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SOCIAL SUPPORT AND MENTAL HEALTH OUTCOMES
OF LBG PEOPLE OF COLOR

by

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B.A. University of San Diego, 2017

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ABSTRACT

Lesbian, gay, and bisexual people of color (LGB PoC) continue to remain an understudied population. Research supports that LGB PoC may experience greater negative health consequences compared to LGB racial/ethnic majority populations. Social support, including family and peer support, is often associated with positive health outcomes for sexual minorities of all backgrounds. The present study sought to evaluate differences between types of social support, including what occurs when one is faced with significant loss of support (i.e., family support). Comparisons between groups sought to determine whether alternative systems of support (i.e., peer social support) buffers against the negative impact of lost family support (i.e., family victimization). LGB ($n = 28$) and LGB PoC ($n = 45$) participated in an online survey where victimization history, social support, self-esteem, internalized homonegativity and psychological health were assessed. Result indicated that LGB PoC experienced family victimization at similar rates as the LGB majority, though LGB PoC reported increasingly less familial support and significantly greater rates of internalized homonegativity. Moderated mediation analysis revealed that social support did not buffer against health consequences for either group, though differences between groups remained. Family victimization and self-esteem significantly predicted depressive and anxiety symptoms for LGB PoC, though these findings were mixed when assessed within the LGB majority sample.

Keywords: victimization; sexual minority; minority stress; psychological health; race; ethnicity

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CHAPTER ONE: INTRODUCTION

Within the last several decades, greater effort has been made to understand the life experiences and health outcomes among sexual minority communities. Research continues to suggest that people who identify as sexual minorities experience unique stressful life circumstances that can place them at greater risk for negative health consequences (Meyer, 2003). In comparison to heterosexuals, lesbian, gay, and bisexual (LGB) individuals often experience significant physical and mental health difficulties subsequently placing these groups at greater risk for severe consequences, such as suicide (Becker et al., 2014; Cochran & Mays, 2000, Cochran, 2001; King et al., 2008; Semlyen et al., 2016). To better understand what contributes to these outcomes, and to promote more positive wellbeing within this community, researchers have directed their efforts toward identifying stressors unique to the LGB experience (Kertzner et al., 2009; Meyer, 2003; Mustanski, Newcomb, & Garogalo, 2011).

Minority Stress Theory

One theoretical framework that has been used to understand the relationship between stress and health disparities among marginalized communities is the minority stress model. The minority stress model, a framework developed from both sociological and psychological foundations, was proposed by Meyer to understand the additional stress sexual minorities tend to experience (Meyer, 2003). The model acknowledges that LGB minority groups experience a set of specific and unique life stressors by simply identifying as a sexual minority (Meyer, 2003). In addition to general stress experienced by those in the majority, chronic secondary and tertiary conflict, usually related to hostile social environments, institutional prejudice, and other acts of

marginalization, can manifest as negative health outcomes jeopardizing an individual's overall

wellbeing (Meyer, 2003). Meyer (2003) describes that the minority stress can be understood as

the relationship between distal stressors (discrimination, prejudice, harassment) and proximal

stressors, typically understood as internalized distress (low self-esteem, negative identity

valence), and their interaction with general stress, stress common across communities regardless

of minority identification (Meyer, 2003).

Specific to this model, research has considered how major discriminatory experiences,

chronic microaggressions (social exchanges that communicate belittlement or other denigrating

messages toward a minority target), and internalized conflicts (such as internalized

homonegativity and negative self-esteem) create additional challenges that LGB communities

must navigate through (Balsam et al., 2011; Sue et al., 2007). Among sexual minorities,

experiences of discrimination or victimization due in part to one's sexual orientation has often

been associated with reduced ratings of psychological well-being, greater levels of depressive

symptoms, and increased prevalence of mental health disorders (Bostwick et al., 2014;

Mustanski et al., 2011; Ryan et al., 2009). At the same time, repeated exposure to stressful

experiences such as microaggressions (nonverbal, intentional or unintentional), in addition to

more macro-lifetime events, has been found to significantly impact a person's wellbeing and

ability to function optimally in everyday situations (Cochran, 2001; Mays & Cochran, 2001;

Meyer, 200; Mustanski, Newcomb, & Garofalo, 2011).

Mays and Cochran (2001) found that, in comparison to heterosexuals, LGB men and

women were more likely to experience discriminatory events due to their sexual orientation, and,

that these experiences interfered by making life more difficult to live. At the same time, this

study found that sexual minorities showed significantly greater risk for psychiatric morbidity and

were more likely to present with a psychiatric disorder compared to general heterosexual populations (Mays & Cochran, 2001). Bostwick, Boyd, Hughes, West and McCabe, (2014) also found similar trends noting that those who reported experiencing discrimination based on sexual orientation, gender and racial/ethnic identity were more like to experience a mental health disorder within the past year. Focusing on psychological outcomes, research consistently supports that perceptions of discrimination or rejection within LGB communities tends to be associated with depressive symptoms, increased anxiety, suicidal ideation and overall poorer health (Almeida et al., 2009; Bostwick et al., 2014; Cochran & Mays, 2000; Mays & Cochran, 2001; Cochran, 2001; Lea, de Wit, & Reynolds, 2014). In sum, LGB communities are at an increased risk for experiencing psychological distress compared to the general population.

The Minority Stress Model is a useful tool for conceptualizing the potential outcomes of various groups based on different structures within one's life. The model is also valuable in helping to recognize the interplay of multiple identities and the intersection of those identities. The Minority Stress Model was originally developed with a focus on minority status as it relates sexual orientation. However, for the purposes of this study, an emphasis was placed on additional identities (i.e., race/ethnicity) in order to understand the intersectional experiences of LGB racial/ethnic minorities. The following section discusses the importance of considering additional aspects of identity and how multiple identities interact within the minority stress framework.

Minority Stress among LGB People of Color

While the minority stress model was developed initially around the context of sexual orientation, its application may be extended to include other minority groups or those holding

multiple minority identities. Understanding the interaction and intersectionality of these identities, and how they might influence health outcomes, has become increasingly important among researchers. Using the minority stress model as a theoretical framework, the current study focuses on the intersectionality of race/ethnicity and sexual orientation.

Purdie-Vaughns and Eibach (2008), discuss the importance of acknowledging intersectional identity status, explaining that if one fails to address the intersection that exists between two or more minority groups, an individual might experience *intersectional invisibility*. Essentially, this means that those whose intersectional identifiers fail to fit the "prototypical" model of an LGB person (Caucasian, gender-conforming, able-bodied etc.), are less likely to have their experience recognized in the larger body of research. As a result, potential issues experienced by LGB people of color (LGB PoC), for example, may continue to go unaddressed (Purdie-Vaughns & Eibach, 2008). Likewise, Cole (2009) examined the position that incorporating intersectionality within psychological research, may work to "repair misconceptions engendered by the erasure of minority groups and the marginal subgroups" allowing a more complete understanding of a particular groups' experiences, in this case LGB PoC (Cole, 2008, p. 172). Similar to the minority stress model that is introduced earlier, the intersectional framework hopes to acknowledge the "non-prototypical" members within a community by giving space to recognize their experiences and the potential compounding effects associated with holding multiple marginalized identities.

Several studies have documented the negative impact that discriminatory or prejudicial experiences can have on one's overall wellbeing (Bostwick et al., 2014; Seng et al., 2012). For individuals who maintain multiple minority identities, these experiences may be multiplied, potentially magnifying their negative impact. Research focused on understanding the impact of

discriminatory experiences posits that when multiple identities are accounted for, that is when an intersectional approach is taken, rather than focusing on experiences related to a single aspect of identity, one can better explain potential health outcomes.

For example, Seng et al. (2012), studied a group of 619 women across varying levels of intersectionality (structural, interpersonal, contextual). Across all groups, multiple interpersonal intersectional identities (e.g., race, gender, age) explained poorer mental health (symptoms related to posttraumatic stress disorder; PTSD) and quality of life compared to any one marginalized identity studied alone (Seng et al., 2012). Seng et al., (2012) found that identification with more than one marginalized identity and increased frequency of everyday discrimination were associated with greater symptoms of PTSD and a reduction in perceived quality of life. Bostwick et al. (2014) found similar support across a nationally representative sample of 577 LGB individuals. Bostwick and colleagues (2014) assessed how discriminatory experiences may influence the development of psychiatric disorders. When assessed independently, discrimination based on racial or sexual identity was not associated with psychiatric problems, however, when participants reported a combination of these two experiences, or additional experience of gender-oriented discrimination, they were significantly more likely to report experiencing a mental health disorder within the past year (Bostwick et al., 2014).

Many have found that LGB minority members tend to experience greater levels of stress, reduced general wellbeing and reduced use of available resources in comparison to heteronormative counterparts (Calabrese et al., 2015; Kertznere et al., 2009; Meyer, Schwartz, & Frost, 2008). Kertzner et al. (2009) studied social and psychological wellbeing among sexual minorities of varying racial/ethnic backgrounds (Black, White, and Latinx). Potential coping

resources (positive attitude toward one's sexual identity, connectedness to LGB community)

were considered as mediators to describe the relationship between depressive symptoms and

social wellbeing. Interestingly, only among Latino respondents were participants more likely to

report depressive symptoms and lower levels of psychological wellbeing compared to white

individuals. Similar patterns of wellbeing have been found across other LGB Latinx

communities. For example, Espín (1993) found that Latina lesbians reported facing loss of ethnic

cultural support when disclosing their sexual orientation to others. Enno (2012) similarly

reported that many LGB, as well as, trans and queer people of color, report increased feelings of

marginalization from both ethnic and sexual minority communities. As understanding of

intersectionality between identities grows, it is important to consider the potential impacts

multiple minority identities can have on LGB men and women. Further research is necessary to

fully understand the impact of these additive life stressors.

Internalized Homonegativity

Related to environmental hostility, LGB groups may experience internalization of

negative beliefs. Internalized homonegativity (IH; sometimes referred to as internalized

homophobia) refers to negative attitudes and beliefs about homosexuality that are oriented

towards the self and others (Shidlo, 1994). Some have referred to this experience as both a

reaction to and incorporation of heterosexist attitudes (Rosser et al., 2008). IH can be considered

a *self-directed stigma* that manifests out of one's internalized acceptance and agreement with

negative evaluations regarding homosexuality (Herek et al., 2015). Put simply, IH reflects

oppressive attitudes (conscious or unconscious) that are reinforced by a heteronormative society

(Herek et al., 2015; Shidlo, 1994). Between one third and one fourth of lesbians and gay men

experience negative attitudes or feelings about their sexuality (Shidlo, 1994). Studies exploring

IH generally find that those who experience IH at greater levels tend to endure more negative

health outcomes (Berg, Munthe-Kaas, & Ross, 2016; Rosser et al., 2008). Berg and colleagues

(2016) conducted a comprehensive meta-analysis regarding empirical research involving IH.

