FAMILY SUPPORT: A PREDICTOR OF OUTNESS AND PSYCHOLOGICAL WELL-BEING IN LGBTQ+ ADULT CHILDREN OF IMMIGRANTS

By

CHRISTINE M. FUSTON

Bachelor of Arts in Psychology
Wichita State University
Wichita, Kansas
2017

Master of Science in Educational Psychology
Oklahoma State University
Stillwater, Oklahoma
2018

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
July, 2022

FAMILY SUPPORT: A PREDICTOR OF OUTNESS

AND PSYCHOLOGICAL WELL-BEING IN LGBTQ+

ADULT CHILDREN OF IMMIGRANTS

Dissertation Approved:

Julie M. Koch, PhD

Dissertation Adviser

John S. C. Romans, PhD

Carlos C. Mahaffey, PharmD, MPH, CCHP

Tamara L. Mix, PhD

ACKNOWLEDGEMENTS

To those who provided a safe container of healing while I outgrew my shell.

Alissa Bey
Tanarah Brady
Mckinzey Porter
Ivan Garcia-Mijares
Andrea Ponds
Aja Molinar
Makenzie Hercules
Ashley Cervantes
Susan Holbrook
Katie Judd
Brandi Martens
April Berry
Ankita Nikalje
Emi Lenes
Alvin Lawrence
Shinlay Rivera

Acknowledgements reflect the views of the author and are not endorsed by committee members or Oklahoma State University.

Name: CHRISTINE M. FUSTON

Date of Degree: JULY, 2022

Title of Study: FAMILY SUPPORT: A PREDICTOR OF OUTNESS AND PSYCHOLOGICAL WELL-BEING IN LGBTQ+ ADULT CHILDREN OF IMMIGRANTS

Major Field: COUNSELING PSYCHOLOGY

Abstract: Researchers have documented mental health disparities of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) populations. Although the LGBTQ+ identity is often a predictor of negative mental health outcomes by itself, those with multiple minority identities may face greater mental health disparities due to higher rates of minority stress. Little research has been conducted to examine the mental health of LGBTQ+ adult children of immigrants. There has yet to be research that explores family support in relation to microaggressions and microaffirmations in LGBTQ+ children of immigrants. The objective of this study was to determine if family support, as measured by interpersonal and environmental microaggressions and microaffirmations, predicted levels of outness and levels of psychological well-being in LGBTQ+ adult children of immigrants. Additionally, the researcher assessed if family support was a moderator in the relationship between outness and wellbeing. The sample size consisted of 109 participants. Results showed that family support did not predict outness in LGBTQ+ adult children of immigrants. Environmental microaffirmations did predict psychological well-being in LGBTQ+ adult children of immigrants. Environmental microaggressions moderated the relationship between outness and psychological well-being. The researcher discusses implications for counseling psychology and future directions for research.

TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

Trans & Gender Diverse Health 2
LGBTQ+ POC 4
Second Generation Mental Health 5
Family Relationships 6
Family Support for LGBTQ+ Children of Immigrants 8
Outness 9
Psychological Wellbeing 10
Purpose of the Study 11

II. METHODOLOGY 13

Participants 13
Procedures 15
Measures 15
Analysis 18

III. RESULTS 20

Family Support and Outness 21
Family Support and Wellbeing 22
Family Support, Outness, and Wellbeing 23

Chapter Page

IV. DISCUSSION 25

Implications for Practice 28
Implications for Future Research 30
Limitations 31
Summary 33

REFERENCES 34

APPENDICES 44
APPENDIX A: An extended Review of the Literature 44
APPENDIX B: Informed Consent 62
APPENDIX C: Online Questionnaire 64
APPENDIX D: Debriefing Statement 72
APPENDIX E: Institutional Review Board Approval Letter 73

LIST OF TABLES

Table Page

1. Participant Demographics 14
2. Scale Descriptives 21
3. Research Question One Analysis 22
4. Research Question Two Analysis 23
5. Research Question Three Analysis 23

