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UNIVERSITY OF MIAMI

PARENTAL RESPONSIVENESS AND FAMILY COHESION: IMPACT ON LGB YOUTH MENTAL HEALTH AND IDENTITY

By

Sara Wigderson

A THESIS

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Master of Science

Coral Gables, Florida

May 2017

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A thesis submitted in partial fulfillment of
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PARENTAL RESPONSIVENESS AND FAMILY COHESION: IMPACT ON LGB YOUTH MENTAL HEALTH AND IDENTITY

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Parental Responsiveness and Family Cohesion: (May 2017)
Impact on LGB Youth Mental Health and Identity

Abstract of a thesis at the University of Miami.

Thesis supervised by Associate Professor Kristin Lindahl.
No. of pages in text. (78)

Parental variables have not been widely studied in relation to LGB youth outcomes, and they have not been examined using observational methods. Additionally, no studies have examined parental ambivalence toward LGB youth sexual orientation. Thus, this study aimed to establish the reliability and validity of a new observational coding system that examined parental acceptance, emotional support, and ambivalence. Additionally, this study examined the impact of these parental variables on LGB youth internalizing and externalizing problems, substance use problem severity, and LGB negative identity, and whether self-reported family cohesion was a protective factor for LGB youth. Participants included 36 LGB parent-youth dyads at baseline, and out of those, 27 completed the 2 year follow-up. Results provided support for the reliability and validity of the SCIFF-LGB. Additionally, parental acceptance of sexual orientation at baseline was inversely related to LGB youth externalizing symptoms two years later, and parental emotional support was inversely related to LGB youth internalizing symptoms and substance use problem severity; however, there were no associations with LGB negative identity. Parental ambivalence was not related to youth adjustment. Finally, family cohesion moderated the relationship between parental acceptance and LGB youth internalizing problems. The results of this study have implications for interventions targeting LGB youth and their parents.

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Chapter 1: Introduction

Research on lesbian, gay, and bisexual (LGB) youth (ages 13-21) shows this minority population to be at risk for a range of mental health issues, particularly in comparison to heterosexual youth. Although not all LGB youth develop mental health problems, on average, LGB youth experience higher rates of both internalizing and externalizing disorders (Bos, Sandfort, de Bruyn, & Hakvoort, 2008; Fergusson, Horwood, & Beautrais, 1999; Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008). When compared to a heterosexual sample, LGB youth have been found to have higher odds of experiencing depression, anxiety, conduct disorder, suicidal ideation and attempts, and substance use (Fergusson et al., 1999). Additionally, a meta-analytic review of depression among youth under the age of 18 found sexual minority youth to report significantly higher rates of depressive symptoms compared to their heterosexual counterparts (effect size of d = .33; Marshal et al., 2011). Furthermore, in another meta-analytic review, Marshal et al. (2008) found that the odds of substance use for LGB youth were 190% higher than that of heterosexual youth.

In addition to general mental health issues, another area of concern for LGB youth is identity development. LGB identity development has been defined in various ways (Feldman & Wright, 2013; Rosario, Schrimshaw, & Hunter, 2011). One of the more influential dimensional models of LGB identity was developed by Mohr and colleagues (Mohr & Fassinger, 2000; Mohr & Kendra, 2011). Their model identifies multiple components of LGB identity, with four dimensions in their model specifically measuring negative attitudes and feelings related to one's sexual orientation. These four dimensions are: 1) difficult process, 2) homonegativity, 3) concealment motivation, and 4)

acceptance concerns. For both statistical and conceptual reasons, Mohr and Kendra (2000) combined these four factors to create the construct "negative identity."

Developing a positive sense of identity may be challenging for many LGB youth, but being able to do so has proven beneficial in several studies. For example, greater sexual identity integration is related to youths' psychological adjustment, even after controlling for social factors such as family and friend support (Rosario et al., 2011). Specifically, Rosario et al. (2011) found that compared to LGB youth reporting low identity integration, those who reported high levels of identity integration had less anxiety and higher self-esteem. Given LGB youth's increased risk for internalizing disorders and identity development concerns, research is needed to examine the factors that impact these outcomes. Using an observational approach, one of the aims of this study was to examine parental and family variables that are related to lesbian, gay, and bisexual (LGB) youth psychological adjustment and identity.

Responses from Parents and LGB Youth Adjustment: Parental Acceptance, Emotional Support, and Ambivalence

In the past decade, there has been an increased focus in the literature on understanding the impact parent and family responses have on LGB mental health outcomes. Parental reactions to LGB youths' sexual orientation vary widely but can have a substantial impact on the psychological health and identity development of their LGB children. Three parenting variables were selected for this study: acceptance of sexual orientation, general emotional support, and ambivalence.

Parental acceptance. Multiple studies suggest that greater parental acceptance of sexual orientation, and conversely less parental rejection, are associated with better

psychological adjustment for LGB adolescents as well as adults (D'Amico & Julien, 2012; D'Augelli, 2002; Rothman, Sullivan, Keyes, & Boehmer, 2012; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1989). Several studies have found parental acceptance to be positively related to youth mental health and identity development. For example, D'Amico and Julien (2012) found that greater parental acceptance was related to better psychological adjustment and identity development, including less discomfort with sexual orientation, less psychological distress, and fewer suicidal ideations. Additionally, Savin-Williams (1989) found that lesbians were most comfortable with their sexual orientation when parents accepted their sexuality, and this was also the case for gay men if parents were perceived to be important to the youth's self-worth. A recent study found that a lack of parental acceptance was associated with internalized homonegativity and rejection sensitivity in a sample of LGB adults. Internalized homonegativity and rejection sensitivity were, in turn, related to depressive symptoms (Feinstein, Wadsworth, Davila, & Goldfried, 2014). Of note, all of the above studies that examined parental acceptance have used cross-sectional methodology, which this study builds upon by utilizing longitudinal data.

Parental Support. In addition to acceptance of sexual orientation from parents, general parental support also is an important predictor of LGB youth mental health and identity development. General support refers to any type of emotional, instrumental, and social support that is not related to sexuality. Parental support has been found to mediate the relationship between sexual orientation and depressive symptoms, drug use, and suicidal thoughts for young women, with lower support related to worse health-related outcomes (Needham & Austin, 2010). General support from friends and family has also

been found to cross-sectionally predict lower levels of depression and increased life satisfaction among bisexual young adults (Sheets & Mohr, 2009). Additionally, in one of the few longitudinal studies done to date, Rosario, Schrimshaw, and Hunter (2008) found that higher perceived family social support at baseline was related to optimal identity integration one year later. Despite its importance, some research suggests that parents may provide less affection and emotional support toward their LGB children, compared to the support received by heterosexual youth (Rosario et al., 2014; Russell, Seif, & Truong, 2001), thus potentially placing LGB youth at risk for internalizing disorders and poor sexual identity development.

The vast majority of the literature that links parental support to mental health issues in LGB youth has failed to differentiate among the various types of support parents might offer. There is some suggestion that general support is related to more global outcome variables (e.g., depression), whereas sexuality-specific support is related specifically to sexuality outcome variables (e.g., lower homonegativity; Sheets & Mohr, 2009), but this has not been well-studied. Two studies have found that non-sexuality specific support (general support) from family is not related to identity development, although it is related to general mental health outcomes (Bregman, Malik, Page, Makynen, & Lindahl, 2013; Doty, Willoughby, Lindahl, & Malik, 2010). However, this also is not yet well studied and has not been studied using longitudinal data; therefore, the present study examined how both sexuality-specific support (i.e., verbal statements of support for and acceptance of sexual orientation) and general emotional support at baseline assessment (i.e., affective attunement and support given not targeted at sexual orientation) affect LGB youth psychological and identity outcomes two years later.

Parental ambivalence. A third parenting variable that may impact LGB youth functioning is ambivalence. Studies tend to examine parental acceptance and rejection of youth sexual orientation in a rather black or white, all-or-none manner. In all likelihood, however, many parents are neither fully accepting nor fully rejecting. Most parents likely seek to be accepting and probably are supportive to some extent, however, they may still harbor some reservations that are communicated to their child. This would result in ambivalent or mixed messages being communicated to LGB youth. Ambivalent messages regarding youths' sexual orientation could include components of acceptance and rejection (e.g., "I am so proud of you as a person, but my religion does not allow me to accept your sexual orientation"). Youth may interpret these messages as rejecting given the overall negative connotations of these ambivalent messages. However, parents may focus on the positive aspect of the message. To date, not a single study has examined ambivalent messages that LGB youth receive from their parents. One of the primary aims of this study was to develop a reliable means of measuring ambivalence. A further aim of this study was to examine the association between ambivalent messages from parents and LGB youth mental health and identity development.

Observational Methods

The three parent variables discussed above—acceptance of sexual orientation, general emotional support, and ambivalence—are herein referred to as parental responsiveness in this study. Although acceptance and support have been studied using self-report, observational data for these variables have not yet been examined. Observational data is important given that self-report data can be biased, especially in the context of variables with a high social desirability load. The potential effect of social

desirability is particularly relevant to the variables in this study. For example, it may be difficult for parents to objectively report on how accepting or supportive they are with their children, as most parents may seek to portray themselves as highly supportive.

Observational methods are often selected when the goal of a study is to examine constructs for which people have limited self-awareness. For example, it is hard for parents to have sufficient self-awareness to make subtle distinctions between how supportive they are generally and how accepting they specifically are about their child's sexual orientation. Parents also are likely to have limited awareness of any ambivalent messages they might be giving to their child. Therefore, behavioral observations of parental responsiveness is ideal for the present study since this methodology allows for independent appraisals of parental behavior that cannot be easily measured using self-report (Kerig, 2001).

Family Cohesion and Youth Adjustment

In addition to parental responsiveness, other family variables may play a role in LGB mental health and identity development. One family-level variable that has garnered research attention is family cohesion. Family cohesion refers to emotional bonding and connectedness that family members experience together (Olson, 2000). Family cohesion is important because it is related to psychological functioning in adolescents and young adults. Studies have found that among adolescents, family cohesion is related to lower levels of depression and higher levels of well-being (i.e., aspirations, confidence, and positive relationships; Crespo, Kielpikowski, Pryor, & Jose, 2011; Cumsille & Epstein, 1994; Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003). Additionally, Cumsille and Epstein (1994) found that the strongest predictor of low depressive

symptomatology was adolescents' satisfaction with family cohesion, suggesting that adolescents' subjective perspectives of family functioning are critical to consider. Adolescent reports of family functioning have also been found to be a better predictor of adolescent functioning than parent reports (e.g., White, Shelton, & Elgar, 2014). Since subjective appraisals of family cohesion may be important for adolescent mental health, this study examined family cohesion from the perspective of youth self-report.