Across 164 studies conducted between 1989 and 2012, spanning several countries and a wide

range of adults (17-69 years), increased levels of IH resulted in greater likelihood for depression,

low self-esteem, and reduced social support among other negative outcomes. Mixed findings

arose when considering differences associated with race/ethnicity, though only three US studies

explored this area. Some research supports that there may be differences across ethnic groups,

with people of color reporting greater feelings of guilt or shame regarding their sexuality (both

integral to IH as a construct; Shidlo, 1994). Within the LGB African American community,

Szymanski and Gupta (2009) found that both racism and IH predicted psychological distress,

though when explored together, only IH was significant in predicting psychological distress.

These researchers also acknowledged other important nuances within this study: If individuals

maintained relationships with racial/ethnic communities, experiences of racism may have a

diminished effect on self-esteem and distress, while internalized homophobia played a more

significant role in mediating this relationship (Szymanski & Gupta, 2009). To add, Espín's

(1993) qualitative study offered that among a small group of adult Latina lesbian women, many

voiced that they would choose to live in a world accepting of their sexuality, rather than one that

only recognizes their Latin heritage and culture. The proposed study aims to further understand

the interplay of these important relationships and their role in predicting IH, self-esteem, and

psychological wellbeing.

Still, some research findings support a more general pattern of distress that exists across LGB racial/ethnic communities (Dube & Savin-Williams 1999; Moradi et al, 2010). Across a sample of 178 LGB adults, Moradi et al. (2010) found no difference between perceptions of internalized homophobia across either white or non-white groups. Others, like Kertzner and colleagues (2009), found that only some racial/ethnic groups (Latinx) presented with greater distress, while others (Black) showed no difference in comparison to majority White groups. The present study attempts to add to the current conversation and clarify the impact IH has within communities of color.

Self Esteem

Another concept worth exploring in this context is self-esteem. When considering the minority stress model, self-esteem can be understood as a proximal stressor, one that is experienced through internalized cognitions that can be influenced by one's surrounding context (Cocker & Major, 1989; Meyer, 2015). Research currently understands that low self-esteem can be considered a risk factor contributing to reduced wellbeing within LGB communities. For example, low self-esteem has been associated with increased levels of internalized homonegativity and psychological distress (Consolacion, Russell, & Sue, 2004; Shidlo, 1994; Szymanski & Gupta, 2009). Despite evidence suggesting that genetic influences impact self-esteem, research supports that self-esteem can best be understood through considering environmental factors (Neiss, Sedikides, & Stevenson, 2002). This may be important for LGB PoC as studies have indicated that particular cultural values and family acceptance may impact self-perceptions and ultimately levels of esteem (Hu & Wang, 2013).

Currently, research on LGB PoC and self-esteem is mixed. Some suggest racial/ethnic intersectionality does not necessarily result in reduced self-esteem (Meyer, 2010). In fact, a portion of the literature suggests holding multiple identities can increase one's resilience or ability to cope with complex situations that one might experience (Kertzner, Meyer, Frost, & Stirratt, 2009). On the other hand, others like Snapp, Watson, Russell, Diaz, & Ryan (2015), found support suggesting that LGB Latino men experience lower overall self-esteem in comparison to other groups. The authors suggest that these findings may be explained by social support, another important factor to consider when measuring self-esteem. Understanding the degree to which self-esteem varies across racial/ethnic LGB groups is still unclear. The present study seeks to elucidate potential factors that influence self-esteem with a particular focus on LGB PoC.

Social Support

Prior research has thoroughly investigated the role of social support and its influence on the ability to manage stressful situations. It is understood that social support is a powerful resource for most people, especially so for those struggling with complex and stressful life circumstances. Social support has been extensively researched, and, when present, continues to exhibit positive effects in regard to overall wellbeing and positive health outcomes (Asberg, 2005; Cobb, 1976; Snapp et al., 2015; Travis, Lyness, Shields, King & Cox, 2004; Uchino, 2006). Social support is defined as one's perception of accessible networks of friends, family or other community members who are able to extend psychological, physical, financial and emotional help to a specified individual during time of need (Ozbay et al., 2007; Cohen, 2004). According to the stress-buffering model, social support works to protect against the negative

effects associated with adversity (Cohen, 2004; Rosengren, et al., 1993; Zea, Reisen, & Poppen, 1999). At the same time, some research finds that not all social support mitigates stress. Kondrat, Sullivan, Wilkins, Barrett, & Beerbower (2017) found that among a large sample ($N = 2,323$) of predominantly white (84.2%), predominantly female subjects (63.7%), data supported only partial mediation of perceived support and impact of stigma on mental health. Because perceived and received support play important roles in guiding adjustment, understanding differences in types of support and potential loss, can assist in understanding of health outcomes, both positive and negative.

Family Social Support. Positive familial support has been regarded as a key indicator for influencing health outcomes. When met with stressful circumstances, those in generalized populations who have positive family relationships tend to fair better with regard to well-being (Weiner, Swain, Gottlieb & 1998). Those who experience family support when identifying as a member of the sexual minority community tend to experience greater overall well-being than those without (Shilo & Savaya, 2011). Exploring biological markers of stress, one study found that LGB adults with high levels of family support tended to have reduced levels of cortisol when met with stressful situations induced in lab setting in comparison to those with low family support (Burton, Bonanno, & Hatzenbuehler, 2014). Literature encompassing familial support on individual development found that those with greater support also tended to show more personal acceptance of their identities as well (Kertzner, 2001; Hershberger & D'Augelli, 1995; Rios & Eaton, 2016). Guan and Fuligni (2016) found that among a diverse sample of Asian, European and Latin American young adults, those with greater family support reported greater self-esteem and reduced depressive symptoms.

Though family acceptance is developmentally important, not all experience the same level of support. Family rejection can become both a stressor and a significant loss of support. Among potentially well-resourced groups, such as physicians, distanced or cut-off family relationships have been associated with reduced self-acceptance and depressive symptoms (Weiner et al., 1998). For sexual minorities who experience familial rejection or significantly reduced levels of support, the impact on well-being can be more devastating. For younger individuals who identified as LGB or transgender, those without parental support tended to report more significant distress. Ryan, Huebner, Diaz, and Sanchez (2009) found that sexual minority youth who experienced greater rates of family rejection were at significantly increased risk for attempting suicide, experiencing depression, and engaging in risky behavior. This study also found that Latino males tended to report greater levels of rejection, in addition to increased rates of depression and suicidal ideation (Ryan et al., 2009). The loss of parental support can result in severe consequences for LGB majority and minority communities. Others have found that family rejection tends to be the greatest predictor of self-acceptance, positive well-being, and general health status of LGB and trans individuals (Rosario, Schrimshaw & Hunter, 2009; Ryan, Russell, Huebner, Diaz & Sanchez, 2010a; Shilo, & Savaya, 2011). Among other LGB samples, negative family attitudes and experiences of family rejection has been associated with overall poor mental health outcomes (Mustanski, et al., 2011). Meyer, Schwartz and Frost (2008), concluded that in comparison to LGB White individuals, people of color experienced significantly more stress and endorsed fewer coping resources, including smaller networks of support. Similarly, for Jamaican gay and bisexual men, family response to one's identity predicted depressive symptoms (White, Sandfort, Morgan, Carpenter, & Pierre, 2016). In sum,

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family support is a critical factor to consider when attempting to understand the psychosocial health of LGB groups.

While family support is important, the protective effect against negative psychosocial adjustment can decrease with age (Mutanaski, Newcomb, & Garofal, 2011). For adult populations, peer support may be more important to understanding well-being. Still, research is mixed as Guam and Fuligni (2015) found that differences can be found across racial and ethnic minority groups.

Peer Social Support. Peer social support is a useful resource when coping with stressful experiences or aversive events. Peer social support has been studied across a number of domains. Research generally supports that peer relationships can act as additional resources to help mitigate stress. For example, among adults who share a common disability with one another, Silverman and colleagues (2017), found that despite the number of non-disabled friends, those with larger peer networks of those with the same physical conditions reported increased life satisfaction and quality of life (Silverman, Molton, Smith, Jensen, & Cohen, 2017). Research provides that peer support can have similar positive effects on psychological health for LGB individuals particularly when there is an absence of family social support (Crocker & Major, 1989; McConnell, Birkett, & Mustanski, 2015;Meyer, 2003).

When in need of support, Frost, Schwartz and Meyer (2016) explain that LGB adults tend to rely on LGB peers for support in everyday matters. Within this same study, researchers describe that LGB individuals often have greater LGB peer support rather than familial support; this being especially true for gay and bisexual, white men. Among a sample of 461 LGB young people, Shilo and Savaya (2011) concluded that peer support was linked to several positive experiences including greater self-acceptance, increased orientation disclosure, and reduced

mental health distress. Similarly, Kertzner et al., (2009) found that peer support was also connected to greater well-being among LGB individuals, offering added support for the positive impact of peer social support.

Literature investigating trends within LGB communities of color, though sparse, tends to support the importance of peer social support. Zea et al., (1999) reported that for gay and lesbian Latinx individuals, social support significantly predicted increased levels of self-esteem and reduced levels of depression. Frost et al. (2016) found that White LGB individuals valued peer social support at the same rate as LGB PoC. Interestingly, many LGB PoC looked to support from others of similar racial/ethnic backgrounds, and subsequently reported less support than their white counterparts. While peer support is just as important for LGB communities of color, it can be more difficult to find. McConnell, Janulis, Phillips II, Truong, & Birkett (2018) identified that LGB Black, Hispanic and Asian men report experiencing racial/ethnic stigma from within LGB supportive spaces. LGB community connection was supportive in reducing stress for LGB white individuals but less so for people of color. To summarize these findings, research indicates that peer support is important for LGB PoC though it tends to be generally less available.

As a whole, social support is especially important for LGB communities. Peer support is increasingly associated with positive health outcomes. This is especially true for LGB individuals who face loss of support in other areas (i.e., familial support). For LGB PoC peer support is important for many of these same reasons. Frost et al., (2016) suggest that some peer groups are more important than others; for LGB PoC, racial/ethnic identity was as important as sexual orientation when seeking out supportive peers. Further research may be necessary to

determine exactly how peer social support differs across LGB communities and whether varying levels of peer support may mitigate negative health outcomes.

Current Study

As intersectional identities do not sit in isolation, the purpose of this research seeks to better understand how intersectionality of culture and sexual orientation impact psychosocial well-being in the face of family rejection. Meyer's minority stress model frames this research with the understanding that holding minority status creates added burden and daily stress which can negatively impact psychological wellbeing and social adjustment. Further, Parra (2017) alludes to the idea that individuals who hold minority status often rely on support from others to buffer against the potential negative effects of prejudice. In this regard, the current study aimed to first give priority to "non-prototypical" LGB members, particularly, LGB people of color who may experience a set of culture specific stressors related to their multiple identity status, and second, identify how variance in social support affects psychological well-being among members of this population.