CHAPTER I

INTRODUCTION

The mental health of lesbian, gay, and bisexual (LGB) individuals has been well-documented by many researchers who have detailed the often negative outcomes associated with having an LGB identity (Alessi et al., 2013; Cochran et al., 2003; Meyer et al., 2008; Nelson & Andel, 2020). Gay and bisexual men are three times more likely to meet criteria for major depression and panic disorder than heterosexual men (Cochran et al., 2003). In addition, lesbian and bisexual women met criteria for generalized anxiety disorder more often than heterosexual women, and were more likely to be diagnosed with two or more mental health disorders (Cochran et al., 2003). Furthermore, LGB individuals have reported higher rates of self-directed violence and self-harm (Liu & Mustanksi, 2012; Lytle et al., 2014).

The heightened rate of negative experiences becomes a significant factor in the development of negative mental health outcomes, which can be explained by minority stress. Minority stress theory explains that individuals of minority identities often experience conflict between the dominant social group, expectation of hostile interactions, and a lack of social institutions supporting their minority identity (Meyer, 2003).

When compared to heterosexual people, LGBs have been found to experience higher rates of prejudice-related events throughout their lifetimes, and are more likely to experience suicidal ideation as well as suicide attempt (Meyer et al., 2008). The pervasiveness of LGB health issues extends to physical health as well. Lesbians have higher rates of diabetes, while poor general health conditions existed among all sexual minorities when compared to health conditions of heterosexual people. (Conron et al., 2010). One study on mental health disorders and substance use found LGB individuals as 1.5 times more likely to misuse substances compared to heterosexual individuals (Osborn et al., 2008). Binge drinking is more common in bisexual women, while gay and lesbian individuals have reported higher rates of drug use, current smoking, and former smoking when compared to heterosexual people (Conron et al., 2010).

Despite the prevalence of negative outcomes related to LGB mental and physical health, researchers have found many positive factors related to resilience and well-being for LGB people (Harris et al., 2015; Holley et al., 2019). For LGB women of color who identify as Black, Latina, or Asian/Pacific Islander, research has shown that engagement in sociopolitical groups was an important factor in supporting their intersectional identities (Harrest et al., 2015). Connecting with others who identify as LGBTQ can provide benefits such as creating a safe place to explore sexuality, challenge negative stereotypes, and increase feelings of normality (Carastathis et al., 2017). Additionally, social support from family and friends has been documented as a protective factor for LGB people vulnerable to negative mental health outcomes (Carastathis et al., 2017; Mcconnell et al., 2016).

Trans and Gender Diverse Health

Research on topics related to transgender and gender nonconforming individuals is often limited due to surveys conflating gender and sex demographics or limiting gender to the binary categories of man or woman (Glick et al., 2018). The findings of limited research have suggested that transgender and gender diverse individuals experience some of the same mental and physical health concerns as LGB individuals. This includes higher rates of victimization and harassment as well as higher rates of self-harm and suicidal ideation in comparison to cisgender people (Lui & Mustanski, 2012).

Depression and anxiety disorders occur at higher rates among gender minority individuals (Streed et al., 2018). This may be in part due to negative experiences perpetuated throughout school environments, which are often hostile towards students who deviate from their respective gender norms (Ocampo & Soodjinda, 2016). Outcomes of prejudice towards gender minorities can also lead to increased anxiety and loss of self-esteem, resulting from perceived inability to meet cultural standards for one's gender (Herek & McLemore, 2013). Physical victimization has also been found to occur at higher rates towards trans individuals (Testa et al., 2012). One study that surveyed 40 trans women and 30 trans men found that almost half of the participants reported experiencing past incidents of physical and sexual violence (Testa et al., 2012).