Few studies have examined family cohesion in LGB populations. In a recent study of 136 family members of sexual minorities, compared to participants reporting low cohesion, those reporting high cohesion reported more sexual minority friends and family, knowledge about sexual minority issues, and internalized affirmativeness (e.g., positive beliefs) toward sexual minorities (Reeves et al., 2010). Although this study did not directly examine sexual minority participants, it is possible that having a more positive family environment could directly impact LGB individuals. A study that included 72 gay young adult men found that those who were in cohesive families prior to coming out perceived less negative parental reactions compared to men in disconnected families (Willoughby, Malik, & Lindahl, 2006). These two studies suggest the importance of family cohesion for LGB individuals; however, more research is needed regarding the effects of family cohesion on LGB mental health and identity development. To date, no studies have examined the relationship between parental responsiveness (e.g., acceptance, support, ambivalence) and family cohesion for LGB youth. In this study, it was hypothesized that high levels of self-reported family cohesion would be a protective factor against low parental acceptance and support, on the one hand, and high parental ambivalence, on the other.

Although increased research attention has been paid to LGB youth and their families in the past two decades, this field of study is still quite small and there is a great deal to be learned (Mustanski, 2015). For example, it is not clear which aspects of parent–child and family relationships have the largest impact on LGB youths' mental health and identity development. Furthermore, the majority of these studies have focused on examining LGB youths' outcomes as they are related to youths' reports of parental variables, but have not directly involved parents. Additionally, almost all studies involving LGB youth and parents are cross-sectional. Finally, there are currently *no* observational studies that have examined parental responsiveness toward LGB youth. The current study addressed these limitations of previous research.

The Current Study

This study examined associations between parent responsiveness, family cohesion, and adjustment in LGB youth. Specifically, this study was the first to use observational data of parent responsiveness to predict LGB youth adjustment and examined whether family cohesion moderated these relationships (see Figure 1). The study had three principal aims.

Aim #1. The first aim of this study was to develop a reliable and valid observational coding system for the three dimensions of parental responsiveness: acceptance of sexual orientation, general emotional support, and ambivalence. Convergent validity was assessed by making comparisons with parent and youth self-report of rejection. Discriminant validity was assessed for observed parental support, by demonstrating that this construct differs from parental rejection. Since a construct of

parental ambivalence of sexual orientation does not yet exist, this variable was compared to parent and youth reports of rejection. The following specific hypotheses were tested:

Hypothesis 1a. It was expected that coders would have a high degree of absolute agreement using intraclass correlations (ICC > 0.70) for parental acceptance, emotional support, and ambivalence.

Hypothesis 1b. It was hypothesized that observed parental acceptance and self-report of rejection (youth and parent report) would be significantly, but inversely, correlated with each other.

Hypothesis 1c. It was hypothesized that parental general support and parental rejection would not be related.

Hypothesis 1d. It was expected that parental ambivalence would be significantly, positively correlated with self-report measures of youths' perceptions of parental rejection, but not parents' report of rejection.

Aim #2. The second aim of the study was to examine how baseline (Time 1; T1) parental acceptance, parental emotional support, and parental ambivalence predicted youth internalizing symptoms and negative identity two years after baseline (Time 2; T2).

Hypothesis 2a. It was hypothesized that parental acceptance of sexual orientation at T1 would be negatively associated with LGB negative identity at T2.

Hypothesis 2b. It was expected that parental emotional support at T1 would be negatively related to youth internalizing symptoms at T2.

Hypothesis 2c. Parental ambivalence at T1 was expected to be related to both youth internalizing symptoms and LGB negative identity at T2.

Aim #3. The third aim of this study was to examine whether family cohesion at T1 buffers the harmful effects of low parental responsiveness (T1) on youth internalizing symptoms and LGB negative identity at T2. It was hypothesized that high family cohesion at T1 would be a protective factor against low acceptance, low emotional support, and high ambivalence as related to T2 outcomes of LGB youth internalizing symptoms and negative identity. Thus, family cohesion was expected to moderate the relationships shown in Figure 1.

Chapter 2: Methods

Participants

This sample consisted of 36 parent–child dyads. Of the 36 dyads that participated at T1, 27 participated in a two year follow-up. See **Table 1** for sample demographics of T1 participants. Of the 36 parents who participated the majority were mothers (91.7%, $n = 33$) and heterosexual (88.9%, $n = 32$). Parents ranged in age from 37 to 63 ($M = 46.75$, $SD = 6.63$). A diverse range of ethnicities was represented among parents and youth, with the majority identifying as Hispanic (parents = 47.2%, $n = 17$; youth = 58.3%, $n = 21$). Among the 36 youth, the majority were male (61.1%, $n = 22$), and their mean age was 17.08 ($SD = 1.80$) with a range of 14 to 21. Youth participants self-identified as gay (52.8%; $n = 19$), lesbian (33.3%, $n = 12$), and bisexual (13.9%, $n = 5$).

Procedures

Prior to data collection, the study received approval from the Institutional Review Board. Next, participants were recruited as part of a larger longitudinal study examining family relationships in LGB youth. Fliers were distributed throughout the community to recruit a diverse group of LGB youth. Participants also were recruited through various community organizations, such as high school and university gay-straight alliances, high school counselors, and peer recruitment. In order to participate, youth were required to have disclosed their sexual identity to at least one parent. Written informed consent was obtained from participants over the age of 18. For participants under the age of 18, written assent was collected in addition to parent permission. The entire data collection process occurred over a two year time period. During this time, data were collected at four time points, once every six months. This study, however, only used data from the

first and last time point. Parents and youth completed a series of questionnaires in person in a laboratory setting. The parent–child dyads also participated in a 10-minute discussion about the coming out process that was videotaped in a laboratory setting only at the first time point. Dyads were compensated with $50 for study participation.

Measures

Background Questionnaire (Appendices A and B). To collect relevant demographic information, participants completed a questionnaire assessing variables, such as age, sex, ethnicity, and sexual orientation status. Participants indicated their sexual identity as “gay,” “lesbian,” “bisexual,” or “other.” The most common “other” description was identifying as “pansexual” or liking people for “who they are” and not their gender. Since these youth identified liking both males and females, they were coded as “bisexual.”

Observational measure (Appendix C). The parent–child interactions were coded at the initial assessment (T1) with an adapted version of the System for Coding Interactions and Family Functioning (SCIFF; Lindahl & Malik, 2000). The SCIFF was adapted for this study to examine parent and LGB youth interactions (SCIFF-LGB). Specifically, one code was adapted from the SCIFF and two were newly created. First, the code that was adapted from the SCIFF was parental emotional support, which represents affective attunement and general support. This code also addresses parents’ competency in reading youths’ emotional signals and providing support when these signals arise. Parental emotional support was rated on a 5-point Likert rating scale from 1 (*very low*) to 5 (*high*). Next, the parental acceptance of sexual orientation and ambivalence codes were newly written for the SCIFF-LGB. The code for parental

acceptance of sexual orientation focuses on the verbal content specific to sexual orientation, and examines parents' statements of reservation or acceptance toward their LGB youth's sexual orientation. Parental acceptance of sexual orientation was also rated on a 5-point Likert rating scale from 1 (*very low*) to 5 (*high*). Parental ambivalence of youths' sexual orientation represents the number of contradictory statements that parents made regarding youth's sexual orientation (e.g., "I am very proud of you, but I cannot accept the fact that you are gay"). These statements typically consist of one positive clause, followed by a "but" statement that is inherently negative. This code was rated on a 5-point Likert rating scale of 1 (*0 ambivalence statements*) to 5 (*4+ ambivalence statements*).

The videotaped interactions were coded by the investigator and two research assistants who were blind to information about the families. The two assistant coders received ten hours of training and watched each interaction at least three times before providing a rating. Performance of coders was monitored and feedback was given weekly to minimize coder drift. After the two coders reached reliability (Cronbach's alpha of at least 0.70 when compared to the primary coder), reliability among all three coders was calculated using intraclass correlation coefficients (ICC). Coders reached reliability on all codes within the first 4 videos. After taking into account these 4 videos, one further video that was used for training purposes, and seven videos that were only coded by one investigator since they were in Spanish, a total of 24 videos remained for the ICC analysis. All English videos were coded individually by the 3 coders, and final scores used for analyses were consensus ratings. The SCIFF has been found to be reliable with multiethnic samples (Lindahl & Malik, 2000).

The Perceived Parental Reactions Scale (Appendices D & E). The Perceived Parental Reactions Scale was used at initial assessment to subjectively measure parental and youth reports of current parental rejection (PPRS; Willoughby, Malik, & Lindahl, 2006). Specifically, this measure was compared against parents' observed acceptance of sexual orientation. The PPRS is a 32-item measure assessing parental response to LGB youths' sexual identity. Participants were asked to think about how they feel about their child's sexuality and then rate their level of agreement to these items on a 5-point Likert scale from 1 *(Strongly Disagree*) to 5 (*Strongly Agree*). The total score was calculated by summing all items. Scores can range from 32 to 160, with higher scores on the PPRS indicating more negative parental reaction. A sample item on the youth measure is "When thinking about how my parent currently feels about my sexuality he/she: is concerned about what the family thinks of him/her." A sample item on the parent measure is "When thinking about how I currently feel about my child's sexuality, I: am concerned about what my family might think of me." The PPRS has been found to have good internal consistency ($\alpha = 0.97$ for mothers; $\alpha = 0.97$ for fathers) and test-retest reliability after two weeks ($r = 0.97$ for mothers; $r = 0.95$ for fathers; Willoughby, Malik, & Lindahl, 2006). In the current study, the youth and parent PPRS demonstrated excellent reliability (youth PPRS Cronbach's alpha = .91; parent PPRS Cronbach's alpha = .90).

Family Cohesion (Appendix E). Family cohesion was measured at initial assessment using youth report on the Family Adaptability and Cohesion Evaluation Scales (FACES-IV; Olson, 2009). The FACES-IV contains six scales; however, only the Cohesion subscale was used for the purpose of this study. This scale includes 7 items,

rated on a 5-point Likert scale, from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). The item scores were summed, ranging from 7 to 35. Scores of 7–18 indicate a cohesion level of “somewhat connected,” scores of 19–28 indicate “connected,” and scores of 29–35 indicate “very connected” (Olson, 2009). Items include “Family members feel very close to each other” and “Our family has a good balance of separateness and closeness.” Adequate reliability and validity has been established for the cohesion scale (α = .89; Olson, 2011). The Cohesion subscale demonstrated good reliability in the current study as well (Cronbach's alpha = .84).