Particularly, past research conducted by Parra et al. (2017), examined the buffering effect of peer support in response to family rejection. A sample of 62 predominantly Caucasian (76%) LGB young adults (ages 17-27 years old) were studied. Majority of the sample spoke English (24% French), and majority identified as a college student (71%; 19% employed; 10% unemployed). Majority of individuals in this sample reported disclosing their sexual orientation to at least one parent and/or another person. Parra and colleagues explored how peer support affects well-being in the presence of negative family support. Their findings identified key differences, importantly that peer social support was inversely related to symptoms of depression

and internalized homonegativity. The authors also identified that peer support moderated the relationship between family support and symptoms of anxiety, and between family victimization and symptoms of depression. Internalized homonegativity and self-esteem were not impacted by the presence of greater peer support. It is important to note that this study was conducted in Canada, among a majority white population and therefore the generalizability of these particular findings is limited (Parra et al., 2017). Given that other complexities arise when considering intersectional minority status, further research in this area is warranted.

The current study aimed to replicate the methods applied in previous research (Parra et al., 2017). The purpose of this study was to investigate the potential role that social support, specifically peer support, may have on impacting the psychological wellbeing of LGB adults of color in the United States who experience family rejection. As noted, psychosocial wellbeing among LGB people of color is largely influenced by family support. When faced with family rejection or victimization, essentially a loss of social support, to what degree does peer support buffer against potential negative psychosocial outcomes. Further, might there be a difference in the role peer support has on self-esteem and cognitions of internalized homonegativity for racial ethnic minorities?

Hypotheses

This study used a quantitative approach to assess the link between family rejection and peer social support on psychosocial wellbeing in samples of LGB adults.

> **H1:** LGB people of color were expected to report negative family attitudes toward their sexual orientation and greater rates of familial victimization compared to White counterparts.

H2: Experience of family victimization was thought to be associated with symptoms

of depression, anxiety, internalized negativity and reduced self-esteem

H3: Perceived peer social support was thought to be negatively associated with

depression, anxiety, and internalized homonegativity and positively associated

with self-esteem.

H4: Specifically, among people of color, peer social support would moderate the

relationship between family victimization and outcomes self-esteem, IH,

depression, and anxiety.

H5: Self Esteem and IH was expected to mediate the relationship between support

and psychological distress (depression, anxiety) for all participants.

CHAPTER TWO: METHODS

Participants

Participants were recruited through two methods. Participants were recruited by distribution of online flyers on a large public college campus, and at community centers throughout the greater metropolitan region. Other participants were recruited through Amazon's Mechanical Turk (MTurk), a crowdsourcing platform. Participants were eligible to participate in this study if they identified as 18 years or older, and if they identified as a sexual minority (Lesbian, Gay, Bisexual, Queer). Eligible participants were compensated $4.50 if recruited through MTurk and $10.00 if recruited by flyer. Compensation was set at different rates for several reasons. MTurk workers can be considered a distinct subject population and generally receive incentives at a standard rate of ten cents a minute. Compensation greater than this rate has potential to jeopardize the validity of the survey, as participants may be coerced into completing the survey more than once. It was expected to take participants about 45 minutes to complete the survey. As a result, the incentive was set at $4.50.

Measures

Demographics.   Basic demographic information (e.g., age, sex assigned at birth, gender identity, racial ethnic identity, sexual orientation) was collected.

Sexual Orientation Disclosure. The 15-item Sexual Orientation Developmental Milestones Questionnaire is a questionnaire designed for participants to report several important LGB related milestones (e.g., "At what age did you first feel that the majority of significant people (family, friends, co-workers, etc.) in your life knew you were homosexual/bisexual?). This questionnaire asks participants to identify at what age they considered themselves LG or B.

Participants were also asked to rate their degree of outness and age of disclosure of their orientation (if ever) to parents or relevant others (Floyd & Stein, 2002; Parra et al., 2017).

Family Attitudes. The 15-item Sexual Orientation Developmental Milestones questionnaire (Floyd & Stein, 2002) also considered perceived family attitude toward orientation: In your family, homosexuality is (1) ridiculed, stigmatized, discriminated; (2) tolerated; (3) accepted, respected; (4) celebrated/appreciated. Lower scores (below 3) on this measure would indicate negative family attitudes toward an individual. Higher scores indicated positive family attitudes (3 and above).

Victimization. Family victimization assesses history of victimization inflicted by family members. Pilkington and D'Augelli (1995)'s measure, Scope and Prevalence of Anti-Lesbian/Gay Victimization, is an 18-item questionnaire asking participants to rate frequency of victimization behaviors by family members, peers, or other people. Items include being verbally insulted, having objects thrown at an individual, being threatened with a weapon, and sexual assault, to name a few (Pilkington& D'Augelli, 1995). Participants indicated the frequency with which they have experienced the item ("once", "twice", "three or more times" or "never"). A reliability assessment for the present sample indicated internal consistency across items as demonstrated by an α coefficient of .92.

Peer Support. To measure peer social support, participants completed the *Interpersonal Relationship Inventory (IRRI/IPRI)* developed by Tilden and colleagues (1990). This measure is a 39-item survey that assesses peer social support via a 5-point Likert-type scale ranging from 'Strongly disagree' to ' Strongly agree.' This measure includes three subscales (support, reciprocity and conflict) to better assess both the emotional and concrete resources of support across interpersonal social networks. Social support is defined as the perceived support one

receives within relationships. Reciprocity is defined as the exchange of resources across social networks. Finally, conflict is described as perceived tension within relationships either as a result of "withholding of help" or by means of intentional behavior. All scores (including reverse scored items) are added to create a total social support score. The total score was centered and used for analysis. Internal consistency has been previously reported as ranging between .83 to .93 (Hagerty et al., 1996).

Anxiety. Anxiety was measured using the Generalized Anxiety Disorder (GAD-7), a 7-item self-report inventory (Spitzer et al., 2006). The GAD-7 measures severity of symptoms related to generalized anxiety within the past 2 weeks. Response are scored on a 4-point Likert-type from 0 (not at all) to 3 (nearly every day). Scores can range from $0 - 21$, with higher scores indicating greater symptom severity and lower scores indicating reduced symptom severity. Psychometric properties for the GAD-7 have been found to be robust. Internal consistency among a nationally representative sample was strongly supported ($\alpha = .89$; Löww et al., 2008). The GAD-7 has also been found to demonstrate strong convergent/divergent validity as scores on the GAD-7 correlated appropriately with associated risk factors for generalized anxiety disorder, depression, and other scales of physical health and perceived stress (Löww et al., 2008; Mills et al., 2014; Rutter & Brown, 2018).

Depressive Symptoms. The Patient Health Questionnaire-9 (PHQ-9) was used to assess symptoms of depression. The PHQ-9 is a 9-item self-report measure that is used to assess, self-symptoms of depression as well as symptom severity. Using a 4-point Likert-type scale, respondents' rate from 0 (not at all) to 3 (nearly every day) the degree to which they have experienced a particular symptom (i.e., little interest or pleasure in doing things) within the past 2 weeks. Symptom scores can range from $0 - 27$, with scores in the higher range indicating more

severe symptoms of depression and scores in the lower range indicating less severe symptoms of depression. Summed scores can be used to determine severity of depressive symptoms, 0-4 (minimal), 5-9 (mild), 10-15 (moderate), 15-19 (moderately severe) and 20+ (severe; Kroenke et al., 2001). Data supports that the PHQ-9 demonstrates strong reliability (α = .89), test-retest reliability, as well as strong convergent validity with other measures such as the Mental Health Inventory-5 (AUC = .95; Kroenke, Spitzer, and Williams, 2001). This measure has also been validated across various racial/ethnic groups (α = .79 - .89; Huang et al., 2006).

Internalized Homonegativity (IH). The Short Internalized Homonegativity Scale (SIHS) was used to assess for internalized homonegativity (Currie et al., 2004). The SIHS is a 13-item self-report scale was developed out of a need for a more contemporary assessment of internalized homonegativity. The measure asks participants to rate how much they agree or disagree with phrases or statements using a 5-point Likert-type scale ranging from strongly disagree to strongly agree. Scores range from 13 – 65 with upper level scores indicating greater levels of internalized homonegativity. This measure has been used in the past to assess internalized homonegativity across several LGB groups including international men and women, people of color, and has even been translated and validated for use in Spanish (Morell-Mengual et al., 2017; Piggot, 2004; Tran et al., 2018). Both English and Spanish versions were used in this study. Both the SIHS and the Spanish adaptation of the SIHS have demonstrated high internal consistency (α = .78; α = .80) and convergent validity across other measures of IH (Currie et al., 2004; Morell-Mengual et al., 2017).

Self-Esteem. Finally, the Rosenberg Self-Esteem Inventory (Rosenberg, 1965), was used to measure self-esteem. This measure consists of 10-items that are scored with a 4-point Likert-type scale where participants are asked to indicate their level of agreement with each item

statement (1 = strongly disagree; 5 = strongly agree). Scores on this measure can range from 0 –

30 where higher scores indicated higher overall (i.e., global) self-esteem (Parra et al., 2017;

Rosenberg, 1965). This measure has demonstrated sound properties, specifically high rates of

reliability (reliability score = .90) and internal consistency (CR = 0.77). Likewise, the Rosenberg

Self-esteem scale has been continuously well validated across research (α = .72 - .87)

(Rosenberg, 1965; Silber & Tippett, 1965; Whiteman & Shorkey, 1978).

Data Analysis Plan

A moderated-mediation analysis was used to assess hypotheses. Previous research

suggests a direct relationship between negative family experience and wellbeing. This was the

first expected hypothesis. It was predicted that this relationship would be mediated by the

presence of IH and self-esteem. Second, similar to what has been found in previous research

(Parra et al., 2017; Shidlo et al., 2011; Zea et al., 1999), peer social support was expected to

moderate the effect of this relationship, specifically that those with reduced social support will

experience more negative psychological outcomes. Finally, significant differences between

groups, between LGB people of color and the LGB racial majority, was proposed. For a depicted

visual representation of these relationships see *Figure 2*.
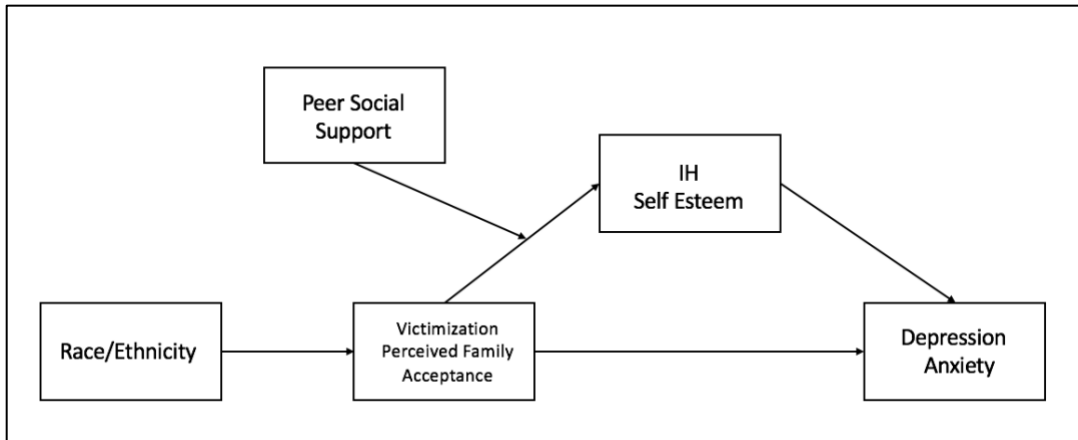
Figure 1: *Proposed model pathway of race/ethnicity, social support and health outcomes*

A between group moderated mediation analysis was conducted to explore the relationship between family victimization and health outcomes by race/ethnicity. Correlations regarding relationships between each independent variable (family victimization, social support, IH, & self-esteem) and mental health outcomes (depression and anxiety) were assessed between groups (White/Caucasian majority and Racial/Ethnic minority). A moderated mediation analyses was conducted to assess whether peer social support moderated IH and self-esteem. The moderator hypothesis is supported if the interaction term is significant for either variable. Main effects for the moderation were explored. IH and self-esteem were predicted to mediate family victimization and outcomes. Direct and indirect effects were assessed.

