Care: Access, Quality, and Help-Seeking

Mental health care findings point to both strengths and gaps in current systems of support. By the two-year follow-up, **most participants who wanted mental health care were receiving it**, and among participants who received care, perceived helpfulness increased substantially over the study period. These improvements may partly reflect participants aging over the course of the study, gaining more autonomy to seek care, becoming better able to identify care that meets



# Interpretations and Implications

their needs, or feeling more comfortable participating in services over time. They may also reflect **continued or increasing need for mental health support**, as anxiety and depression remained high across the study period. However, barriers to care persisted, including cost, parent or caregiver permission, fear of discussing mental health, fear of not being taken seriously, and concerns that providers would not understand their LGBTQ+ identities. According to these findings, access to care alone is not sufficient; care must also be affordable, affirming, developmentally appropriate, and responsive to LGBTQ+ young people's intersecting identities and needs.

Help-seeking patterns during suicidal crises further show the central role of informal and peer-based support. Friends were the most common source of support across the study period, followed by mental health professionals and intimate partners. Helpline use increased significantly, while help-seeking from parents, caregivers, doctors, and religious leaders remained less common. The consistently low rates of help-seeking from doctors (4–6%) represent a **missed opportunity**, given that primary care is often young people's most regular point of contact with the health system. Moreover, nearly one-third of participants who experienced suicidal thoughts reported seeking help from no one, and this remained consistent across the study period. This is deeply concerning because it suggests that **many LGBTQ+ young people may be navigating moments of crisis without any safety net, including support from family, friends, professionals, or crisis services**. Improving crisis response therefore requires more than making services accessible; young people need to feel that support is safe, trustworthy, and accessible before a crisis escalates.

## Temporal Relationships and Causal Insights

Across the two-year study, LGBTQ+ young people's mental health was closely tied to the social, material, and policy environments in which young people were living. Across models, victimization, discrimination, economic insecurity, and barriers to gender affirmation consistently predicted poorer mental health over time, while affirming relationships, supportive home environments, gender euphoria, and access to gender-affirming resources were associated with better outcomes. This pattern is consistent with minority stress theory and prior research documenting the protective role of affirming environments and relationships (Meyer, 2003; Russell & Fish, 2016; Ryan et al., 2010). Statistical models examining suicide attempts did not reliably converge because attempts were relatively rare events, so suicide attempts are described descriptively earlier in the report rather than interpreted as modeled outcomes.

# Interpretations and Implications

**Victimization and discrimination stood out as some of the strongest and most consistent predictors of poor mental health across the models**, suggesting that stigma-related harm may have lasting implications for mental health trajectories, not only immediate effects on safety and well-being. Economic insecurity also emerged as a consistent predictor: houselessness and unmet basic needs were predictive of anxiety, depression, self-harm, and suicidal ideation. Together, these findings suggest that anxiety, depression, self-harm, and suicidal ideation were closely tied to ongoing social and material stressors, rather than simply reflecting individual vulnerability.

**Recent mental health-related hospitalization** was also associated with higher likelihood of anxiety, self-harm, and suicidal ideation over time, with a particularly strong association for self-harm. This should not be taken to mean that hospitalization itself causes poorer mental health. More likely, hospitalization is a marker of acute clinical severity, identifying young people who were already at higher risk. It does, however, underscore the importance of robust post-discharge support and continuity of care for LGBTQ+ young people following psychiatric hospitalization, a period known to carry heightened risk.

For TGNB participants, **barriers to gender affirmation** were closely linked with mental health risk. Being prevented from using a bathroom that corresponded with one's gender identity was predictive of all four adverse outcomes, while being able to change identification documents and access desired hormones were predictive of better mental health outcomes. Taken together, these findings reinforce that gender affirmation across social, legal, and medical settings is closely tied to better mental health among TGNB young people.

**Conversion therapy threats or exposure remained among the most concerning risk factors**, particularly for suicidal ideation. Participants who had been threatened with or subjected to conversion therapy were more likely to experience anxiety, depression, self-harm, and suicidal ideation over time. Seeing these associations repeatedly across multiple waves of data collection strengthens concern that conversion therapy may contribute to later mental health harms, rather than simply occurring alongside existing distress. These findings add to a growing body of evidence documenting the harms associated with conversion therapy (Forsythe et al., 2022).