LGB Negative Identity (Appendix G). At the two year follow-up, youth participants completed the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Fassinger, 2000), a 27-item measure designed to assess six dimensions of LGB identity. However, a second-order factor analysis conducted by Mohr and Fassinger (2000) suggested that four of the subscales, Difficult Process, Internalized Homonegativity/Binegativity, Concealment Motivation, and Acceptance Concerns, load on a single, second-order factor. This factor, referred to here as negative identity, reflected the degree to which sexual minorities have difficulties with their sexual orientation identity (Mohr & Fassinger, 2000; Mohr & Kendra, 2011). Only the negative identity composite was used in this study.

The four subscales that comprise the composite negative identity scale were administered. The Difficult Process subscale measures difficulty with self-acceptance of LGB identity development (5 items; e.g., “Admitting to myself that I’m an LGB person has been a very slow process”). The Internalized Homonegativity/Binegativity subscale measures rejection of one’s LGB identity by internalizing negative societal beliefs

regarding LGB identity (5 items; e.g., “I wish I were heterosexual”). The Concealment Motivation subscale measures concern and motivation to protect one’s privacy as an LGB individual (6 items; e.g., “My sexual orientation is a very personal and private matter”). The Acceptance Concerns subscale measures preoccupation with being stigmatized as a LGB person (5 items; e.g., “I often wonder whether others judge me for my sexual orientation”). Items are rated on a 7-point Likert scale, from 1 (*Disagree Strongly*) to 7 (*Agree Strongly*). Negative identity composite scores were calculated by taking the average of scores on the difficult process, internalized homonegativity/bi-negativity, concealment motivation, and acceptance concerns subscales (Mohr & Fassinger, 2000). Higher scores indicate a more negative identity. Evidence of good validity and reliability has been established (Mohr & Kendra, 2011). In the current study, the Negative identity composite demonstrated an acceptable internal consistency (Cronbach's alpha = .65).

The Behavior Assessment for Children, Second Edition (Appendices H & I). Youth and parent participants reported symptoms of internalizing and externalizing problems (utilized in post-hoc analyses), respectively, at the two-year follow-up using the Behavior Assessment System for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004). This Internalizing Problems composite is composed of 70 items on the youth form (Self-Report–Adolescent, SRP–A) and the Externalizing Problems composite is composed of 32 items on the parent form (Parent Rating Scales–Adolescent, PRS–A). The Internalizing Problems composite on the BASC-2 SRP–A consists of items from seven scales: anxiety, depression, atypicality, locus of control, social stress, sense of inadequacy, and somatization. Sample items include “I worry but I don’t know why,” “I feel sad,” and “Nothing about me is right.” Youth participants indicate their level of

agreement with statements using true/false and 4-point Likert scale responses (1 = *Never* to 4 = *Almost Always*). The Externalizing Problems composite on the BASC-2 PRS–A consists of items on three scales: hyperactivity, aggression, and conduct problems. Sample items include “Teases others,” “Breaks the rules,” and “Acts out of control.” Parent participants are asked to rate the degree to which the items pertain to their children only using the 4-point Likert scale. Raw scores for each scale are calculated by summing the individual scale items, and these scores are then converted into T-Scores (*M* = 50, *SD* = 15). The composite scores are calculated by summing the T-Scores for each of the scales that make up each composite, and then converting the sum into a new T-Score. A higher T-Score on the Internalizing Problems composite indicates a greater level of problem severity. Normative data from 1,900 youth were used to generate T-Scores (Reynolds & Kamphaus, 2004). The BASC-2 has been found to have adequate reliability (α = 0.95 - 0.96 for SRP-A), test-retest reliability after several weeks (r = 0.81 for SRP-A), and validity (Reynolds & Kamphaus, 2004). In the current study, the internalizing composite score demonstrated excellent internal consistency (Cronbach’s alpha = .96), and the externalizing composite score also demonstrated good internal consistency (Cronbach’s alpha = .87).

The Personal Experience Screening Questionnaire (Appendix J). The Problem Severity subcale of the Personal Experience Screening Questionnaire (PESQ; Winters, 1992) was used in post-hoc analyses to assess youths’ alcohol and drug use severity at the two-year follow-up. The 18-item subscale measures how often an individual purchases, sells, and uses substances, in addition to measuring substance use consequences. Sample items on the Problem Severity subscale include “How often have you made excuses to

your parents about your alcohol or drug use?", "How often have you spent money on things you wouldn't normally buy?", and "How often have you used alcohol or other drugs at the homes of friends or relatives?" Respondents are asked to choose from four response options (1 = *Never*, 2 = *Once or Twice*, 3 = *Sometimes*, and 4 = *Often*). A total score is calculated by summing all 18 items. Scores range from 18 to 72, with higher scores indicating a greater severity of problematic substance use. The Problem Severity subscale has been found to have good internal consistency for heterosexual youth (α = 0.91; (Winters, 1992) as well as for gay and bissexual young men (α = 0.92 - 0.95; (Winters, Stinchfield, & Henly, 1996). The Problem Severity scale also demonstrated convergent and discriminate validity in a study of gay and bisexual young men. (Winters et al., 1996). The Problem Severity scale demonstrated excellent reliability in the current study as well (Cronbach's alpha = .93).

Data Analytic Strategy

To address the first aim of the study, which was to provide descriptive, reliability, and validity information on the observational variables of interest (i.e., parental acceptance of sexual orientation, parental emotional support, and parental ambivalence of sexual orientation), descriptive statistics, intraclass correlation coefficients, and bivariate correlations were utilized, respectively.

To address the second aim of the study, which was to examine how parental acceptance of sexual orientation, parental emotional support, and parental ambivalence predict youth internalizing symptoms and LGB negative identity, regression was used to examine the hypothesized relationships. A separate regression was conducted for each predictor on the respective hypothesized outcomes (see Figure 1). The following

variables were examined as potential confounding variables: years since sexual orientation disclosure to parent, youth gender, and age. None of these variables were related to the dependent variables, and subsequently they were not controlled for.

To address the third aim of the study, moderated regression was used to examine if family cohesion at T1 moderated the relationship between the three parental variables at T1 (i.e., parental acceptance of sexual orientation, parental emotional support, and parental ambivalence) and youth internalizing symptoms and LGB negative identity at T2. Each predictor and outcome variable were examined in separate models. The Hayes PROCESS macro was used for moderator analyses (Hayes, 2013). Through this macro, the predictor and moderator variables were centered by subtracting the sample mean of each variable from each individual score for that variable. Interaction terms were also created in the macro by multiplying the centered predictor and moderator variables. All analyses were performed using SPSS Version 23.

Chapter 3: Results

Descriptive Statistics

See **Table 2** for means, ranges, and standard deviations of all study variables. Reports of skewness and kurtosis are also included in this table. There were no outliers among the 36 participants on any variable. Given the skewness of parental ambivalence, this variable was transformed using a natural logarithm. However, the transformation of ambivalence did not result in a normally distributed variable, violating one of the assumptions of using multiple regression. Therefore, only the parental acceptance and emotional support variables were used in subsequent multiple regression analyses. The parental ambivalence variable was instead examined using independent samples t-test analyses, with a rating of "0" representing no statements of ambivalence, and a rating of "1" representing one or more ambivalent statements.

Reliability

A high degree of absolute agreement was found between the three raters for each item on the coding system, indicating good reliability. The average measure ICC for parental acceptance of sexual orientation was .91, with a 95% confidence interval from .83 to .96 ($F(23,46) = 11.20$, $p < .001$). Second, the average measure ICC for parental emotional support was .87, with a 95% confidence interval from .72 to .94 ($F(23,46) = 9.01$, $p < .001$). Finally, the average measure ICC for parental ambivalence was .92, with a 95% confidence interval from .84 to .96 ($F(23,46) = 12.67$, $p < .001$). These results are concordant with Hypotheses 1a and provide support that the SCIFF-LGB is reliable.

Validity

To examine validity, observational codes and corresponding self-report measures from T1 were correlated using Pearson's r (see **Table 3**). However, due to the skewness

of the parental ambivalence variable, Spearmans's rank-order correlation was used for correlating the self-report measures with ambivalence. First, as expected (Hypothesis 1b), the observational code of parental acceptance was significantly and negatively related to both youth ($r(33) = -.47$, $p < .01$) and parent ($r(36) = -.41$, $p < .05$) reports of parental rejection, demonstrating convergent validity. Next, as expected (Hypothesis 1c), the observational code of emotional support was unrelated to youth and parent reports of parental rejection (*ps* >.05), demonstrating discriminate validity for the coding system and indicating that acceptance and general emotional support are two related, yet also different constructs. Finally, as expected (Hypothesis 1d), the observational code of parental ambivalence was positively related to youth report of parental rejection ($r_s(33) = .37$, $p < .05$), but not parental report ($p > .05$). Overall, these results provide support for the validity of the SCIFF-LGB.

Observational Measures and Youth Outcomes

Multiple regression analyses and t-tests were conducted to examine the relationship between parental responsiveness variables at T1 and LGB youth outcomes at T2. First, to examine Hypothesis 2a, regression was used to examine the relationship between parental acceptance of sexual orientation and LGB negative identity; however, no significant relationship was found (see **Table 4**). Next, to examine Hypothesis 2b, regression was used to examine the relationship between parental emotional support and LGB youth internalizing problems. The results indicated that parental emotional support significantly accounted for 19.4% of the variance in LGB youth internalizing problems at T2 ($R^2 = .194$, $F(1, 25) = 6.02$, $p < .05$), indicating that higher levels of emotional support were related to lower internalizing problem scores ($t(26) = -2.45$, $p < .05$; see **Table 4**).

Hypothesis 2c was examined using independent samples t-tests, and as shown in **Table 5**, no significant relationships were found between parental ambivalence and LGB youth negative identity and internalizing problems.

Family Cohesion as a Moderator

To address Aim 3, family cohesion was examined as a moderator between parental acceptance and LGB negative identity and also as a moderator of the relationship between parental emotional support and youth internalizing problems. As described above, due to issues of non-normality, the moderating relationship of family cohesion between parental ambivalence and the outcome variables was not examined. As shown in **Table 6**, family cohesion did not moderate these relationships.

Post Hoc Exploratory Outcomes

Several post hoc analyses were conducted to explore the relationships between parental acceptance and emotional support with mental health outcome variables. Specifically, since previous studies have found relationships between parental variables and LGB youth substance use, and LGB youth are at a heightened risk for externalizing problems, these two variables were of interest. Therefore, it was hypothesized that higher observed parental acceptance and emotional support would be inversely related to externalizing problems and substance use problem severity.

Next, given this study's finding that parental emotional support inversely predicted youth internalizing problems and previous research that is mixed regarding whether sexuality specific variables only predict sexuality specific variables, the relationship between parental acceptance and youth internalizing problems was also examined. It was expected that greater parental acceptance would be related to lower

internalizing problem scores. Furthermore, family cohesion was examined as a moderator of this relationship. Multiple regression was used to test these hypotheses.