An a priori power analysis was performed for sample size estimation based on a previously published study by Parra and colleagues ($N = 62$; Parra et al.2017), comparing peer social support and health outcomes. The effect size (ES) in this study was .36, considered to be medium using Cohen's (1998) criteria. With an alpha = .05, and power = .95, the projected sample size needed with this effect size was approximately $N = 74$ for this simplest between group comparison.

CHAPTER THREE: RESULTS

Sample Description

Data was analyzed using IBM SPSS Statistics 25. A combined total of 265 people responded to the online survey. A total of 220 participants responded to the survey through MTurk. Of those, 129 people attempted to complete the survey but were disqualified due to not identifying as a sexual minority. Of the remaining participants ($n = 91$), 43 were disqualified from the study due to failing to successfully answer validity checks (e.g., validity check required participant to accurately restate demographic information such as age, orientation, gender). As a result, these participants were excluded from analysis. Finally, 2 participants discontinued the survey part-way through, and 9 participants had missing data. These individuals were not included in analysis. The data from 37 participants recruited from MTurk was included in the final sample.

Other participants were recruited from online social media platforms, by flyer, or by word of mouth. A total of 45 participants responded to the non-MTurk online survey. In this set of participants, three were disqualified due to not meeting eligibility criteria (e.g., not identifying as sexual minority), one was disqualified due to failing to successfully answer validity checks, and five others were disqualified due to missing data. A total of 36 participants were recruited through online/flyers recruitment sourcing. Overall, 73 participants were qualified to participate in the study (see Appendix for consort diagram).

The average age of participants was 29 ($SD = 8.34$). Almost half of the sample identified as male (48.65%), 34 identified as female, and 2 participants identified as non-binary or gender-queer. Majority of the sample self-identified as people of color (57.5%). Most participants

identified their sexual orientation as bisexual (n = 28), while 28.8% identified as gay (n = 21), and 24.7% as Lesbian (n = 18). Six participants identified as other or asexual. For a full list of demographics (see table 1).

Prior to analysis, the sample was split into two groups, racial/ethnic majority and racial/ethnic minority (i.e., people of color). There were 28 participants in the racial/ethnic majority group and 45 in the racial/ethnic minority group. Most racial/ethnic minority participants identified as gay (n= 18). An equal number of participants in this group identified as lesbian or bisexual (n = 13; n = 13), and one person identified as "Other" (gender queer; see table 1). Within racial/ethnic minority group, an almost equal number of participants identified as male (n = 23) and female (n = 22). LGB PoC were about 28-years old (M = 27.8, SD = 7.1). Most LGB PoC completed a 4-year (40%, n = 18) or 2-year (31.11%, n = 14) degree. About 16% (n = 7) completed some college, while 4.4% (n = 2) earned their high school diploma/GED, and 8.9% (n=4) completed graduate school. Less than 30% (n = 13) of LBG PoC were enrolled in college when they participated in the survey.

For the racial/ethnic majority, 42.9% (n = 12) identified as female, 46.4% (n = 13) identified as male, 7.1% (n = 2) identified as other, and 3.6 (n = 1) identified as transgender. Within the LGB majority group, more than half identified as bisexual (53.6%, n = 15), while 17.9% (n = 5) identified as lesbian, 14.3% (n = 4) identified as "Other" (gender queer; see table 1), 10.7% (n = 3) identified as gay, and 3.6% (n = 1) identified as asexual. The average age across the LGB majority group was about 32 (M = 31.82 SD = 9.65). One individual (3.6%) reported obtaining a diploma/GED. Several others reported having some college education (25%, n = 7). Most individuals in the LGB majority group had completed a 4-year (46.4%, n = 13) or

2-year degree (10.7%, $n = 3$), while three participants (10.7%) indicated that they completed graduate school.

Initial Analysis

      Family Attitudes & Family Victimization. The first hypothesis aimed to examine perceptual experiences between LGB PoC and LGB majority individuals. It was hypothesized that PoC would perceive their families as having negative attitudes toward their sexual orientation, more so than the majority group. Due to differences in sample size, a non-parametric analysis was used to assess these groups. A Mann-Whitney test indicated that among this LGB sample, PoC perceived their families as holding negative attitudes (*Mdn* = 2) toward their sexual orientation more often than LGB majority individuals (*Mdn* = 3), U = 450.5, *p* = .031. LGB PoC were more likely to report higher rates of IH (*Mdn* = 41.37), U = 826.5, *p* = .03. compared to the LGB Majority (*Mdn* = 29.98). Alternatively, the LGB majority indicated similar rates of depressive symptoms, anxiety symptoms, family victimization, self-esteem, and social support (see Table 2).

      Further analysis looked to explore the relationship between mental health and family victimization. The second hypothesis predicted that those with experiences of family victimization would also likely experience symptoms of depression, anxiety, internalized homonegativity and low self-esteem. Correlations between variables of interest were assessed prior to regression analysis. Scores indicated that for the racial majority, depression and anxiety were significantly negatively correlated with family victimization, while IH was significantly positively correlated with family victimization (see Table 3). Self-esteem was also found to be negatively correlated with depression, anxiety, and family victimization. A series of regression

analysis followed to assess anxiety and depressive symptoms on predictors: self-esteem, internalized homonegativity, and family victimization. For the LGB majority, the regression analysis indicated that family victimization and self-esteem were significant predictors of depression, $R^2 = .56$, R^2 adjusted $= .51$, $F(3, 24) = 10.33$, $p < .001$ (see Table 4). A similar result was found when predicting anxiety symptoms, $R^2 = .38$, R^2 adjusted $= .30$, $F(3, 24) = 4.91$, $p = .008$; self-esteem and family victimization significantly predicted anxiety.

For LBG racial minorities, a multiple regression analysis indicated that family victimization and self-esteem were significant predictors of depressive symptoms, $R^2 = .77$, R^2 adjusted $= .76$, $F(3, 41) = 46.09$, $p < .001$. Together, these variables accounted for about 77% of variance. These same variables also accounted for about 70% of variance with regard to anxiety symptoms, $R^2 = .72$, R^2 adjusted $= .71$, $F(3, 41) = 36.18$, $p < .001$. Specifically, the analysis demonstrated that family victimization and self-esteem accounted for a significant amount of variance for both depressive and anxiety symptoms respectively (see Table 4).

Moderated Mediation Analysis

The PROCESS macro for IBM SPSS, developed by Hayes (2013), was used to assess the relationship between family victimization and health outcomes (depressive and anxiety symptoms). A moderated mediation analysis was performed; in addition to the above hypothesis, social support was predicted to moderate the relationship between family victimization and mediators, internalized homonegativity and self-esteem.

Analysis of LGB Majority. The moderated mediation model assessing depressive symptoms among LGB majority indicated that the model was significant ($R^2 = .56$, $MSE = 25.20$, $p < .001$). Closer inspection indicated that social support was not a moderator of IH ($p = .41$) nor

self-esteem ($p = .27$). Because the moderation was not successful and this study was interested in understanding the potential mediating properties of IH and self-esteem, a separate mediation analysis was performed. Using a parallel mediation analysis, an analysis in which two predictor variables are hypothesized to indirectly and independently influence an outcome variable, it was found that self-esteem better predicted depressive outcomes over family victimization alone ($R^2 = .56$, $MSE = 25.20$, $p < .001$). The direct path between family victimization and depressive symptoms was positive and significant ($b = 3.86$, $SE = 1.52$, $p = .02$). The a path between self-esteem on victimization approached significance ($b = 2.30$, $SE = 1.17$, $p = .06$), while the path from self-esteem to depression was significant ($b = .64$, $SE = .19$, $p = .002$). Further inspection of the indirect effects, that is the multiplicative effect of both of the ab path, indicate that self-esteem is a better predictor of depressive symptoms over family victimization ($IE = 1.47$, CI 95% [.24, 1.03]). The mediation between victimization and depressive symptoms by IH was also assessed. A significant relationship between victimization on IH was observed ($b = 6.69$, $SE = 1.71$, $p = .006$), although the effect from IH and depressive symptoms was not retained ($b = -.08$, $SE = .12$, $p = .53$). The indirect effects revealed that IH did not mediate the relationship between victimization and psychological distress ($IE = -.55$, 95% CI [-2.34, 2.55]) (see figure 3).

For the second analysis, a similar procedure was performed. The parallel mediation model predicting anxiety symptoms was significant ($R^2 = .38$, $MSE = 26.74$, $p = .008$). The a path between self-esteem on victimization approached significance ($b = 2.30$, $SE = 1.17$, $p = .06$), while the path from self-esteem to anxiety was significant ($b = .64$, $SE = .20$, $p = .003$). The indirect effect of self-esteem on anxiety symptoms was significant (IE = 1.03, 95% CI [.03, 2.54]). IH, when regressed onto victimization, was significant ($b = 6.69$, $SE = 1.71$, $p = .006$), although the effect from IH and anxiety symptoms was not retained ($b = -.11$, $SE = .13$, $p = .43$).

Further, the indirect effect of IH on anxiety symptoms was not significant (IE = -.72, 95% CI [-2.77, 2.19]). When accounting for self-esteem, family victimization (DE = 2.96, 95% CI [-.27, 6.19]) no longer predicted anxiety symptoms. The indirect effect of IH was not significant and did not predict anxiety (IE = -.72, 95% CI = [-2.78, 2.19]).

Analysis of LGB Minority. The moderated mediation model assessing depressive symptoms among LGB racial minorities was significant (R_2 = .77, $RMSD$ = 10.73, p < .001). Upon further inspection, social support did not moderate the relationship between family victimization and internalized homonegativity (p = .28) or self-esteem (p = .42). Because this study was also interested in assessing the potential mediation of IH and self-esteem on victimization and psychological outcomes, a parallel mediation model analysis was performed. The relationship between victimization and self-esteem was significant (b = 2.71, SE = 1.09 p = .02). The relationship between self-esteem and depressive symptoms was also significant (b = .80, SE = .11, p < .001), suggesting that self-esteem partially mediated the relationship between victimization and depression. Inspection of the indirect effects support that self-esteem mediated the relationship between victimization and depressive symptoms (IE = .21, 95% CI [.03, .39]), though the direct effect of victimization on depression remained significant even when accounting for self-esteem, (DE = 4.45, 95% CI [2.62 – 6.28]). IH was assessed as a mediator between outcomes and victimization. IH and victimization held a significant relationship, (b = 4.58, SE = 1.61, p = .007), though the relationship between IH and depression symptoms was not significant, (b = .06, SE = .07, p = .42). The indirect effects for IH on victimization indicated that the relationship was not significant, (ID = .27, 95% CI [-.67, 1.50]).