Similar to the LGB population, trans and gender diverse individuals have been shown to find resilience through social support (Singh, 2013). Transgender youth of color have described the ability to connect with a community of other LGBTQ youth as an important factor in increasing resilience (Singh, 2013). This theme was supported by additional research showing that connection to group-level support, such as family acceptance and community belonging, was found to help transgender individuals gain access to positive role models and cope with minority stress (Matsuno & Israel, 2018).

LGBTQ+ POC

Having an LGBTQ+ identity is a significant factor in mental health outcomes even before taking into account a second minority identity such as being a racial or ethnic minority. Research has documented higher rates of negative mental health outcomes between LGBTQ+ people of color (POC) and White heterosexual individuals (Lytle et al., 2014; Meyer et al., 2008). Black and Multiracial students without an LGB identity have reported more suicide attempts when compared to their White peers (Lytle et al., 2014). Furthermore, Asian, Black, and Multiracial LGB emerging adults have shown increased risk of attempting suicide when compared to their White peers (Lytle et al., 2014).

People who have both a racial/ethnic minority identity as well as an LGBTQ+ identity are at greater risk of exposure to prejudicial stressors when compared to White heterosexual men (Meyer et al., 2008). These stressors may originate from both the interpersonal level, involving relationships and interactions, as well as the systemic level, involving environmental factors such as residence location and school. Social support is often sought to reduce feelings of isolation and burdensomeness (Davidson & Wingate, 2011), but may be difficult to find with LGBTQ+ POC, who report seeking “comfort zones” with people who share the same ethnic and sex/gender minority identities (Holly et al., 2019).

Consistent with minority stress theory, having a racial/ethnicity minority identity added substantial vulnerability to stress exposure for participants who also had a sexual minority status (Meyer et al., 2008). These findings suggest that extra resources and support may be required for mitigating and protecting LGB POC from potential mental health consequences of substantial stress. LGB Latino people have reported higher levels of

depressive symptoms combined with lower levels of psychological well-being when compared to White LGB people.

In one study of young transgender adults of color, participants described being unable to separate their racial/ethnic identity from their gender identity (Singh, 2013). The same study found that the development of both their racial/ethnic identity and their gender identity was found to be an important theme in the development of trans POC resilience (Singh, 2013). Unfortunately, this development may be obstructed when one's surrounding environment has limited opportunity to find others with similar identities (Singh, 2013). Additionally, LGB people who identify as multiracial have higher rates of self-directed violence (Lytle et al., 2014). These conclusions detail only some of the increased mental and physical health stressors that LGBTQ+ POC may experience.

Second Generation Mental Health

Research on the mental health of immigrants has supported two perspectives: the immigrant paradox and the acculturative stress frameworks (Harker, 2001). The immigrant paradox suggests that people who transition from one country to start life in a new country are generally healthier compared to non-immigrants (Harker, 2001). Alternatively, the acculturative stress framework suggests that immigrant youth tend to have higher rates of mental health problems when compared to non-immigrant youth, due to higher exposure to economic disadvantage and discrimination (Berry, 1997). The support for these two distinct theories highlights the importance of understanding intersectionality within LGBTQ+ children of immigrants.

For children of immigrants, research has shown that their mental health experiences are nuanced depending on the child's race/ethnicity and the type of mental health issue (Kim

et al., 2018). Asian American and Latino children of immigrants have shown higher rates of parent-adolescent conflict, family dysfunction, and poor mental health when the child assimilated to the new culture at a faster rate than their parent (Lee et al., 2005). In addition to one's race/ethnicity, research has also shown differences in mental health for children with one immigrant parent when compared to children of two immigrant parents. For Asian American and Pacific Islanders, adolescents whose parents were both immigrants reported higher rates of depression and disruptive behavior symptoms when compared to children of immigrants with one immigrant parent and one US-born parent (Kim et al., 2018).