As shown in **Table 7**, parental acceptance of sexual orientation significantly predicted LGB youth externalizing problem scores and there was a trend toward significance for the relationship between parental emotional support and externalizing scores. The results indicated that parental acceptance significantly accounted for 16.6% of the variance in LGB youth externalizing problems ($R^2 = .166$, $F(1, 25) = 4.99$, $p < .05$), indicating that higher levels of parental acceptance were related to lower externalizing problem scores ($t(26) = -2.23$, $p < .05$). Furthermore, parental emotional support accounted for 11.0% of the variance in LGB youth externalizing problems ($R^2 = .110$, $F(1, 25) = 3.08$, $p = .091$), indicating that higher levels of emotional support were related to lower externalizing problem scores ($t(26) = -1.76$, $p = .091$). However, this relationship should be viewed with caution, given that it only exhibited a trend toward significance.

As demonstrated in **Table 7**, parental emotional support significantly predicted youth substance use problem severity scores. The results indicated that parental emotional support significantly accounted for 18.8% of the variance in LGB youth substance use problem severity scores ($R^2 = .188$, $F(1, 25) = 5.78$, $p < .05$), indicating that higher levels of parental emotional support were related to lower substance use severity scores ($t(26) = -2.41$, $p < .05$). There was no significant relationship between parental acceptance of sexual orientation and substance use.

Next, as shown in **Table 7**, there was a trend toward significance for the relationship between acceptance of sexual orientation and LGB youth internalizing

problem scores. The results indicated that parental acceptance of sexual orientation accounted for 10.7% of the variance in LGB youth externalizing problems ($R^2 = .107$, $F(1, 25) = 3.00$, $p = .096$), indicating that higher levels of emotional support were related to lower internalizing problem scores ($t(26) = -1.73$, $p = .096$). However, this relationship should be viewed with caution, given that it only exhibited a trend toward significance. Finally, the relationship between parental acceptance of sexual orientation and youth internalizing scores was significantly moderated by family cohesion. Specifically, as shown in **Table 8**, when the interaction term between family cohesion and parental acceptance was entered into the model, it explained a significant increase in the variance of youth internalizing problems, $\Delta R2 = .14$, $F(1, 23) = 7.24$, $p < .05$. When examining simple slopes, the only significant slope was when family cohesion scores fell one standard deviation below the mean (see **Figure 2**). Specifically, when youth experienced low family cohesion (i.e., -1 standard deviation), youth internalizing problem scores significantly decreased (improve) as parental acceptance of sexual orientation increased. Youth who experienced low family cohesion and parental acceptance had the highest internalizing problem scores, whereas youth who experienced high family cohesion had low levels of internalizing problems across levels of parental acceptance.

Chapter 4: Discussion

This is the first study to use observational methods to differentiate important, yet subtly different parental responsiveness variables, and one of the first studies to include both LGB youth and their parents. The results of this study point to multiple key findings. First, the SCIFF-LGB coding system is both a reliable and valid measure for examining interactions between parents and their LGB youth. Additionally, this study was the first to examine parental ambivalence and found that this variable was related to youths' reports of rejection. Furthermore, this study provides evidence that LGB youth outcomes at a two year follow-up are predicted by two different types of support (i.e., sexuality specific and general support). Specifically, parental acceptance of sexual orientation was related to lower LGB youth externalizing symptoms two years post-baseline, and parental emotional support was related to lower LGB youth internalizing symptoms and substance use problem severity. Finally, family cohesion moderated the relationship between parental acceptance of sexual orientation and youth internalizing problems, suggesting that high cohesion is a buffer against low parental acceptance.

A key finding of this study was that the SCIFF-LGB was found to be reliable, suggesting that this coding system is able to clearly and accurately capture several key elements of parental responsiveness in interactions between parents and their LGB youth. Using observational methods was quite useful as it allowed for the assessment of constructs that may be hard for parents to differentially and accurately report on, like ambivalence, and acceptance of sexual orientation versus general support.

The SCIFF-LGB also demonstrated convergent and discriminate validity, meaning that constructs that were expected to be related to each other were in fact

related, and constructs that were not expected to be related were not related. As expected, the observational code of parental support was not related to parental rejection. This suggests that although parental acceptance and support are correlated with one another, they also have unique characteristics. The data also show how these constructs can be successfully differentiated using an observational coding system. Perhaps more importantly, however, these findings also suggest that parents can be generally supportive, but not necessarily accepting of their children's sexual orientation.

Also as expected, the observational code of parental acceptance was inversely related to youth-report of parental rejection, but was unrelated to parents' self-reports of rejection. This suggests that parents do not perceive their ambivalent messages as rejecting, while their LGB children do. This is the first study to examine parental ambivalence toward child sexual orientation. However, when examining parental ambivalence dichotomously, it did not significantly predict LGB youth negative identity or internalizing problems two years later.

One of the goals of this study was to tease apart parental support from parental acceptance and examine how these two dimensions of parental responsiveness are related to youth mental health outcomes. While some studies have found parental acceptance to be related to both fewer internalizing symptoms as well as positive LGB identity (D'Amico & Julien, 2012; Feinstein et al., 2014; Savin-Williams, 1989), others have suggested that sexuality-specific variables, such as parental acceptance of sexual orientation, are primarily related to sexuality-specific outcomes (Bregman et al., 2013; Doty et al., 2010; Sheets & Mohr, 2009). Unexpectedly, in this study, sexuality specific-support (acceptance) was not related to youth LGB identity. One possibility for this null

relationship is that observed parental acceptance may not matter as much to youths' identity as does their own perceptions of and value placed on parental acceptance. In line with this, Savin-Williams (1989) found that among gay male youths, parental acceptance was related to comfort being gay, only if parents were also perceived to be important to youths' own self-worth. Another possibility for the null relationship is that this observational code did not perfectly capture parental acceptance. It is possible that the observational task was not set up well enough to gather ample information on true parental acceptance. Therefore, it would be helpful for future research to directly compare observed and self-reported parental acceptance.

Although unrelated to LGB identity, parental acceptance was related to general mental health outcome variables, especially externalizing behavior. Parental acceptance was also inversely related to internalizing symptoms, though this finding was a trend and not statistically significant, likely due to the small sample size. It is possible that parental acceptance was significantly related to externalizing problems because youth may outwardly react more toward their parent's lack of acceptance. One possibility is that when parents' actions and words indicate a lack of acceptance, anger more than sadness is triggered for the youth, perhaps resulting in what parents' report to be increased externalizing behavior. Since the externalizing composite score used in this study was from parental report, it is likely that parents reported on the negative behaviors that adolescents displayed in reaction to little to no acceptance. However, there is currently no research on parental acceptance and externalizing behaviors, and it needs to be further studied to better understand how these two variables are specifically linked. Qualitative analysis of observed interactions could also help to shed light on this relationship.

With regard to parental emotional support, parental emotional understanding and validation was inversely related to LGB youth report of internalizing symptoms as well as self-report of substance use problem severity. These results are consistent with previous research that has shown higher parental support to be related to decreased depression and substance use for LGB youth (Needham & Austin, 2010; Rothman et al., 2012). In this study, substance use severity was predicted by general parental emotional support, but not by parental acceptance. There is some suggestion in the literature that supportive parenting is particularly important regarding youth substance use. A review on parenting styles demonstrated that the authoritative parenting style (high affective warmth and low control) was the most protective against adolescents' substance use (Becoña et al., 2012). Furthermore, one study also failed to find an association between parental acceptance of sexual orientation and youth substance use, while instead finding a relationship between parental rejection and substance use (D'Amico & Julien, 2012).

Family cohesion is an important factor related to youth mental health outcomes, but it has rarely been examined for LGB youth. Only one study has directly examined how family cohesion affects sexual minorities, with results suggesting that compared to gay men in disconnected families, gay men who were in cohesive families prior to coming out perceived less negative parental reactions (Willoughby et al., 2006). In the present study, family cohesion was examined as a moderator. Unexpectedly, family cohesion did not moderate the relationships between the hypothesized variables (parental acceptance and LGB identity or between parental emotional support and LGB internalizing symptoms); however, when examining post-hoc relationships, family cohesion was found to moderate the relationship between parental acceptance of sexual

orientation and LGB youth internalizing scores. Specifically, when compared to youth who reported low family cohesion, youth who experienced high family cohesion had internalizing problem scores that remained relatively low across levels of parental acceptance. Of note, youth who experienced low family cohesion and low parental acceptance had the highest internalizing problem scores. This demonstrates that high family cohesion may have a protective effect against low parental acceptance. This is consistent with previous literature suggesting that family cohesion is directly related to depression and well-being (Crespo et al., 2011; Cumsille & Epstein, 1994; Reinherz et al., 2003), and extends upon this research base by applying the construct of family cohesion to LGB individuals and examining it as a moderator. Family cohesion may be especially important for LGB youth, given the additional stressors they face as sexual minorities. Further, it is important to consider that having family connectedness outside of the parent-child relationship can be protective for LGB individuals. Family cohesion needs to be further studied to clarify its direct and/or moderating effects on LGB youth.

This study extends past research in multiple ways. First, this study adds to the literature by providing observational data on parental responsiveness to LGB youth. Previous research has been limited to self-report data, particularly from only youths' perspectives on both their individual and parental variables. In addition, previous studies that have found relationships among parental responsiveness and LGB youth outcomes have used cross-sectional data. This study extends previous research by looking at two-year outcomes for LGB youth. Finally, family cohesion has rarely been studied with LGB youth, and this study demonstrated that high family cohesion can protect LGB youths from negative mental health outcomes.

Limitations

Despite this study being the first observational study of LGB youth and parents, multiple limitations should be considered when interpreting results. First, a limitation of this study was its small sample size. This sample size was sufficient to detect moderately large effects (R= .4 to .5), but not smaller ones. A larger sample size would have also allowed for comparisons across ethnic and sexual minority groups in this diverse sample. A second limitation was that the majority of the participants in this study were recruited from community or university settings that serve sexual minority youth. By having a sample of parents and youth that were open to participating in the study, it is likely that the parents in this sample were more accepting of their LGB children when compared to the general population. Therefore, the results of this study cannot generalize to all LGB youth and parents of LGB youth. Recruiting LGB youth and parents to participate in research is difficult, and it is an even greater challenge to recruit non-accepting parents. The final limitation of this study was that it was not able to compare observed parental emotional support and ambivalence to self-report measures that would provide convergent validity, given that these were not available in the existing data set.