As with the previous analysis, the same process was followed to assess IH and self-esteem as potential mediators between victimization and anxiety symptoms. A parallel process

model was performed. A significant relationship was observed between victimization and self-esteem, ($b = 2.70$, $SE = 1.09$, $p = .02$). The relationship between self-esteem and anxiety was also found to be significant, ($b = .74$, $SE = .12$, $p < .001$). Assessment of indirect effects offer that self-esteem mediated the relationship between victimization and anxiety, ($IE = 2.01$, 95% CI [.15, 4.12]). The direct effect between victimization and anxiety remained significant, ($DE = 4.29$, 95% CI [2.33, 6.25]) IH was also assessed. IH and victimization held a significant relationship, ($b = 4.58$, $SE = 1.61$, $p = .007$), though the relationship between IH and anxiety outcome was not significant, ($b = .07$, $SE = .07$, $p = .38$). The indirect effects for IH on victimization indicated that the relationship was not significant, ($ID = .03$, 95% CI [-.08, .11]).
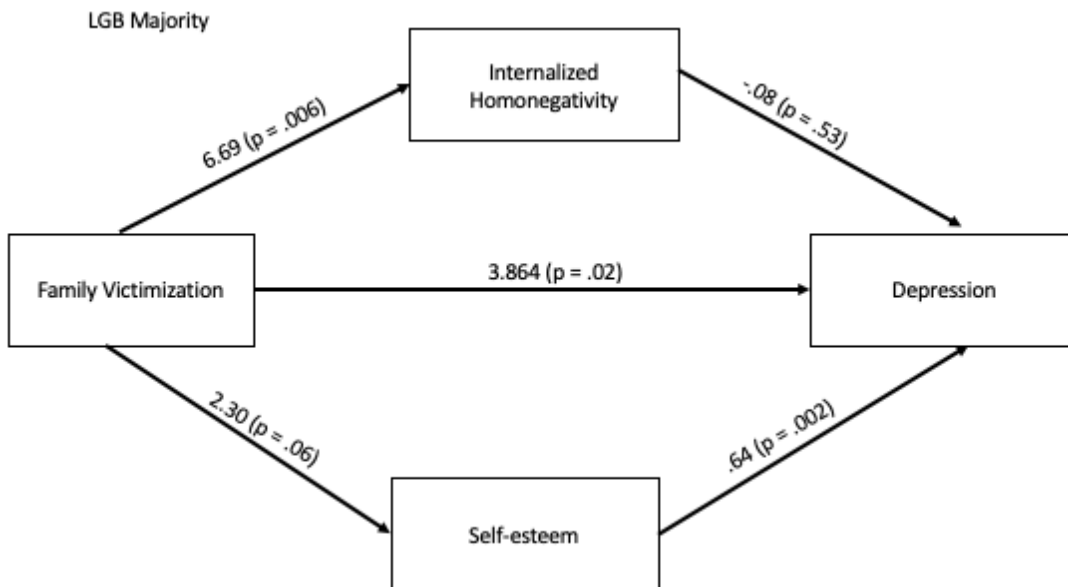
Figure 2: *Parallel mediation model on depressive outcomes for LGB racial majority*
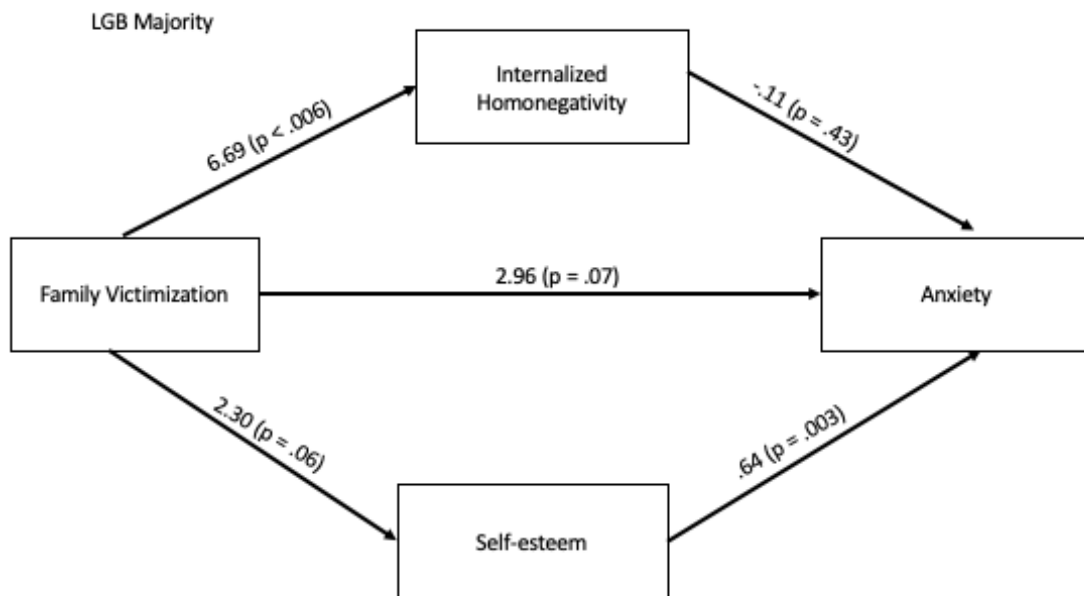
Figure 3: *Parallel mediation model on anxiety outcomes for LGB racial majority*
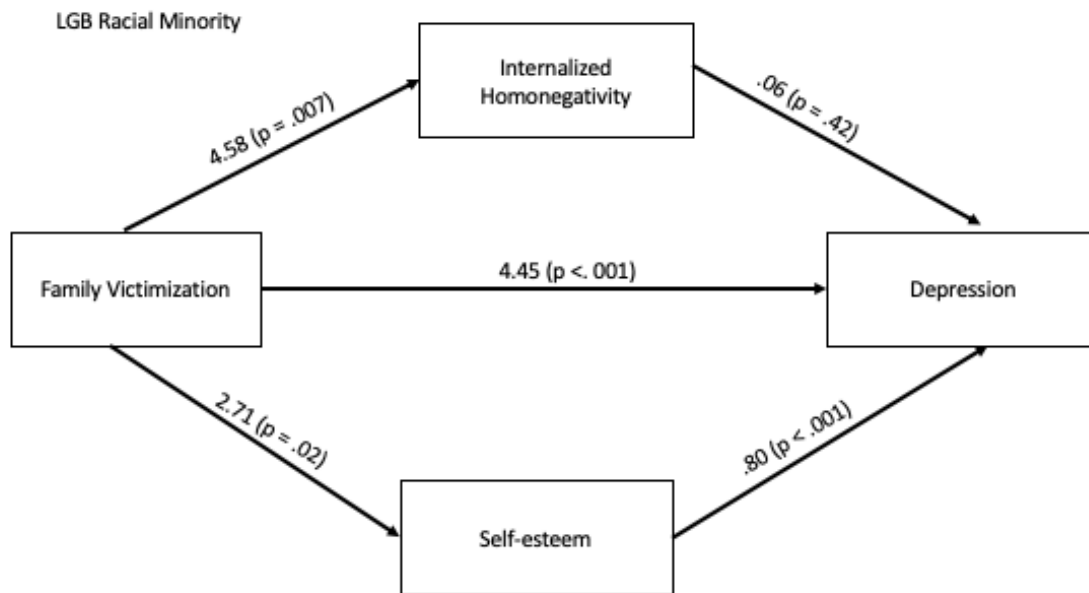
Figure 4: *Parallel mediation model on depressive outcomes for LGB racial minority*

Figure 5: *Parallel mediation model on anxiety outcomes for LGB racial minority*

CHAPTER FOUR: DISCUSSION

LGB PoC remain an understudied community. This study intended to shed light on the experiences of LGB racial and ethnic minorities, a population that tends to experience diminished health outcomes compared to majority population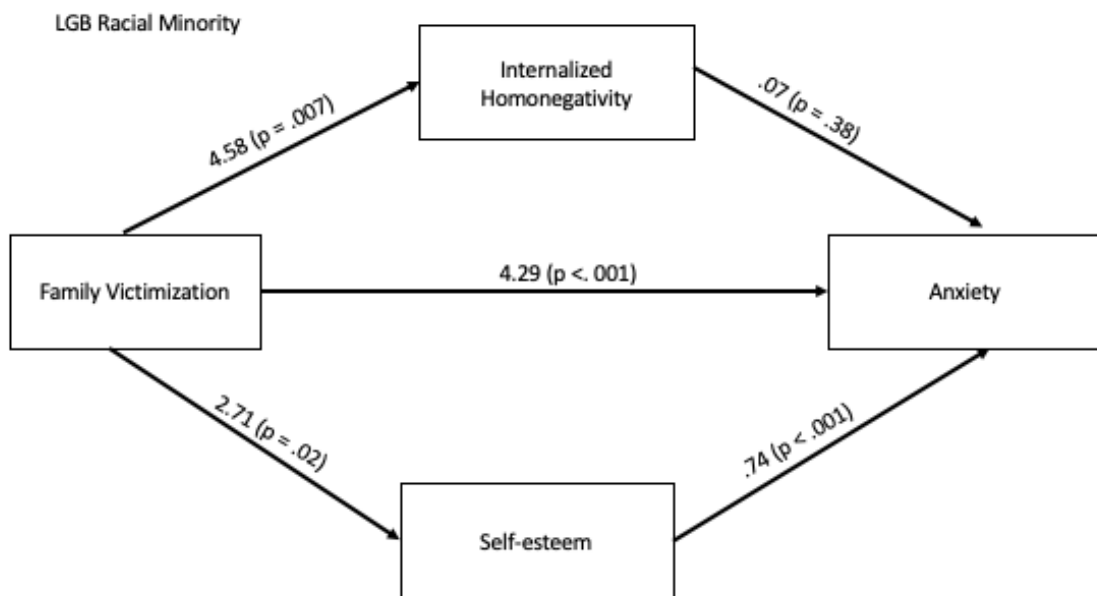s. The aim of the current study sought to identify factors that potentially contribute to reduced psychological well-being among LGB groups. Further this study aimed to identify factors that may potentially buffer against these negative consequences. Family support is one of the strongest predictors of positive psychosocial well-being for LGB youth and adults. Past research has demonstrated the buffering effect of peer social support within LGB communities, yet little is known as to whether this buffering endures for LGB PoC (Parra et al., 2017). LGB PoC report loss of family and community support when disclosing their sexual orientation to family and friends (Enno, 2012; Espín, 1993; Frost et al., 2016). Using the minority stress model as the theoretical framework for this research, the current study explored what happens when support is lost and replaced with abuse or victimization. How does victimization impact psychological health long term, and second, does peer social support aid in offsetting these negative experiences?