Just as importantly, the models identified several factors associated with better mental health. Affirming home environments, family support, and gender euphoria were each predictive of lower likelihood of anxiety, depression, self-harm, and suicidal ideation.

# Interpretations and Implications

These findings suggest that **support is more than simply the absence of rejection; it appears to actively promote better mental health**. Gender euphoria, in particular, highlights the importance of promoting positive identity-related experiences, not only reducing distress or risk (Bauer et al., 2021). Gender euphoria also showed among the strongest protective associations of any factor in the models, suggesting that interventions and environments that **actively cultivate gender positivity** – not only those that reduce harm – may be especially promising.

Overall, these findings reinforce that LGBTQ+ young people's mental health does not develop in isolation. Experiences of victimization, discrimination, conversion therapy, economic insecurity, and barriers to gender affirmation were linked to poorer mental health over time, while affirming family, home, and gender-related supports were consistently associated with better outcomes. Although these observational data cannot establish causality, the **consistency of these patterns across two years provides strong evidence that social environments matter** for LGBTQ+ young people's mental health.

## Broader Context and Policy Implications

This report was conducted during a period when LGBTQ+ young people were navigating persistent stigma, economic insecurity, and uneven access to affirming care and support. Across the U.S., recent policy debates and state-level legislation have focused heavily on transgender youth, including restrictions on transgender health care, participation in school activities, bathroom access, and legal recognition of gender identity (KFF, 2026; Movement Advancement Project, 2026a, 2026b, 2026c; Arrayales & Redfield, 2026). The pattern of findings in this report – increasing gender identity-based discrimination, persistently high physical threats, continued bathroom access barriers, and little progress on identification document changes, particularly among TGNB participants and during the second study year – is consistent with the pressures TGNB young people may face in a restrictive policy environment. This interpretation also aligns with prior evidence linking anti-transgender legislation to increased suicide attempts among TGNB young people (Lee et al., 2024). Notably, even as access to desired hormones and gender-expression tools increased over time, bathroom restrictions and difficulties changing identification documents remained common. In light of the longitudinal associations between discrimination, victimization, economic insecurity, and later adverse mental health outcomes, these barriers are not peripheral concerns;

# Interpretations and Implications

they may help create and sustain the conditions that make it harder for young people to feel safe, recognized, and supported.

Conversion therapy is also particularly important to name in this policy context because protections against conversion therapy for minors remain legally contested following the U.S. Supreme Court's decision in *Chiles v. Salazar* (*Chiles v. Salazar*, 2026; Movement Advancement Project, 2026d). Improving LGBTQ+ youth mental health therefore requires attention to both affirming access and the broader policy and structural environments in which young people live.

## Limitations

Despite its strengths, this study has several limitations. First, all measures were **self-reported**. Self-reported data are appropriate for understanding young people's lived experiences, but it can also introduce recall bias or social-desirability bias, especially for sensitive topics such as suicide, self-harm, hospitalization, and conversion therapy. Although the study used validated screeners and standardized items where possible, administrative or clinical data would be needed to confirm hospitalization and treatment histories.

Second, some measures used **different recall windows** at baseline and follow-up. For example, some baseline questions asked about lifetime or current experiences, while follow-up questions asked about experiences in the past year. These differences make some estimates harder to compare directly over time and should be considered when interpreting changes across the study period.

**Attrition** is another important limitation. Generalized linear mixed models allowed participants to contribute data even if they missed one or more follow-up surveys. However, these models rely on the assumption that missing data can be explained by factors measured in the study, such as age, identity, or baseline symptoms. If participants who stopped participating differed from those who remained in ways the study did not measure, the results may be biased. In addition, descriptive analyses in this report are restricted to participants with sufficient data across the two-year study period for a given variable. As a result, some baseline and one-year follow-up estimates may differ from those presented in the interim one-year report.