Implications and Future Directions

Despite these limitations, this is the first observational study of LGB youth and parents. This study provided both parental and youth report of multiple variables at a two year follow-up. The results of this study underscore the importance of parents' responsiveness to their LGB youth. There is some controversy regarding how "at risk" LGB youth are (Savin-Williams, 2001); however, the results of this study demonstrate that a lack of parent sexuality-specific and general support can put LGB youth at risk for

a variety of negative mental health outcomes. This makes parental acceptance and emotional support important variables to intervene on in clinical settings. Working with parents in therapy, in addition to LGB youth, should be an important target for clinicians. It may also be important to focus on increasing family cohesion, especially if parents are not accepting of their child's sexual orientation.

Along with addressing parent acceptance, emotional support, and family cohesion, the concept of parental ambivalence should be addressed by clinicians and researched further. Although parental ambivalence did not predict LGB youth outcomes, it was cross-sectionally associated with youths' perceptions of parental rejection, but not parents' perceptions. This provides clinicians with an initial framework for addressing parental ambivalence, given that youth likely perceive ambivalence as rejecting, and rejection has been associated with multiple negative outcomes for LGB youth. Contrastingly, parents may not recognize that the ambivalent messages they provide to their children are perceived as rejecting; this supports why they need to be addressed clinically. It may be difficult to assess parental ambivalence via self-report, hence the importance of using observational measures in research and clinical settings. Ambivalent statements may also be more frequently used than rejecting statements, since parents may not perceive the ambivalent statements to be as harsh. The long-term implications of ambivalent statements from parents, however, are less clear. This study did not find longitudinal associations between parental ambivalence and youth adjustment, and it may be that due to its less harsh nature, ambivalence from parents does not have significant mental health consequences. This study is limited in its power to detect longitudinal associations due to a small sample size and limited change over time. More research is

clearly needed on parental ambivalence. For example, with a larger sample and longer time frame, it could be helpful to know if the parents who are initially ambivalent are later accepting. If this is the case, then the null findings in this study would not be surprising.

More research is also needed in determining the distinctions between sexuality-specific and general parental support. It is possible that some sexuality specific variables may be predicted by sexuality-specific parent variables; however, this study did not examine variables other than LGB negative identity. Instead, both types of parent support were predictive of general mental health outcomes for LGB youth. Parental responsiveness should continue to be examined in future studies, especially from an observational perspective. Parenting variables can be difficult to accurately self-report on, and as demonstrated by this study, they can have a substantial impact on LGB youth.

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Table 1. *Sample Demographics*

Variable (n = 36)	n (%)
Youth Gender	
Male	22 (61.1%)
Female	14 (38.9%)
Youth Ethnicity	
Hispanic	21 (58.3%)
Caucasian	10 (27.8%)
Black	5 (13.9%)
Youth Sexual Orientation	
Gay	19 (52.8%)
Lesbian	12 (33.3%)
Bisexual	5 (13.9%)
Parent Gender	
Male	3 (8.3%)
Female	33 (91.7%)
Parent Ethnicity	
Hispanic	17 (47.2%)
Caucasian	13 (36.1%)
Black	6 (16.7%)
Parent Sexual Orientation	
Heterosexual	32 (88.9%)
Lesbian	3 (8.3%)

Table 2. *Sample Size, Means, Standard Deviation, Skewness, and Kurtosis of Study Variables*

Variable	*n*	Means (*SD*)	Skewness	Kurtosis
Parent Acceptance of Sexual Orientation	36	3.56 (*1.16*)	-.67	.05
Parent Emotional Support	36	3.03 (*1.18*)	-.06	-.76
Parent Ambivalence	36	1.94 (*1.22*)	1.22	.54
Family Cohesion	36	24.61 (*6.44*)	-.556	-.26
BASC Externalizing Symptoms	27	44.0 (*5.48*)	.799	-.05
BASC Internalizing Symptoms	27	47.67 (*11.39*)	.36	-1.23
Substance Use Problem Severity	27	31.22 (*11.21*)	1.05	.46
LGB Negative Identity	27	2.89 (*0.74*)	.27	-.92

Table 3. *Correlations Between Observed and Self-report Variables at T1*

Variable	1	2	3	4	5
1. Observed Parental Acceptance of Sexual Orientation	—				
2. Observed Parental Emotional Support	.72**	—			
3. Observed Parental Ambivalence[a]	-.47**	-.26	—		
4. Youth Self-Report of Parental Rejection	-.47**	-.13	.37*	—	
5. Parental Self-Report of Parental Rejection	-.41*	-.22	.09	.50**	—

* $p < .05$, ** $p < .01$
[a] Spearman's rho

Table 4. *Multiple Regressions Predicting Hypothesized Outcomes*

	LGB Negative Identity	Internalizing Problems
Predictor	β (SE)	β (SE)
Acceptance of Sexual Orientation	-0.07 (0.13)	----
Parental Emotional Support	----	-4.16 (1.70)*

* $p < .05$

Table 5.

Independent Samples t-tests of Parental Ambivalence and LGB Youth Outcomes

	Parental Ambivalence					
	0		≥ 1			
	M *(SD)*	n	M *(SD)*	n	t	df
LGB Negative Identity	3.05 *(0.87)*	13	2.74 *(0.59)*	14	0.96	25
Internalizing Problems	49.85 *(11.60)*	13	45.64 *(11.23)*	14	1.11	25

Table 6.

Multiple Regressions with Family Cohesion as a Moderator

	LGB Negative Identity	Internalizing Problems
Predictor	β (SE)	β (SE)
Acceptance of Sexual Orientation	-0.04 (0.19)	----
Family Cohesion	-0.02 (0.02)	
Accept x Cohesion	0.01 (0.04)	
Parent Emotional Support	----	-3.13 (2.20)
Family Cohesion		-0.45 (0.49)
Support x Cohesion		0.20 (0.45)

Table 7.

Multiple Regressions Predicting Post-Hoc Outcomes

	Externalizing Problems	Substance Use Severity	Internalizing Problems
Predictor	β (SE)	β (SE)	β (SE)
Acceptance of Sexual Orientation	-1.94 (0.87)*	-0.94 (1.94)	-3.24 (1.87)†
Parental Emotional Support	-1.51 (0.86)†	-4.03 (1.68)*	----

* $p < .05$; † = trend toward significance $.1 > p > .05$

Table 8.

Post-Hoc Moderation Analysis of Family Cohesion on Parental Acceptance of Sexual Orientation and LGB Youth Internalizing Problems

	Internalizing Problems
Predictor	β (SE)
Acceptance of Sexual Orientation	-2.31 (0.29)
Family Cohesion	-0.47 (1.78)
Accept x Cohesion	0.72 (0.27)*

* $p < .05$

Figure 1. Proposed moderation study models

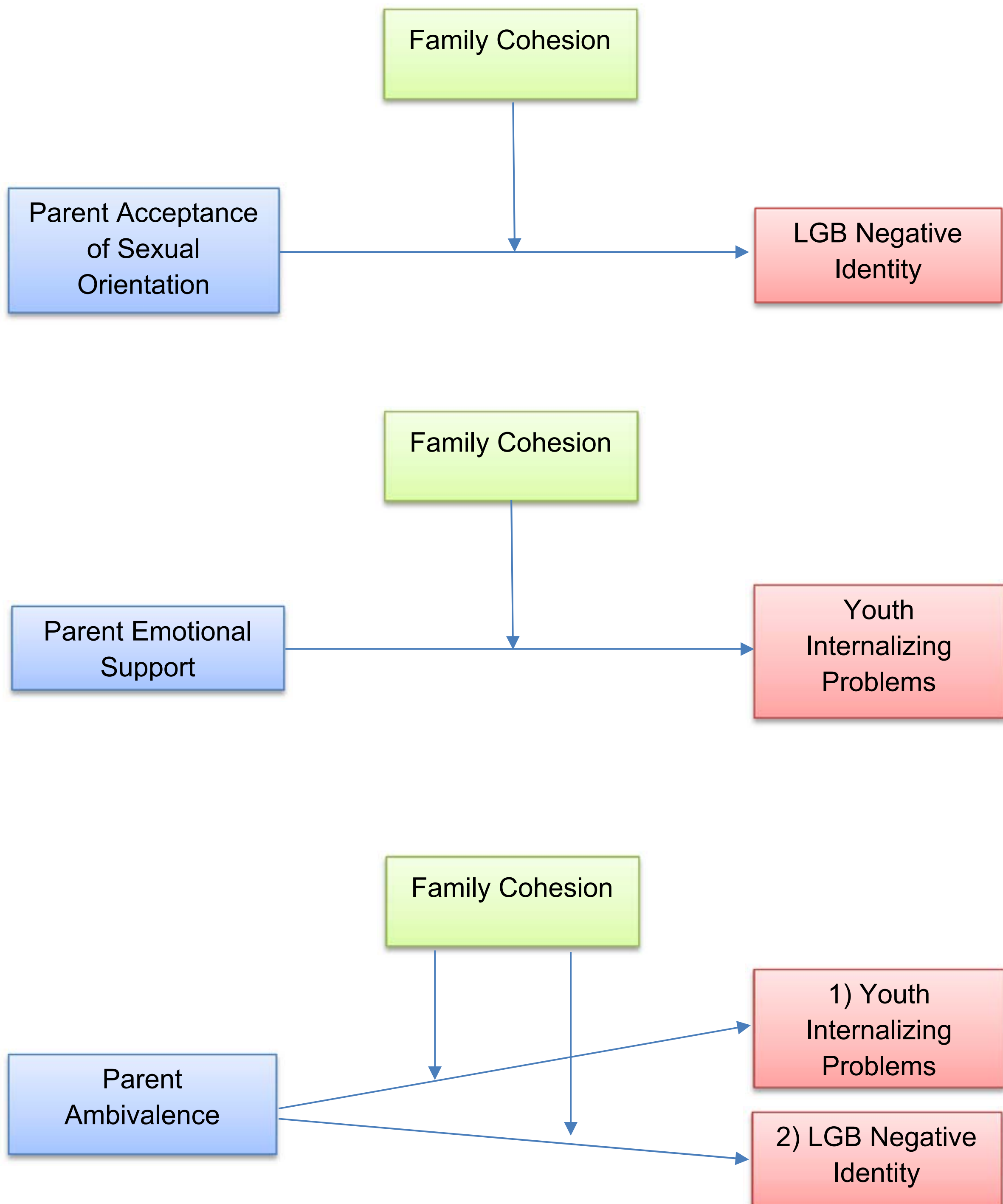
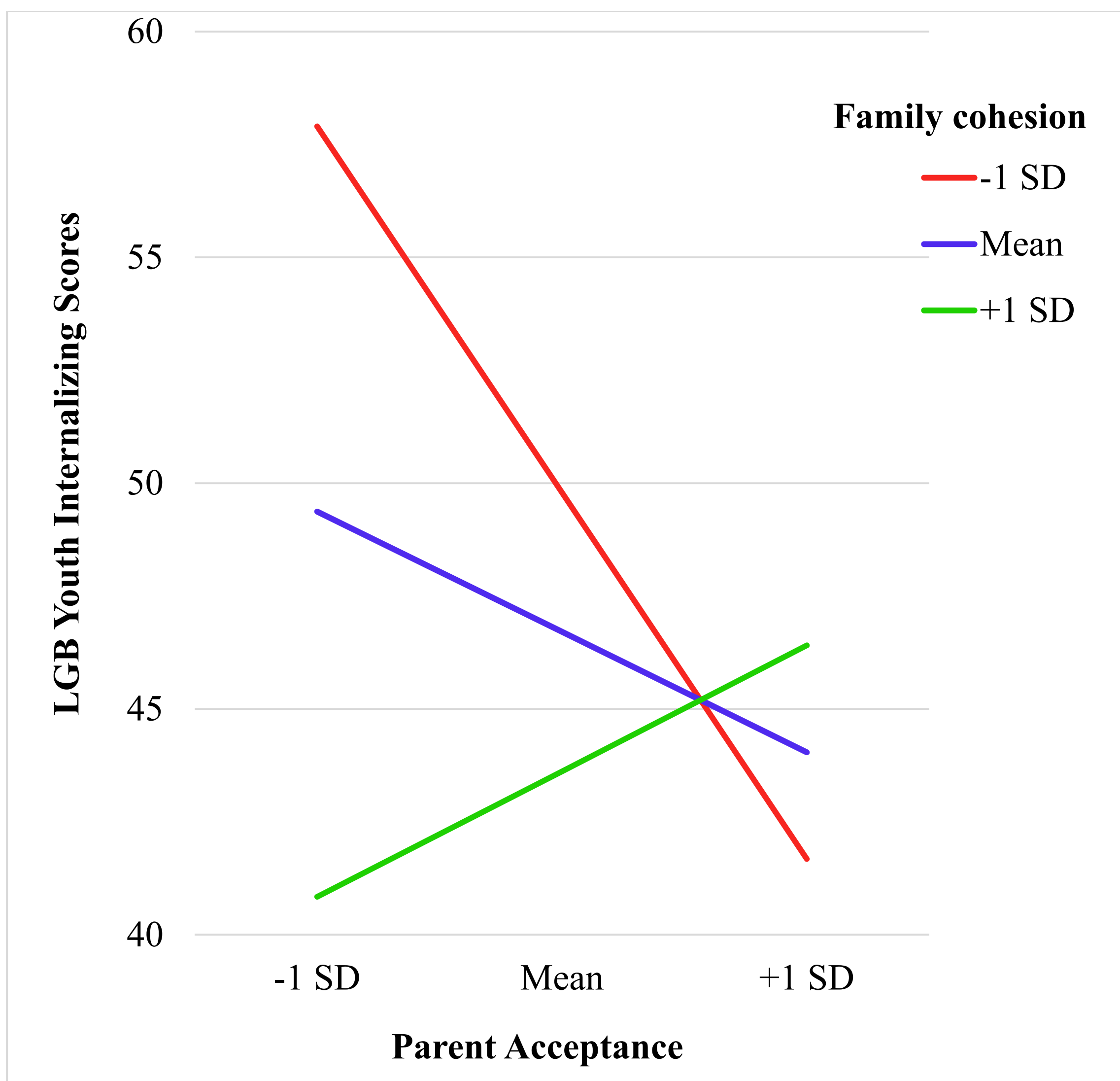