Initial findings indicated that LGB PoC perceived their families as holding more negative attitudes toward their sexual orientation compared to the LGB majority. A group difference was found between LGB PoC and the LGB majority, where LGB PoC reported high rates of IH compared to others. This observation suggests that LGB PoC may experience an increased risk for developing negative internalized identities. Several studies report findings of increased levels of IH among LGB PoC (Berg et al., 2016;

Shidlo, 1994; Szymanski, & Gupta, 2012). Some researchers have suggested that sociocultural pressures unique to LGB PoC may explain these differences. Of the literature that has focused on experiences of LGB PoC, many reports, qualitative and quantitative, indicate that communities of color tend to be to be less accepting of sexual minorities (Brown, 2002; Chan, 1989; Greene, 1994; Kuper, Coleman, & Mustanski, 2013; Ryan, Huebner, Diaz, & Sanchez, 2010b). Richter et al.'s (2017) examination on LGB ethnic minorities revealed that parental homonegativity fully mediated the relationship between family rejection and ethnicity, where ethnic parents showed significantly greater homonegative views. Others have found that factors such as religiosity and gender role expectations may explain why some families experience difficultly accepting their LGB children (Greene, 1998; Kuper et al. 2013). Willoughby, Doty, & Malik (2010) reported that family rejection and victimization explained development of negative LGB identity (including IH) in a sample of diverse young adults. The present findings, in conjunction with prior literature, suggest that negative family attitudes may impact the development of internalized homonegativity. Considering that LGB PoC may encounter additional familial and cultural stigma, it is likely the case that these additional experiences contribute to increased levels of IH within LGB ethnic communities.

Because family victimization is both a loss of support and a targeted act against one's personal identity, it was postulated that for both LGB majority and LGB PoC, family victimization would relate to negative internalized identities (IH and self-esteem), depression, and anxiety (Hypothesis 2). For the LGB majority, self-esteem was the strongest predictor of anxiety, while self-esteem and family victimization were the

strongest predictors of depression. For LGB PoC, family victimization and self-esteem were the strongest predictors of depression and anxiety. These results complement past research suggesting that family victimization continues to be an important factor in understanding reduced mental well-being within the LGB community (Parra et al., 2017; Willoughby, Doty, & Malik 2010).

Hypotheses 3 and 4 suggested that peer support would moderate the relationship between victimization and internalizing outcomes, IH and self-esteem, though this theory was unsupported (see Figure 3-10). Social support did not moderate IH or self-esteem for either groups suggesting peer support alone does not mitigate the effect of family victimization. Past studies have indicated that peer support has many benefits for LGB communities, especially when faced with family victimization or rejection (Parra, et al. 2017; Snapp et al., 2015). Though this study did was not able to support this finding, more investigation is required to determine if this continues to remain the case across LBG racial/ethnic communities.

It was further hypothesized (Hypothesis 5) that acts of victimization would predict self-esteem and IH. For both groups, family victimization was predictive of IH. This suggests that while acts of violence may not occur as frequently, their impact on LGB identity remains salient. Interestingly, although related to family victimization, IH was not predictive of psychological outcomes for either group. As it turned out, self-esteem was a significant predictor of depression and anxiety for both LGB majority and LGB PoC. For LGB PoC, family victimization predicted self-esteem, which later explained symptoms of depression and anxiety. For the LGB majority these findings were mixed;

family victimization did not impact self-esteem, yet self-esteem was the best predictor of anxiety and depressive symptoms. Although victimization contributed to depressive symptoms, self-esteem remained the strongest predictor of psychological distress for the LGB majority.

Taken together, it can be concluded that family victimization contributes significantly to overall health for LGB PoC, impacting levels of self-esteem, IH, anxiety and depression. For the LGB majority this was only true for IH and only partially true for depressive symptoms. These findings substantiate previous research suggesting that family support is critical to psychological health especially among LGB groups, particularly LGB racial minorities (Snapp et al., 2015; Ryan et al., 2009). Several studies suggest that accounting for victimization based on race and sexual orientation may better explain observed negative outcomes often found among LGB PoC (Bostwick et al., 2014; Seng et al., 2012). For LGB PoC, family victimization may negatively impact aspects of both ethnic and sexual identity. This could explain the relationship between victimization and esteem and victimization and IH. This also may explain why family victimization continued to be an important predictor of health outcomes for LGB PoC rather than both groups. Still, in addition to victimization, self-esteem was an important contributing factor to reduced well-being.

A next step for future research may be to consider ways to improve self-esteem and/ or challenge heightened levels of IH. Understanding cultural impacts on LGB PoC can also further enhance present interventions and preventative strategies. When considering implications for clinical work, these findings support that clinicians and health care

workers pay attention to family and cultural experiences, as well as perceptions of self-worth, as these factors likely contribute to the distress a patient may be experiencing. Finally, theorists may consider expanding the current minority stress model. By including space for intersection of identities, one can better explain the relationship between experiences and resulting health consequences. Doing so serves to acknowledge additional stressors that LGB PoC, as well as other non-prototypical members within this group, seem to experience.

Limitations

It is important to recognize that the present study is not without limitations. First, the mechanism for recruiting participants can come with several drawbacks making conclusions about these findings difficult. As noted, participants were recruited through Amazon MTurk, a crowdsourcing platform where individuals can receive payment for participating in surveys and research. This method was chosen in order to obtain a representative sample of the LGB community. Although there are methods for ensuring quality responding, there currently are no specifications to limit recruitment to LGB specific populations. Although the study included eligibility screeners, several respondents attempted bypassing these screens. Validity checks were used to ensure accurate responding and it was through these validity checks that researchers were able to delineate true from untrue survey attempts. Still, it could be the case that a respondent is able to bypass eligibility screens and validity checks should they truly wish to. Second, it was the case that technical glitches resulted in the early termination of several individuals' surveys prior to reaching completion. For 3 participants, the Qualtrics survey

failed to deliver the entire survey and participants were automatically directed to the end of the survey, unable to return to their last completed section. As a result, these individuals could not be included in the study. Occurrences like this indicate that technical errors are always present and researchers conducting online research should remain vigilant of such possibilities. Another limitation to this study was that the samples between groups was discrepant in size. The sample of LGB minorities outweighed the majority group by a little over one third. Though the aim was to look at differences between groups, this difference may have contributed to some of the findings encountered. Future studies ought to focus on obtaining larger, equal sample sizes for most accurate comparisons.

CHAPTER FIVE: CONCLUSION

LGB populations are at increased risk for negative psychological health outcomes. The present study indicated that for LGB PoC, family victimization impacts self-worth and acceptance of LGB identity. Family attitudes and family behaviors (i.e., victimization) contribute significantly to negative health outcomes including depression, anxiety, and the development of negative internalized identities (IH). Additionally, this research indicates that LGB PoC experience greater levels of IH, suggesting cultural experiences, family attitudes, and victimization may uniquely effect people of color. Results support that important differences exist between LGB and LGB PoC. Considering these differences within the larger framework of the minority stress model will be important as researchers aim to further develop efficacious treatments and successful preventative strategies.

APPENDIX A:
TABLES

Table 1:
Sample Characteristics.

Characteristics		N = 73	Percentage
Age (M, SD)		(29.37, 8.34)	
Gender			
	Female	34	46.58%
	Male	36	48.65%
	Non-binary/ Gender Queer	2	2.7%
	Transgender	1	1.3%
Race/Ethnicity			
	Non-Hispanic White	28	38.36%
	Hispanic White	3	4%
	Latinx/Hispanic	20	27.40%
	Black/African American	11	15%
	Asian	8	11%
	Pacific Islander	1	1.40%
	Native American	1	1.40%
	Biracial	1	1.40%
People of color			
	Non-Hispanic White	28	38.35%
	Persons of color	45	61.60%
Sexual Orientation			
	Gay	21	28.80%
	Lesbian	18	24.70%
	Bisexual	28	38.40%
	Asexual	1	1.40%
	Other (queer, polyamorous)	5	6.80%
Education			
	High school diploma/ GED	3	4.10%
	Some College	14	19.18%
	2-year degree	17	23.29%
	4-year degree	31	42.47%
	Graduate School	7	9.60%
	Technical School	1	1.40%
Employment Status			
	Full-time	53	72.60%
	Part-time	9	12.30%
	Unemployed	2	2.70%
	Student	6	8.20%
	Other	3	4.10%
Income			
	Less than 20,000 a year	10	16.70%
	20,000 - 34,999	18	25%
	35,000 - 49,999	13	17.80%
	50,000 - 74,999	17	23.29%
	75,000 - 99,999	13	17.80%

Characteristics	N = 73	Percentage
Over 100,000	2	2.70%
Relationship Status		
Single	26	35.60%
In committed relationship	26	35.60%
Cohabitating	8	11%
Married	10	16.70%
Divorced	1	1.40%

Table 2:
Descriptive Statistics

Racial Majority		*M*	*SE*	Minimum	Maximum
	Depression	9.11	1.22	0	27
	Anxiety	7.21	1.03	0	21
	Family Attitudes	2.57	.174	1	4
	Family Victimization	1.57	.16	1	3.78
	IH	49.43	1.80	34	71
	Self Esteem	17.9	1.14	9	30
	Social Support	20.21	1.04	9	28
Racial Minority					
	Depression	7.31	.877	0	23
	Anxiety	5.27	.84	0	21
	Family Attitudes	2.16	.12	1	4
	Family Victimization	1.44	.10	1	3.44
	IH	53.24*	1.12	33	75
	Self Esteem	19.9	.84	6	30
	Social Support	18.16	.75	9	31

Table 3:
Correlations among key variables by group status

LGB Racial Majority	1	2	3	4	5	6	7
1. Depressive symptoms	1.000	-	-	-	-	-	-
2. Anxiety symptoms	.78**	1.000	-	-	-	-	-
3. Family victimization	.58*	.45*	1.000	-	-	-	-
4. Self-Esteem	-.66**	-.53**	-.33†	1.000	-	-	-
5. IH	.23	.12	.61**	-.07	1.000	-	-
6. Family attitudes	.13	.09	-.04	-.14	-.17	1.000	-
7. Social Support	-.04	-.05	-.13	.48**	-.21	.39*	1.000

LGB Racial Majority	1	2	3	4	5	6	7
1. Depressive symptoms	1.000	-	-	-	-	-	-
2. Anxiety symptoms	.92**	1.000	-	-	-	-	-
3. Family victimization	.68**	.67**	1.000	-	-	-	-
4. Self-Esteem	-.75**	-.73**	.36*	1.000	-	-	-
5. IH	.19	.20	.40**	.08	1.000	-	-
6. Family attitudes	-.22	-.25†	-.26†	.14	-.21	1.000	-
7. Social Support	-.26†	-.18	-.20	.14	-.02	.01	1.000