# Interpretations and Implications

The sample, though large and diverse, is **not nationally representative**. Recruitment occurred primarily online through paid social media advertisements, which may exclude youth without reliable internet access or those who are less connected to online LGBTQ+ spaces. This is especially important for interpreting findings related to social media, online safety, and cyberbullying, as participants recruited online may differ from LGBTQ+ young people who do not use social media as often or who have limited internet access. The current socio-political context may also have influenced who chose to participate in the study, as LGBTQ+ young people's willingness to engage in research may be shaped by safety concerns. For this reason, point estimates should not be generalized to all LGBTQ+ young people in the U.S. Instead, the study is most useful for understanding how risk and protective factors are associated with mental health and suicide-related outcomes over time within this large and diverse longitudinal sample.

Finally, while the longitudinal design allows for examination of associations over time, causal inferences remain limited due to **possible unmeasured confounding variables and the observational nature of the study**. The broader sociopolitical context – including anti-LGBTQ+ legislation, policy debates, and rhetoric during the study period – likely influenced participants' experiences and mental health, but the study was not designed to isolate the effects of specific external events or policies. These limitations highlight the need for cautious interpretation and underscore the importance of continued data collection and analysis in future waves.



# Recommendations and Next Steps

Project SPARK's two-year findings point to the need for multi-level strategies that reduce exposure to stigma-related harm while strengthening the supports that protect LGBTQ+ young people's mental health. Schools, families, health systems, community organizations, and policymakers all have a role to play in making the places where LGBTQ+ young people live, learn, seek care, and build relationships safer and more affirming. This includes reducing discrimination, victimization, conversion therapy threats or exposure, gender-based exclusion, and barriers to everyday safety, while expanding affirming home, school, peer, and care environments. These priorities are consistent with research showing that family acceptance, social support, and affirming environments are protective for LGBTQ+ youth mental health and suicide-related risk (DeFerro et al., 2024; Nath et al., 2025; Russell & Fish, 2016; Ryan et al., 2010). They are also consistent with Project SPARK's longitudinal findings showing that affirming home environments, family support, and gender euphoria were associated with lower likelihood of anxiety, depression, self-harm, and suicidal ideation over time. Because average family supportive action scores remained near 2 on a 4-point scale across all three time points, **family-focused interventions – such as programs that help parents and caregivers move from tolerance toward active support – stand out as one practical area where meaningful change may be possible.**

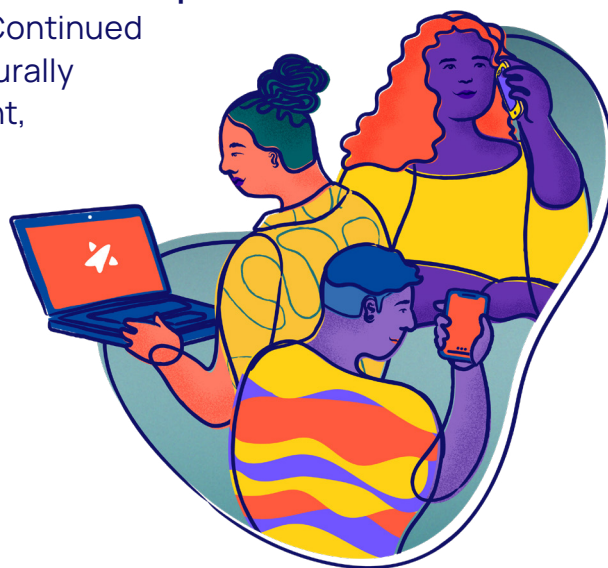
Suicide prevention for LGBTQ+ young people should extend beyond crisis response to address the social and structural conditions that shape risk over time. Project SPARK findings show that victimization, discrimination, conversion therapy, economic insecurity, and bathroom access barriers were associated with poorer mental health outcomes, self-harm, and suicidal ideation. These findings suggest that **suicide prevention efforts should include reducing victimization and discrimination, protecting young people from conversion therapy, addressing housing instability and unmet basic needs, ensuring gender affirmation for TGNB youth, strengthening family support, and expanding access to affirming care – not only individual-level screening or treatment.** The significant increase in past-year houselessness during the second study year – a period when many participants were aging into adulthood – highlights a vulnerable transition point, when some young people may be leaving family homes, schools, or other sources of support without stable housing in place.

Additionally, the finding that nearly one-third of participants experiencing suicidal thoughts sought help from no one further underscores the need to build systems that young people perceive as safe, trustworthy, confidential, and accessible before a crisis escalates.