Figure 2. Family cohesion as a moderator of parental acceptance of sexual orientation and LGB youth internalizing problems



Appendix A

Background Questionnaire for Parents

Instructions: These questions ask about your background.

1. What is your gender ?

☐ Male ☐ Female

☐ Other (please describe) ________________________________

2. Please indicate your ethnicity (check all that apply)

☐ Asian or Pacific Islander

☐ Black (African American; non-Hispanic)

☐ Haitian or other Caribbean

☐ White (Caucasian; non-Hispanic)

☐ Hispanic/Latino

☐ Cuban

☐ Mexican

☐ Latin-American

☐ Native American or American Indian

☐ Other (please indicate) ________________________________

3. What is your age?

_______ years

4. How would you describe your sexual orientation?

☐ Heterosexual

☐ Gay

☐ Lesbian

☐ Bisexual

4a. If heterosexual, gay, lesbian, or bisexual do not adequately describe your sexuality, please write your own description in the box below:

Appendix B

Background Questionnaire for Youth

Instructions: These questions ask about your background.

1. What is your gender ?

☐ Male ☐ Female
☐ Other (please describe) ________________________________

2. Please indicate your ethnicity (check all that apply)

☐ Asian or Pacific Islander
☐ Black (African American; non-Hispanic)
☐ Haitian or other Caribbean
☐ White (Caucasian; non-Hispanic)
☐ Hispanic/Latino
  ☐ Cuban
  ☐ Mexican
  ☐ Latin-American
☐ Native American or American Indian
☐ Other (please indicate) ________________________________

3. What is your age?

_______ years

4. How would you describe your sexual orientation?

☐ Gay
☐ Lesbian
☐ Bisexual

4a. If these do not adequately describe your sexuality, please write your own description in the box below:

Appendix C

System For Coding Interactions And Family Functioning (Lindahl & Malik, 2000) – adapted for parent and LGB youth interactions

PARENT CODE: ACCEPTANCE OF SEXUAL ORIENTATION (verbal/content code)

This code assesses the content of what is said by parents to indicate supportiveness. This code does not assess the warmth and actions displayed by parents, but instead focuses on content statements like: "I don't care who you like, as long as you're happy."

1 – Very Low. The parent clearly expresses non-acceptance of sexual orientation and tells this to the child. The parent may show passive acceptance of the youth's ideas and attempts but offers no open acknowledgment of the value of the youth's sexual orientation.

2 – Low. The parent has major reservations about the youth's sexual orientation. The parent is not characteristically supportive but may show some acceptance for the youth's sexual orientation. The parent may express that they do not approve of the youth's orientation, but they are trying to understand and it will be a long process.

3 – Moderate/Mixed. The parent has some reservations but also has slightly positive statements toward the youth's sexual orientation. The parent about half the time verbally discusses acceptance for the youth's sexual orientation. The parent may express past reservations with the youth's sexual orientation, but how changes in his/her beliefs have been made (e.g., "it was difficult to accept at first, but I've made progress").

4 – Moderately High. The parent expresses mostly positive statements but still has some reservations about the youth's sexual orientation. However, these reservations are non-judgmental. The parent generally values and shows acceptance for the youth's sexual orientation.

5 – High. For the whole interaction, the parent expresses very positive statements toward the youth's sexual orientation and has no reservations about it. The parent shows consistent acceptance and support for the youth's orientation. The parent encourages the youth to articulate and express his/her ideas. The parent may express in some sense that he/she only wants the youth to be happy, and sexual orientation does not factor into this.

PARENT CODE: EMOTIONAL SUPPORT (affective code)

This code assesses the affective/emotional aspect of the supportiveness of the parent-youth relationship. Emotional support refers to the parent's ability to 1) recognize and 2) meet the youth's emotional needs and provide warmth. This code assesses how sensitive, or attuned, the parent is to the youth's emotional state, needs, and perspective, and how well s/he modifies his/her behavior accordingly. Affective attunement includes examine facial expressions, body language, and the tone of voice.

A parent who is emotionally supportive is one who is able to respond in a nurturing way. When a parent is affectively attuned, the parent is able to "read" the youth's verbal and/or nonverbal signals of emotions. Whether the youth's emotions are positive or negative, an affectively attuned parent is able to tailor his or her comments, behavior, and emotional expression to fit the youth's best interests, always helping the youth to regulate emotions and feel as good as the youth can, given the situation. For example, an attuned parent may soften his/her voice, lean over and touch the youth, or otherwise modify his/her behavior to indicate awareness of the youth's affective state.

A parent who is not well attuned to his/her youth can be identified when there is a mismatch between the youth's needs and the parent's behavior. In other words, the parent seems oblivious to or unaware of the youth's needs. For example, a parent may be extremely affectionate with his/her youth when the youth is withdrawn, oppositional, or needy of structure. If the parent does not change his/her behavior to meet the youth's needs, that parent is not attuned to the youth.

1 – Very Low. The parent expresses little to no emotional support or no attunement to the youth's feelings. The parent does not provide emotional support, even if the youth shows some distress. Very little or no sensitivity to the youth's emotional state, needs, or perspective is shown. In other words, there is not a good fit or match between the youth's emotional state and the parent's behavior.

2 – Low. The parent expresses some support or attunement toward the youth, but it is minimal in terms of its quantity and quality (e.g., the moments of emotional support/affective attunement are fleeting and sometimes not obviously sincere). The parent may miss obvious occasions to show acceptance or sensitivity or provide comfort and reassurance to the youth. The parent may show signs of being aware of the youth's emotional needs but has some difficulty modifying his or her own behavior to meet the youth's needs. For example, there may be times when the parent is trying to meet the youth's needs or be sensitive, but those attempts are typically off-base and ineffective. In other words, the parent, though trying at times, cannot seem to figure out how to help the youth or meet the youth's needs.

3 – Moderate. The parent expresses a moderate amount of emotional support and/or affective attunement toward the youth, which is clearly genuine when it occurs. The parent about half the time shows emotional support toward the youth's feelings. The parent is inconsistent: he/she is generally "tuned in" but not always (e.g., the parent

sometimes is too directive, detached, abrupt, passive, or otherwise "out of sync").

4 – Moderately High. The parent generally expresses emotional support and affective attunement toward the youth. The parent is usually competent at reading youth's emotional signals and responds supportively most of the time. The parent is usually caring when responding, but sometimes these qualities seem a little lacking. On rare occasions, the parent may miss some opportunities to show acceptance and sensitivity to the youth or provide the youth with comfort. Despite occasionally "missing the mark" in trying to be attuned to the youth's emotional state, the parent does not seem to be ignoring or insensitive to youth.

5 – High. The parent expresses emotional support and affective attunement virtually throughout the interaction. The parent is very aware of the youth's emotional needs and finds effective ways of providing support. The parent is competent at reading the youth's emotional signals and tailors his or her behavior to meet the needs of the youth. The parent rarely or never misses times to provide support.

PARENT CODE: AMBIVALENCE/MIXED MESSAGES

Instructions: *Code mixed messages that parents give to their child that indicate ambivalence of their support of the youth's sexual orientation. These can include what the parents are saying (content of statement) in contrast to what they are showing through body language, facial expressions, or their tone of voice. Mixed messages can also include statements that have contradictory content (e.g., "I want you to be happy, but my religion doesn't allow me to support this"). **Write down each instance.***

1 – None. There are 0 instances in which mixed messages are given.