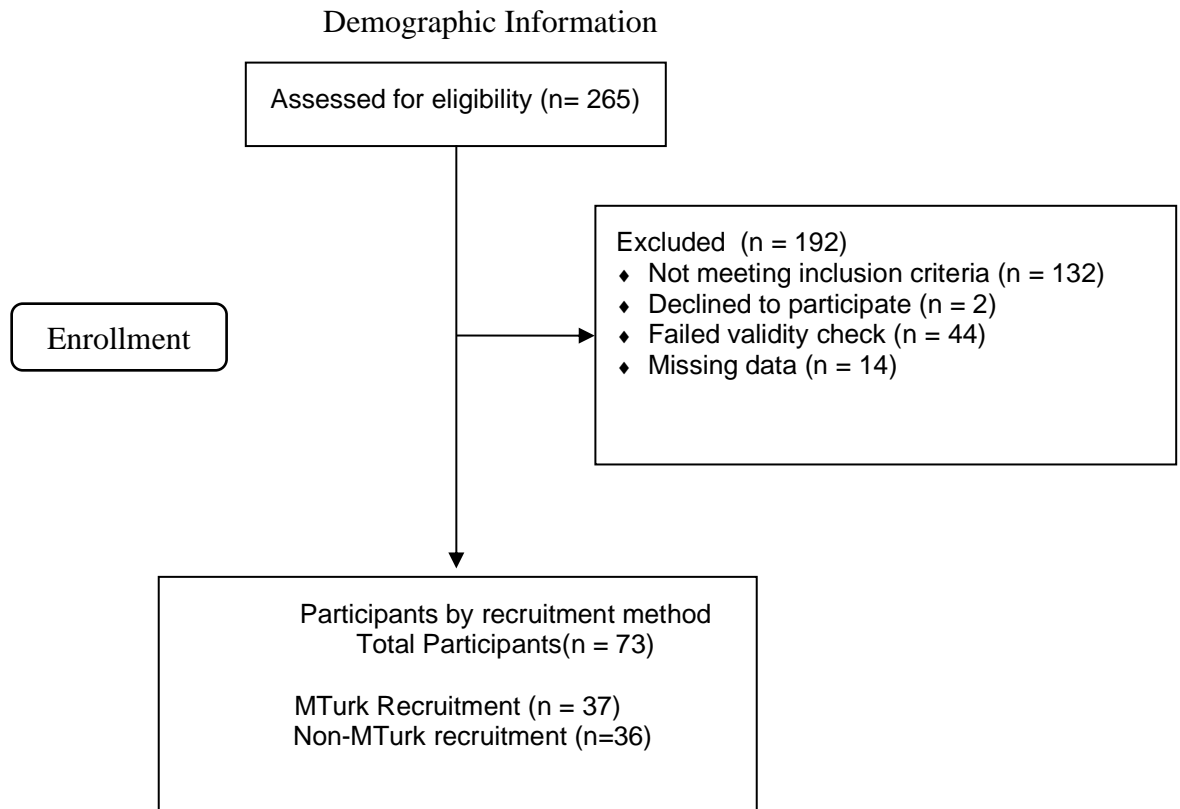*Note.* IH = Internalized homonegativity. * p <.05 ** p < .01, †, trending toward significance

Table 4:
Summary of regression analysis

Racial Majority		Depressive Symptoms					Anxiety Symptoms				
	Independent Variables	*B*	*SE*	*β*	t	p	*B*	*SE*	*β*	t	p
	(Constant)	5.17	6.66		.78	.45	7.76	6.86		1.13	.27
	Family Victimization	3.86	1.52	.47	2.54	.02*	2.97	1.56	.41	1.89	.07†
	Self Esteem	.64	.19	.49	3.35	.003*	.45	.20	.40	2.29	.03*
	Internalized Homonegativity	-.08	.13	-.11	-.63	.53	-.11	.13	-.16	-.80	.43
Racial Minority		Depressive Symptoms					Anxiety Symptoms				
	Independent Variables	*B*	*SE*	*β*	t	p	*B*	*SE*	*β*	t	p
	(Constant)	-6.14	4.306		-1.43	.16	-9.24	4.60		-2.01	.05
	Family Victimization	4.45	.91	.44	4.91	.001**	4.29	.97	.44	4.43	.001**
	Self Esteem	.80	.11	.60	7.28	.001**	.74	.12	.56	6.33	.001*
	Internalized Homonegativity	.06	.07	.70	.81	.42	.07	.08	.08	.88	.38

* p <.05; ** p < .01; † - trending toward significance

APPENDIX B:
CONSORT DIAGRAM

Study Enrollment Consort Diagram

Demographic Information

Assessed for eligibility (n= 265)

Enrollment

Excluded (n = 192)
- Not meeting inclusion criteria (n = 132)
- Declined to participate (n = 2)
- Failed validity check (n = 44)
- Missing data (n = 14)

Participants by recruitment method
Total Participants(n = 73)

MTurk Recruitment (n = 37)
Non-MTurk recruitment (n=36)

APPENDIX C:
RECRUITMENT MATERIALS

Now Recruiting!

LGB individuals

- Help inform & advance research on LGB specific topics
- Completely confidential

The current research study is looking for participant who identify as part of the LGB community. Those identifying as racial/ethnic minorities are highly encouraged to participate!

Tell me about this study?

This study will explore different types of social support, health and well-being across various LGB community groups. Particularly important to this research is exploring these topics across communities of color.

To participate go to:
ucf.qualtrics.lgbhealth

Questions, Comments, Concerns?
Contact:
Jessica
at
jruiz2017@knights.ucf.edu

(407) 823-3910

Social Support and Health Outcomes
¡Ahora Reclutando!
LGBTQ+ individuos

- Ayuda a informar y avanzar la investigación sobre temas específicos de LGBTQ+
- Completamente confidencial

El estudio de investigación actual está buscando participantes que tengan 18+ años y que se identifiquen como parte de la comunidad LGBTQ+. ¡Aquellos que se identifican como minorías raciales / étnicas son altamente animados a participar!

Cuéntame sobre este estudio?

El objetivo de este estudio es comprender mejor el impacto del apoyo social disponible para diferentes comunidades LGBTQ + con un interés particular en explorar el apoyo social entre las minorías raciales / étnicas que también se identifican como LGBTQ +

http://ucf.qualtrics.com/jfe/form/SV_1zVK5yx NCTPjalZ

Escanee el código QR de arriba con la cámara de su teléfono o uso el enlace de Internet

I ❤ UCF

Preguntas, comentarios, inquietudes?
Contacto a :
Jessica Ruiz
jruiz2017@knights.ucf.edu
(407) 823-3910

Dr. Clint Bowers
clint.bowers@ucf.edu

APPENDIX D:
SURVEY MATERIALS

NonMturk English Social Support and Health

Q1 Please complete this short screening for eligibility purposes.
Q2 Ethnicity or Race (select all that apply)

☐ Native American / American Indian

☐ Black or African American

☐ Latino/a, Chicana/o or Hispanic

☐ Asian American

☐ Pacific Islander

☐ Native Alaskan

☐ White / Caucasian

☐ Other: _____

Q3 To whom are you sexually or romantically attracted?

○ Only same sex attracted

○ Mostly same sex attracted

○ Equally same sex and other sex attracted

○ Mostly other sex attracted

○ Only other sex attracted

○ Other: _____

Q4 Age

_____

Q5 Gender

- ○ Female

- ○ Male

- ○ Transgender (female identified)

- ○ Transgender (male identified)

- ○ Other: _____

Q6 How do you self-identify?

- ○ Heterosexual

- ○ Lesbian

- ○ Gay

- ○ Bisexual

- ○ Transgender

- ○ Non-binary /Non-conforming

- ○ Other (please describe): _____

End of Block: Screening

Start of Block: Consent

Q7

 EXPLANATION OF RESEARCH
   Title of Project: Social Support and Health Outcomes Principal Investigator: Jessica Ruiz, BA Other Investigators: Annelise Cunningham, MA; Madeline Marks, MA; Regina Ruiz, Macy Kraus Faculty Supervisor: Dr. Clint Bowers
   You are being invited to take part in a research study. Whether you take part is up to you.   The following study aims better understand the impact of social support available to different LGBTQ+ communities with a particular interest in exploring social support among racial/ethnic minorities who also identify as LGBTQ+.
          This is an online survey that will be completed through Qualtrics software.   The survey should take participants 35 to 45 minutes to complete Participants will be compensated $10 in an electronic amazon gift card for each completed survey.

   Your participation in this study is voluntary. You are free to withdraw your consent and discontinue participation in this study at any time without prejudice or penalty. Your decision to participate or not participate in this study will in no way affect your relationship with UCF, including continued enrollment, grades, employment or your relationship with the individuals who may have an interest in this study.
   Should you choose to participate in this study you will be asked to provide a valid email address that will be used to award compensation upon completion of the survey. Once data is downloaded and encrypted to a secure password protected hard drive, participants will be immediately assigned a research number and email addresses will be separated from the data file. An encrypted file will be created to store this information only as a means to offer compensation. Identifying information will not be associated with collected data after compensation is issued. Only the research team will have access to this information and information will be archived for the required minimum of 5 years after the study closure.

You must be 18 years of age or older to take part in this research study.
  Study contact for questions about the study or to report a problem:
 If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team directly. Please contact Jessica Ruiz, jruiz2017@knights.ucf.edu or Dr. Clint Bowers at clint.bowers@ucf.edu.
  IRB contact about your rights in this study or to report a complaint: If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901, or email irb@ucf.edu

- ○ Yes
- ○ No

Q8 Relationship Status

- ○ Single
- ○ In a committed relationship
- ○ Cohabitating
- ○ Married
- ○ Divorced
- ○ Widowed
- ○ Other: _____

Q9 Highest Level of Education

- ○ Less than high school/ GED
- ○ High school / GED
- ○ Some college
- ○ 2 year degree (AA, AS)
- ○ 4 year degree (BA, BS)
- ○ Graduate School
- ○ Technical or Trade School
- ○ Other (please describe) : _____

Q10 Are you currently a college or university student?

- ○ No
- ○ Yes

Q11 Annual Income

- ○ Less than $20,000 a year
- ○ $20,000 - 34,999
- ○ $35,000 - 49,999
- ○ $50,000 - 74,999
- ○ $75,000 - 99,999
- ○ Over $100,000

Q12 Current employment status:

- ○ Employed Full Time (40+ hrs)
- ○ Employed Part Time (up to 39 hrs)
- ○ Unemployed
- ○ Student
- ○ Retired
- ○ Other (please describe): _____

Q13 Please choose if you'd like to continue this survey.

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

End of Block: DemoPt.2

Start of Block: Sexual Orientation Developmental Milestones

Q14

In this next section we'd like to ask you some questions about your personal history.

Q15 The following series of questions are aimed at describing the timing of different experienc-es, thoughts and feelings in relation to your sexual identity formation. Because people may have different preferred terms to indicate same-sex sexual orientation the word homosexual is used here for simplicity and should be taken to encom-pass all these terms. Likewise, bisexual includes any significant amounts of both same-sex and opposite sex eroticism. Please answer each question by giving a specific age (in years) or writing 'never' if what is described has never applied to you. If you are unsure of the exact age, please choose the one age which is your best guess rather than writing a range.

Q16 At what age did you consider that you were definitely homosexual/ bisexual? (If you are not, write Never).