# Recommendations and Next Steps

At the same time, the significant increase in helpline use during suicidal crises — the only source of support that grew over the study period — suggests that **crisis services are reaching more LGBTQ+ young people and warrant sustained investment.**

Two additional gaps deserve attention: help-seeking from doctors and general practitioners remained consistently low (4–6%), suggesting that **primary care settings are an underused opportunity** for suicide risk identification and support; and the strong association between recent mental health-related hospitalization and subsequent self-harm underscores the **importance of comprehensive post-discharge follow-up and continuity of care.** Continued investment in crisis services, peer support, and culturally responsive mental health care is especially important, but these services must be paired with broader efforts to reduce the conditions that place LGBTQ+ young people at risk. Additionally, because many LGBTQ+ young people turn to online spaces for information, connection, and support, **digital spaces should be part of any suicide prevention strategy.** Efforts to support LGBTQ+ youth should include both reducing online harassment and strengthening safe, affirming opportunities for online connection.



For TGNB youth, next steps should focus on **protecting and expanding access to gender affirmation** across social, legal, medical, and community settings. Project SPARK findings show that access to desired hormones, accurate identification documents, affirming home environments, and gender euphoria were associated with better mental health outcomes among TGNB participants, while bathroom access barriers were associated with greater mental health risk. These findings support the importance of policies and practices that help TGNB young people safely access transgender health care, identity documents, affirming schools, appropriate facilities, and tools related to gender expression or transition. The age gap in hormone access at the two-year follow-up (73% among those 18 and older versus 33% among minors) shows how sharply access can differ by age, and why younger TGNB youth may need particular support navigating consent-related, legal, and practical barriers. Prior research also shows that gender affirmation,

# Recommendations and Next Steps

including chosen name use and access to transgender health care, is associated with better mental health among transgender and nonbinary youth and young adults (Russell et al., 2018; Tordoff et al., 2022). In the current policy context, where restrictions on transgender health care, bathroom access, school participation, and legal recognition remain active areas of debate, protecting access to gender affirmation is central to supporting TGNB youth well-being (KFF, 2026; Movement Advancement Project, 2025, 2026a, 2026b, 2026c).

Mental health systems should also address both access and quality of care. Although most participants who wanted mental health care were receiving it by the two-year follow-up, and perceived helpfulness of care improved substantially over the study period, barriers such as cost, parent or caregiver permission, fear of discussing mental health, fear of not being taken seriously, and concerns that providers would not understand participants' LGBTQ+ identities persisted. Notably, not wanting to seek a parent or caregiver's permission was the most commonly reported barrier at the two-year follow-up (49%), underscoring the **importance of confidential care pathways** and, where legally and ethically appropriate, minor consent policies for mental health services. Moreover, these findings demonstrate that care must be affordable, developmentally responsive, and affirming of young people's intersecting identities. Mental health providers and systems should be equipped to support LGBTQ+ youth experiencing stigma, family conflict, economic insecurity, suicidal thoughts, and gender-related stressors, while also recognizing positive identity-related experiences such as gender euphoria as part of well-being.

Future Project SPARK analyses will track how LGBTQ+ youth mental health evolves as participants grow older and navigate a changing social and political landscape. Subsequent data waves will clarify if declines in self-harm and suicide attempts persist, whether depression, anxiety, and suicidal ideation remain high, and how changes in risk and protective factors change mental health over time. Ultimately, these insights will help pinpoint where urgent support is needed, identify which protective factors are most effective, and inform how policies and systems can create safer, more affirming spaces for young people.

# Recommendations and Next Steps

Project SPARK is an ongoing longitudinal study, and continued participation from participants is essential for understanding how LGBTQ+ young people's mental health, experiences, and sources of support change over time. Engagement from participants will help ensure that Project SPARK continues to reflect the lives of LGBTQ+ young people as they grow, face new challenges, and build sources of support over time.



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The Trevor Project is the leading suicide prevention organization for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) young people.

We provide 24/7 crisis services for LGBTQ+ young people via a phone lifeline, text, and chat. We also operate innovative research, advocacy, public training, and peer support programs.



Crisis Services



Peer Support



Research



Advocacy



Education and  
Public Awareness