2 – Low. There is 1 instance in which mixed messages are given.

3 – Moderate. There are 2 instances in which mixed messages are given.

4 – Moderately High. There are 3 instances in which mixed messages are given.

5 – High. There are 4+ instances in which mixed messages are given.

Appendix D

Perceived Parental Reactions Scale – Parent Version
(Willoughby et al., 2006)

INSTRUCTIONS: Think about how you **currently** feel about your child's sexual orientation as you respond to the following questions. Read the following statements and indicate how much you agree or disagree with each statement. Remember, there are no correct or incorrect answers. These are your opinions.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

When thinking about how I currently feel about my child's sexuality, I:

Statement	Rating
1. support my child	1 2 3 4 5
2. am worried about what my friends and other parents will think of me	1 2 3 4 5
3. have the attitude that homosexual people should not work with children	1 2 3 4 5
4. am concerned about what my family might think of me	1 2 3 4 5
5. am proud of my child	1 2 3 4 5
6. believe that marriage between homosexual individuals is unacceptable	1 2 3 4 5
7. am concerned about the potential that I wouldn't get grandchildren from my child	1 2 3 4 5
8. realize my child is still 'him/herself', even though they are gay/lesbian/bisexual	1 2 3 4 5
9. believe that homosexuality is immoral	1 2 3 4 5
10. think it is great	1 2 3 4 5
11. have a problem seeing two homosexual people together in public	1 2 3 4 5
12. am concerned about having to answer other peoples' questions about my child's sexuality	1 2 3 4 5
13. have currently kicked my child out of the house	1 2 3 4 5
14. don't believe my child	1 2 3 4 5
15. yell and/or scream	1 2 3 4 5

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

Item	Rating
16. pray to God, asking him to turn my child straight	1 2 3 4 5
17. blame myself	1 2 3 4 5
18. call my child derogatory names, like ‘faggot’ or ‘queer’	1 2 3 4 5
19. pretend that my child isn’t gay/lesbian/bisexual	1 2 3 4 5
20. am angry at the fact my child is gay/lesbian/bisexual	1 2 3 4 5
21. want my child not to tell anyone else	1 2 3 4 5
22. cry tears of sadness	1 2 3 4 5
23. say he/she is no longer my son/daughter	1 2 3 4 5
24. tell my child it is just a phase	1 2 3 4 5
25. am mad at someone I think has turned my child gay/lesbian/bisexual	1 2 3 4 5
26. want my child to see a psychologist who can make him/her straight	1 2 3 4 5
27. am afraid of being judged by relatives and friends	1 2 3 4 5
28. withhold financial support	1 2 3 4 5
29. bring up evidence to show that my child must not be gay/lesbian/bisexual, such as “You had a girlfriend/boyfriend, you can’t be gay/lesbian/bisexual.”	1 2 3 4 5
30. am mad at my child for doing this to me	1 2 3 4 5
31. want my child not to be gay/lesbian/bisexual	1 2 3 4 5
32. am ashamed of my child’s homosexuality	1 2 3 4 5

Appendix E

Perceived Parent Reactions Scale – Youth Version
(Willoughby et al., 2006)

INSTRUCTIONS: Think about how your parent **currently** feels about your sexuality as you respond to the following questions. Read the following statements and indicate how much you agree or disagree with each statement by circling a number. Remember, there are no right or wrong answers. These are your opinions.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

When thinking about how my parent currently feels about my sexuality, he/she:

Statement	Rating
1. supports me	1 2 3 4 5
2. is worried about what his/her friends and other parents think of him/her	1 2 3 4 5
3. has the attitude that homosexual people should not work with children	1 2 3 4 5
4. is concerned about what the family thinks of him/her	1 2 3 4 5
5. is proud of me	1 2 3 4 5
6. believes that marriage between homosexual individuals is unacceptable	1 2 3 4 5
7. is concerned about the potential that he/she won't get grandchildren from me	1 2 3 4 5
8. realizes that I am still 'me', even though I am gay/lesbian/bisexual	1 2 3 4 5
9. believes that homosexuality is immoral	1 2 3 4 5
10. thinks it is great	1 2 3 4 5
11. has problems seeing two homosexual people together in public	1 2 3 4 5
12. is concerned about having to answer other peoples' questions about my sexuality	1 2 3 4 5
13. has currently kicked me out of the house	1 2 3 4 5
14. doesn't believe me	1 2 3 4 5

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	1	**2**	**3**	**4**	**5**
16. prays to God, asking Him to turn me straight	1	2	3	4	5
17. blames himself/herself	1	2	3	4	5
18. calls me derogatory names, like ‘faggot’ or ‘queer’	1	2	3	4	5
19. pretends that I am not gay/lesbian/bisexual	1	2	3	4	5
20. is angry at the fact I am gay/lesbian/bisexual	1	2	3	4	5
21. wants me not to tell anyone else	1	2	3	4	5
22. cries tears of sadness	1	2	3	4	5
23. says I am no longer his/her child	1	2	3	4	5
24. tells me it is just a phase	1	2	3	4	5
25. is mad at someone he/she thought has ‘turned me gay/lesbian/bisexual’	1	2	3	4	5
26. wants me to see a psychologist who can ‘make me straight’	1	2	3	4	5
27. is afraid of being judged by relatives and friends	1	2	3	4	5
28. withholds financial support	1	2	3	4	5
29. brings up evidence to show that I must not be gay/lesbian/bisexual, such as “You had a girlfriend/boyfriend, you can’t be gay/lesbian/bisexual”	1	2	3	4	5
30. is mad at me for doing this to him/her	1	2	3	4	5
31. wants me not to be gay/lesbian/bisexual	1	2	3	4	5
32. is ashamed of my homosexuality/bisexuality	1	2	3	4	5

Appendix F

Family Adaptability and Cohesion Evaluation Scales, Version IV – Cohesion Subscale
(Olson, 2009)

Directions: Circle the number corresponding to your responses next to each statement.

1	2	3	4	5
Strongly Disagree	Generally Disagree	Undecided	Generally Agree	Strongly Agree

1. Family members are involved in each others lives.
1 2 3 4 5

7. Family members feel very close to each other.
1 2 3 4 5

13. Family members are supportive of each other during difficult times.
1 2 3 4 5

19. Family members consult other family members on important decisions.
1 2 3 4 5

25. Family members like to spend some of their free time with each other.
1 2 3 4 5

31. Although family members have individual interests, they still participate in family activities.
1 2 3 4 5

37. Our family has a good balance of separateness and closeness.
1 2 3 4 5

Appendix G

Selected Subscales from the Lesbian, Gay, and Bisexual Identity Scale
(Mohr & Fassinger, 2000)

Instructions: For each of the following statements, mark the response that best indicates your experience as a lesbian, gay, or bisexual (LGB) person. Please be as honest as possible in your responses.

1----------2----------3-----------4----------5----------6----------7
Disagree Strongly — Agree Strongly

Difficult Process (5 items)

4. _______ Coming out to my friends and family has been a very lengthy process.
14. _______ Admitting to myself that I'm an LGB person has been a very painful process.
18.* _______ Developing as an LGB person has been a fairly natural process for me.
22. _______ Admitting to myself that I'm an LGB person has been a very slow process for me.
27.* _______ I have felt comfortable with my sexual identity just about from the start.

*These items are reverse coded for scale calculation.

The Internalized Homonegativity/Binegativity Scale (5 items)

3. _______ I would rather be straight if I could.
8.* _______ I am glad to be an LGB person.
13. _______ Homosexual lifestyles are not as fulfilling as heterosexual lifestyles.
17.* _______ I'm proud to be part of the LGB community.
25. _______ I wish I were heterosexual.

*These items are reverse coded for scale calculation.

Concealment Motivation (6 items)

1. _______ I prefer to keep my same-sex romantic relationship rather private.
6. _______ I keep careful control over who knows about my same-sex relationship.
11. _______ My private sexual behavior is nobody's business.

15. _______ If you are not careful about whom you come out to, you can get very hurt.
20. _______ I think very carefully before coming out to someone.
24. _______ My sexual orientation is very personal and private matter.

Acceptance Concerns (5 items)

2. _______ I will never be able to accept my sexual orientation until all of the people in my life have accepted me.
7. _______ I often wonder whether others judge me for my sexual orientation.
12. _______ I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
16. _______ Being an LGB person makes me feel insecure around straight people.
21. _______ I think a lot about how my sexual orientation affects the way people see me.

Appendix H

Selected Items from the Behavior Assessment for Children, Second Edition – Self-Report - Adolescent
(Reynolds & Kamphaus, 2004)

Directions:

This booklet contains sentences that young people may use to describe how they think or feel or act. Read each sentence carefully. For the first group of sentences, you will have two answer choices: **T** or **F**.

Circle **T** for **True** if you agree with a sentence.

Circle **F** for **False** if you do not agree with a sentence.

Here is an example:

1. I like parties. (T) F

For the second group of sentences, you will have four answer choices: **N, S, O,** and **A**.

Circle **N** if the sentence **never** describes you or how you feel.

Circle **S** if the sentence **sometimes** describes you or how you feel

Circle **O** if the sentence **often** describes you or how you feel.

Circle **A** if the sentence **almost always** describes you or how you feel.

Here is an example:

2. I enjoy doing homework. N (S) O A

If you wish to change an answer, mark an X through it, and circle your new choice, like this:

2. I enjoy doing homework. N (S̸) (O) A

Give the best response for you for each sentence, even if it is hard to make up your mind. There are no right or wrong answers. Please do your best, tell the truth, and respond to every sentence.