_____

Q17 Currently you socialize with (please choose the most appropriate):

- ○ No homosexual/bisexual people
- ○ One or very few homosexual/ bisexual people
- ○ Some homosexual/bisexual people
- ○ Many homosexual/bisexual people
- ○ Most or only homosexual/bisexual people

Q18 How old were you when you disclosed your homosexuality to the following? (If you have not, write Never; If not applicable, write n/a).

- ○ Your Mother _____
- ○ Your Father _____
- ○ A Sister _____
- ○ A Brother _____
- ○ A member of your extended family _____
- ○ A co-worker _____

Q19 At what age did you first feel that the majority of significant people (family, friends, co-workers, etc.) in your life knew you were homosexual/bisexual?

_____

Q20 Currently you are out to (please choose the most appropriate):

- ○ No one
- ○ Very few people
- ○ Some friends, family and/or co-workers
- ○ Many significant people in your life
- ○ Most or all the significant people in your life

Q21 Currently you feel about your homosexuality/bisexuality (please choose the most appropriate):

- ○ Very Negatively
- ○ Negatively
- ○ Sometimes negatively, sometimes positively
- ○ Positively
- ○ Very positively

Q22 In your family, homosexuality is (please choose the best group of descriptors):

- ○ Ridiculed, stigmatized, discriminated
- ○ Tolerated
- ○ Accepted, respected
- ○ Celebrated, appreciated

Q23 In your social circle, homosexuality is (please choose the best group of descriptors):

- ○ Ridiculed, stigmatized, discriminated
- ○ Tolerated
- ○ Accepted, respected
- ○ Celebrated, appreciated

Q24 In your work environment, homosexuality is (please choose the best group of descriptors):

- ○ Ridiculed, stigmatized, discriminated
- ○ Tolerated
- ○ Accepted, respected
- ○ Celebrated, appreciated

Q25 Please choose if you'd like to continue this survey.

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

End of Block: Sexual Orientation Developmental Milestones

Start of Block: Victimization

Q26 Please indicate in the space provided the number of times you have been subject to the following forms of violence because the aggressor either knew or assumed your sexuality. For each question select only one response from the given choices.

Aggression by family members:

	Never	Once	Twice	Three or more times
Verbal Insults	○	○	○	○
Threats of physical violence	○	○	○	○
Destruction or damage to your belongings	○	○	○	○
Being followed or chased	○	○	○	○
Being spit on	○	○	○	○
Having objects thrown at you	○	○	○	○
Being hit, kicked or beaten	○	○	○	○
Sexual assault	○	○	○	○
Threatened with a weapon	○	○	○	○

Q27 Aggression by peers or by people other than family members:

	Never	Once	Twice	Three or more times
Verbal Insults	○	○	○	○
Threats of physical violence	○	○	○	○
Destruction or damage to your belongings	○	○	○	○
Being followed or chased	○	○	○	○
Being spit on	○	○	○	○
Having objects thrown at you	○	○	○	○
Being hit, kicked or beaten	○	○	○	○
Sexual assault	○	○	○	○
Threatened with a weapon	○	○	○	○

Q28 Please choose if you'd like to continue this survey.

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

Q29 Most relationships with people we feel close to are both helpful and stressful. Below are statements that describe close personal relationships.

Please read each statement and circle the answer that best fits your situation. There are no right or wrong answers.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I know someone who makes me feel confident in myself.	○	○	○	○	○
Within my circle of friends, I get just as much as I give	○	○	○	○	○
Some people I care about share similar views with me.	○	○	○	○	○
I'm available to my friends when they need to talk.	○	○	○	○	○
When I have helpful information, I try to pass it on to someone who could use it.	○	○	○	○	○
I think I put more effort into my friends than they put into me.	○	○	○	○	○
There is someone I can turn to for helpful advice about a problem.	○	○	○	○	○

I don't mind
loaning money
if a person I
care about
needs it.
    ○   ○   ○   ○   ○

I can talk
openly about
anything with
at least one
person I care
about.
○　　○　　○　　○　　○

I'm satisfied
with the give
and take
between me
and people I
care about.
○　　○　　○　　○　　○

There is
someone I
could go to for
anything.
○　　○　　○　　○　　○

Some people
in my life are
too pushy.
○　　○　　○　　○　　○

I'm happy
with the
balance of how
much I do for
others and how
much they do
for me.
○　　○　　○　　○　　○

I can count on
a friend to
make me feel
better when I
need it.
○　　○　　○　　○　　○

When I need help, I get it from my friends, and when they need help, I give it back.	○	○	○	○	○
There is someone in my life who gets mad if we have different opinions.	○	○	○	○	○
It's safe for me to reveal my weaknesses to someone I know.	○	○	○	○	○
Someone I care about stands by me through good times and bad times.	○	○	○	○	○
I have the kind of neighbors who really help out in an emergency.	○	○	○	○	○
There is someone I care about that I can't count on.	○	○	○	○	○
If I need help, all I have to do is ask.	○	○	○	○	○

I have enough
opportunity to
talk things
over with
people I care
about.

    ○   ○   ○   ○   ○

Q30 Please choose if you'd like to continue this survey.

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

Q31 These next statements ask you how often something happens.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
I have enjoyable times with people I care about.	○	○	○	○	○
I spend time doing things for others when I'd really rather not.	○	○	○	○	○
Some people I care about invade my privacy.	○	○	○	○	○
I let people I care about know that I appreciate them.	○	○	○	○	○
I am embarrassed by what someone I care about does.	○	○	○	○	○
Some people come to me for a boost in their spirits.	○	○	○	○	○
Someone I care about tends to take advantage of me.	○	○	○	○	○
Some people I care about are a burden to me.	○	○	○	○	○
I tell others when I think they're great.	○	○	○	○	○
I wish some people I care about were more sensitive to my needs.	○	○	○	○	○
People I care about make me do things I don't want to do.	○	○	○	○	○

Some people I care about come to me for advice.	○	○	○	○	○
There is tension between me and someone I care about.	○	○	○	○	○
I have trouble pleasing some people I care about.	○	○	○	○	○
At least one person I care about lets me know they believe in me.	○	○	○	○	○
Some people I feel close to expect too much of me.	○	○	○	○	○
I let others know I care about them.	○	○	○	○	○

Q32 Please choose if you'd like to continue this survey.

○   I want to continue the survey

○   I DO NOT want to continue the survey

Q33 Over the past 2 weeks, how often have you been bothered by any of the following?

Q34 Little interest of pleasure in doing things

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q35 Feeling down, depressed, or hopeless

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q36 Trouble falling or staying asleep, or sleeping too much

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q37 Feeling tired or having little energy

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q38 Poor appetite or overeating

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q39 Feeling bad about yourself - or that you are a failure or have let yourself or your family down

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q40 Trouble concentrating on things, such as reading the newspaper or watching television

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q41 Moving or speaking so slowly that other people could have noticed? Or the opposite -being so fidgety or restless that you have been moving around a lot more than usual

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q42 Thoughts that you would be better off dead or of hurting yourself in some way

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly everyday

Q43 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not at all difficult
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

Q44 Please choose if you'd like to continue this survey.

- ○   I want to continue the survey

- ○   I DO NOT want to continue the survey

Q45

Over the last 2 weeks, how often have you been bothered by the following problems?

Q46 Feeling nervous, anxious, or on edge

- ○   Not at all sure

- ○   Several Days

- ○   Over half the days

- ○   Nearly everyday

Q47 Not being able to stop or control worrying

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q48 Worrying too much about different things

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q49 Trouble relaxing

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q50 Being so restless that it's hard to sit still

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q51 Becoming easily annoyed or irritable

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q52 Feeling afraid as if something awful might happen

- ○ Not at all sure
- ○ Several days
- ○ Over half the days
- ○ Nearly everyday

Q53 If you agreed to any of the above statements, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

Q54 Please choose if you would like to continue the survey

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

End of Block: GAD-7

Start of Block: Self Esteem

Q55 Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement. All answers will remain anonymous.

	Strongly Agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself.	○	○	○	○
At times I think I am no good at all.	○	○	○	○
I feel that I have a number of good qualities.	○	○	○	○
I am able to do things as well as most other people.	○	○	○	○
I feel I do not have much to be proud of.	○	○	○	○
I certainly feel useless at times.	○	○	○	○
I feel that I'm a person of worth, at least on an equal plane with others.	○	○	○	○
I wish I could have more respect for myself.	○	○	○	○
All in all, I am inclined to feel that I am a failure.	○	○	○	○
I take a positive attitude toward myself.	○	○	○	○

Q56 Please choose if you'd like to continue this survey.

○ I want to continue the survey

○ I DO NOT want to continue the survey

Page Break

Q57 Please answer the following questions:

Q58 I am comfortable about people finding out about my orientation.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q59 It is important to me to control who knows about my orientation.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q60 I feel comfortable discussing sexual orientation in a public situation.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q61 Even if I could change my sexual orientation I wouldn't.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q62 I feel comfortable being seen in public with an obviously gay person.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q63 Most gay people cannot sustain a long-term committed relationship.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q64 Most gay people prefer anonymous sexual encounters.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q65 Gay people tend to flaunt their sexuality inappropriately.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q66 Gay people are generally more promiscuous than others.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q67 I often feel intimidated while at gay venues.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q68 Social situations with other gay people makes me feel uncomfortable.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q69 I feel comfortable in gay bars.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q70 Making advances to those I am interested in is difficult for me.

- ○ Strongly disagree
- ○ Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Agree
- ○ Strongly agree

Q71 Please choose if you'd like to continue this survey.

- ○ I want to continue the survey
- ○ I DO NOT want to continue the survey

End of Block: IH

Start of Block: End of Survey Demographics

Q72 Ethnicity or Race (select all that apply)

- ☐ Native American / American Indian
- ☐ Black or African American
- ☐ Latino/a, Chicana/o or Hispanic
- ☐ Asian American
- ☐ Pacific Islander
- ☐ Native Alaskan
- ☐ White / Caucasian
- ☐ Other: _____

Q73 To whom are you sexually or romantically attracted?

- ○ Only same sex attracted
- ○ Mostly same sex attracted
- ○ Equally same sex and other sex attracted
- ○ Mostly other sex attracted
- ○ Only other sex attracted
- ○ Other: _____

Q74 Age

_____

Q75 Gender

- ○ Female
- ○ Male
- ○ Transgender (female identified)
- ○ Transgender (male identified)
- ○ Other: _____

Q76 How do you self-identify?

- ○ Heterosexual
- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Transgender
- ○ Non-binary /Non-conforming
- ○ Other (please describe): _____

End of Block: End of Survey Demographics

APPENDIX E:
IRB APPROVAL LETTER

UNIVERSITY OF CENTRAL FLORIDA

<u>EXEMPTION DETERMINATION</u>

April 29, 2019

Dear Jessica Ruiz:

On 4/29/2019, the IRB determined the following submission to be human subjects research that is exempt from regulation:

Type of Review:	Initial Study, Category 2(iii)
Title:	Social Support and Health Outcomes
Investigator:	Jessica Ruiz
IRB ID:	STUDY00000206
Funding:	
Grant ID:	

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Renea Carver
Designated Reviewer

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