Mark: T = True F = False

1.	I like who I am.	T	F
2.	Nothing goes my way.	T	F
3.	My muscles get sore a lot.	T	F
4.	Things go wrong for me, even when I try hard.	T	F
5.	I used to be happier.	T	F
6.	I often have headaches.	T	F
7.	I can never seem to relax.	T	F
8.	My classmates don't like me.	T	F
9.	If I have a problem, I can usually work it out.	T	F
10.	What I want never seems to matter.	T	F
11.	I worry about little things.	T	F
12.	Nothing is fun anymore.	T	F
13.	I never seem to get anything right.	T	F
14.	My friends have more fun than I do.	T	F
15.	I cover up my work when the teacher walks by.	T	F
16.	I wish I were different.	T	F
17.	Nobody ever listens to me.	T	F
18.	Often I feel sick in my stomach.	T	F
19.	My parents have too much control over my life.	T	F
20.	I just don't care anymore.	T	F
21.	Sometimes my ears hurt for no reason.	T	F
22.	I worry a lot of the time.	T	F
23.	I get along well with my parents.	T	F
24.	Other children don't like to be with me.	T	F
25.	I wish I were someone else	T	F
26.	I can handle most things on my own	T	F
27.	My parents are always telling me what to do.	T	F

28. I often worry about something bad happening to me. - - - - - - - - - - - -	T	F
29. I don't seem to do anything right. -	T	F
30. Most things are harder for me than for others. - - - - - - - - - - - - - - - - - -	T	F
31. Other children are happier than I am- -	T	F
32. I never quite reach my goal. -	T	F
33. I feel good about myself -	T	F
34. Sometimes, when alone, I hear my name. -	T	F
35. Nothing ever goes right for me.- -	T	F
36. I get sick more than others. -	T	F
37. My parents blame too many of their problems on me. - - - - - - - - - - - -	T	F
38. Nothing about me is right. -	T	F
39. My stomach gets upset more than most people's. - - - - - - - - - - - - - - - -	T	F

Remember: N = Never S = Sometimes O = Often A = Almost Always

40. I get so nervous I can't breathe. -	N	S	O	A
41. I am proud of my parents. - - - - - - - - - -- -	N	S	O	A
42. Other kids hate to be with me. -	N	S	O	A
43. I like the way I look. -	N	S	O	A
44. People say bad things about me. - - - - - - - - - - - - - - - - - - - - - - - - - - -	N	S	O	A
45. I am dependable. - - - - - - - - - - -	N	S	O	A
46. I get blamed for things I can't help. -	N	S	O	A
47. I worry when I go to bed at night. -	N	S	O	A
48. I feel like my life is getting worse and worse. - - - - - - - - - - - - - - - - - - -	N	S	O	A
49. Even when I try hard, I fail. -	N	S	O	A
50. People act as if they don't hear me. -	N	S	O	A
51. I am disappointed with my grades. -	N	S	O	A
52. I get upset about my looks. -	N	S	O	A
53. I feel like people are out to get me. -	N	S	O	A

54. I feel depressed.	N	S	O	A
55. No one understands me.	N	S	O	A
56. I feel dizzy.	N	S	O	A
57. Someone wants to hurt me.	N	S	O	A
58. I feel guilty about things.	N	S	O	A
59. I like going places with my parents.	N	S	O	A
60. I feel like nobody likes me.	N	S	O	A
61. I am good at things.	N	S	O	A
62. I am lonely.	N	S	O	A
63. I can solve difficult problems by myself.	N	S	O	A
64. I get nervous.	N	S	O	A
65. My parents expect too much from me.	N	S	O	A
66. I worry but I don't know why.	N	S	O	A
67. I feel sad.	N	S	O	A
68. When I take tests, I can't think	N	S	O	A
69. I am left out of things.	N	S	O	A
70. Even when alone, I feel like someone is watching me.	N	S	O	A
71. I want to do better, but I can't.	N	S	O	A
72. I hear voices in my head that no one else can hear.	N	S	O	A
73. My looks bother me.	N	S	O	A
74. I am good at making decisions.	N	S	O	A
75. My parents are easy to talk to.	N	S	O	A
76. I see weird things.	N	S	O	A
77. I get nervous when things do not go the right way for me.	N	S	O	A
78. My mother and father like my friends.	N	S	O	A
79. People think I am fun to be with.	N	S	O	A
80. Other people find things wrong with me.	N	S	O	A
81. I like to make decision on my own.	N	S	O	A

82. Little things bother me.	N	S	O	A
83. I am blamed for things I don't do.	N	S	O	A
84. I worry about what is going to happen.	N	S	O	A
85. My mother and father help me if I ask them to.	N	S	O	A
86. I fail at things.	N	S	O	A
87. I feel out of place around people.	N	S	O	A
88. Someone else controls my thoughts.	N	S	O	A
89. I quit easily.	N	S	O	A
90. I am slow to make new friends.	N	S	O	A
91. I do things over and over and can't stop.	N	S	O	A
92. My friends come to me for help.	N	S	O	A
93. My parents listen to what I say.	N	S	O	A
94. I like to be close to my parents.	N	S	O	A
95. I hear things that others cannot hear.	N	S	O	A
96. I am liked by others.	N	S	O	A
97. I feel that others do not like the way I do things.	N	S	O	A
98. I am someone you can rely on.	N	S	O	A
99. People get mad at me, even when I don't do anything wrong.	N	S	O	A
100. I am afraid of a lot of things.	N	S	O	A
101. My parents trust me.	N	S	O	A
102. My parents are proud of me.	N	S	O	A
103. Other people are against me.	N	S	O	A

Appendix I

Selected Items from the Behavior Assessment for Children, Second Edition – Parent Rating Scales - Adolescent
(Reynolds & Kamphaus, 2004)

Instructions:

On the pages that follow are phrases that describe how children may act. Please read each phrase, and mark the response that describes how this child has behaved recently (in the last several months).

Circle N if the behavior **never** occurs.

Circle S if the behavior **sometimes** occurs.

Circle O if the behavior **often** occurs.

Circle A if the behavior **almost always** occurs.

Please mark every item. If you don't know or are unsure of your response to an item, give your best estimate.

How to Mark Your Responses

Be certain to **circle** completely the letter you choose, like this:

N (S) O A

If you wish to change a response, mark an X through it, and circle your new choice, like this:

N (S) (O) A

Remember: N = Never S = Sometimes O = Often A = Almost Always

1. Calls other adolescents names. - N S O A
2. Cries easily. - N S O A
3. Complains of being sick when nothing is wrong. - - - - - - - - - - - - - - - N S O A
4. Annoys others on purpose. - N S O A
5. Worries about making mistakes. - N S O A
6. Uses foul language. - N S O A
7. Cannot wait to take turn. - N S O A
8. Has stomach problems. - N S O A
9. Steals. - N S O A
10. Acts without thinking. - N S O A
11. Complains about being teased. - N S O A
12. Is nervous. - N S O A
13. Says, “I’m not very good at this.”- N S O A
14. Drinks alcoholic beverages. - N S O A
15. Says, “Nobody understands me.”- N S O A
16. Teases others. - N S O A
17. Is negative about things. - N S O A
18. Complains of shortness of breath.- N S O A
19. Threatens to hurt others. - N S O A
20. Worries about what teachers think. - N S O A
21. Sneaks around.- N S O A
22. Has poor self-control. - N S O A
23. Says, “I think I’m sick.”- N S O A
24. Smokes or chews tobacco. - N S O A
25. Interrupts parents while they are talking on the phone. - - - - - - - - - - N S O A
26. Says, “I hate myself”. - N S O A

27. Tries too hard to please others. -	N	S	O	A
28. Has headaches. -	N	S	O	A
29. Says, "I get nervous during tests" or "Tests make me nervous". - - - -	N	S	O	A
30. Is in trouble with the police. -	N	S	O	A
31. Says, "I want to kill myself". -	N	S	O	A
32. Argues when denied own way. -	N	S	O	A
33. Changes moods quickly. -	N	S	O	A
34. Complains about health. -	N	S	O	A
35. Hits other adolescents. -	N	S	O	A
36. Worries about things that cannot be changed. - - - - - - - - - - - - - - - - - -	N	S	O	A
37. Breaks the rules. -	N	S	O	A
38. Acts out of control. -	N	S	O	A
39. Lies. -	N	S	O	A
40. Interrupts others while they are speaking. -	N	S	O	A
41. Is easily upset. -	N	S	O	A
42. Worries about what other adolescents think. - - - - - - - - - - - - - - - - - - -	N	S	O	A
43. Complains about chest pain. -	N	S	O	A
44. Gets into trouble. -	N	S	O	A
45. Says, "I want to die" or "I wish I were dead". - - - - - - - - - - - - - - - - - - -	N	S	O	A
46. Bullies others. -	N	S	O	A
47. Seems lonely. -	N	S	O	A
48. Complains of pain. -	N	S	O	A
49. Loses temper too easily. -	N	S	O	A
50. Is fearful. -	N	S	O	A
51. Uses illegal drugs. -	N	S	O	A
52. Fiddles with things while at meals. -	N	S	O	A
53. Breaks the rules just to see what will happen. - - - - - - - - - - - - - - - - - -	N	S	O	A
54. Says, "Nobody likes me". -	N	S	O	A

	N	S	O	A
55. Worries. -	N	S	O	A
56. Gets sick. -	N	S	O	A
57. Deceives others. -	N	S	O	A
58. Seeks revenge on others.- -	N	S	O	A
59. Says, “I don’t have any friends”. -	N	S	O	A
60. Is afraid of getting sick. -	N	S	O	A
61. Is cruel to others. -	N	S	O	A
62. Attends to issues of personal safety. -	N	S	O	A
63. Disrupts other adolescents’ activities. -	N	S	O	A
64. Lies to get out of trouble. -	N	S	O	A
65. Is sad. -	N	S	O	A
66. Says, “I’m afraid I will make a mistake”. -	N	S	O	A
67. Expresses fear of getting sick. -	N	S	O	A
68. Disobeys -	N	S	O	A

Appendix J

The Personal Experience Screening Questionnaire – Problem Severity Subscale
(Winters, 1992)

These questions ask about you and your experiences, including those with alcohol and other drugs. Some questions ask how often certain things have happened. Others ask if you agree with a statement. Please read each question carefully. Circle the * for the answer that is right for you. *Circle only one response option for each question.* Please answer every question.

	Never	Once or Twice	Some-times	Often
How often have you used alcohol or other drugs:				
1. at home?	*	*	*	*
2. at places on the street where adults hang around?	*	*	*	*
3. with older friends?	*	*	*	*
4. at the homes of friends or relatives?	*	*	*	*
5. at school activities, such as dances or football games?	*	*	*	*
6. at work?	*	*	*	*
7. when skipping school?	*	*	*	*
8. to enjoy music or colors, or feel more creative?	*	*	*	*
How often have you:				
9. made excuses to your parents about your alcohol or drug use?	*	*	*	*
10. gotten drugs from a dealer?	*	*	*	*
11. used alcohol or drugs secretly, so nobody would know you were using?	*	*	*	*
12. made excuses to teachers about your alcohol or drug use?	*	*	*	*
13. been upset about other people talking about your using or drinking?	*	*	*	*
14. spilled things, bumped into things, fallen down, or hand trouble walking around?	*	*	*	*
15. seen, felt, or heard things that were not really there?	*	*	*	*
16. spent money on things you wouldn't normally buy?	*	*	*	*
17. found out things you said or did while using or drinking that you did not remember?	*	*	*	*
In order to get or pay for alcohol or other drugs, how often have you?				
18. sold drugs?	*	*	*	*