In support of the immigrant paradox, research has shown that Black and African American children of immigrants show lower levels of disruptive behavior when compared to Black and African American children of non-immigrants (Kim et al., 2018). A hypothesis from Portes and Zhou suggests that immigrant families may attempt to shelter their offspring from the consequences of socioeconomic discrimination and socioeconomic disadvantage (1993). This may manifest as parents maintaining a tight knit community around their child and close parental monitoring, and is advantageous when integrating into the new culture (Portes & Zhoue, 1993). This hypothesis is in line with the more recent findings showing that family closeness in immigrant families is a protective factor against immigrant-related stressors (Patterson, 2002).

Family Relationships

Researchers have documented how family relationships can predict outcomes related to mental health for LGBTQ+ individuals. Family support has been associated with positive health outcomes for LGB people such as better physical health, lower levels of depression, fewer suicide attempts, and less internalized homophobia compared to LGB peers who did

not receive family support (Rothman et al., 2012; Savin-Williams, 1998; Wong & Tang, 2004). Alternatively, LGB individuals who were rejected by family members have been shown to experience higher levels of depression and distress (Rothman et al., 2012; Willoughby et al., 2008), more frequent suicide attempts, and homelessness (Savin-Williams, 1998).

Family support or lack of family support can take various forms. Blatant forms of rejection may include verbal and physical abuse, punishment, disownment, condemnation, and direct statements showing disgust, dissatisfaction or unacceptance of one's LGB identity (Carastathis et al, 2017). In one study on LGBTQ+ children of immigrants, participants of rejecting parents reported being taken to conversion therapy, or being threatened that they would be sent back to the parent's native country (Ocampo, 2017). More subtle forms of rejection may appear passive and covert, such as invalidation, denial, withholding comfort and care, and withholding expressions of love (Carastathis et al., 2017).

Overt forms of discrimination toward LGBTQ+ individuals, such as bullying, physical abuse, and hate crimes, are more commonly studied than microaggressions (Kosciw et al., 2014). Alternatively, microaggressions have been less studied, and include more subtle forms of racism. Microaggressions are defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008). In relation to family support, feelings of rejection toward LGB children have been associated with internalized heterosexism, weekend self-esteem, increased depression, and increased alcohol and drug use (Carastathis et al., 2017; Willoughby et al., 2008).

While microaggressions help explain negative interactions, microaffirmations help to explain positive interactions. Similar to microaggressions, they are subtle in nature, but show affirmations and acceptance rather than rejection. Minimal research exists regarding microaffirmations, especially within the context of family systems and LGBTQ+ POC children (Sterzing & Gartner, 2020). Both microaggressions and microaffirmations warrant further study, as past research has shown that LGBTQ adolescents often experience both rejection and acceptance within the same family system (Sterzing & Gartner, 2020). This finding suggests that family support can be complex and nuanced for each individual.

Family Support for LGBTQ+ Children of Immigrants

Family support for LGBTQ+ POC requires more research to deepen our understanding of outcomes related to the intersection of racial/ethnic minority identities and family support. Many studies regarding family support for LGB people often pull from predominantly White samples or fail to include specifiers for identities other than White (Cochran et al., 2003; Willoughby et al., 2008). Research on the Latino experience with LGB support suggests that individual-level connections from family and friends explain more positive health-related outcomes than do community-level connections (Mulvaney-Day et al., 2007). For Latino and Filipino second generation Americans, participants of one study reported parents' initial responses to their identity disclosure ranged from conditional acceptance to explicit rejection (Ocampo, 2014).

However, not all second generation LGB participants reported experiencing rejection after disclosing their LGB identity. A participant of one study reported that his parents immigrated to the United States at a young age, and therefore had more exposure to openly gay people and reacted in a calm and supportive manner when he came out (Ocampo, 2014).

Because immigrant family experiences are nuanced, more research is required to understand how family support may look for LGBTQ+ POC children of immigrants.

Outness

For many LGB individuals, the process of coming out often includes anxiety and fear related to the expectation of possible rejection and the possibility of disrupting family relationships (Carastathis et al., 2017). In their development an Outness measurement, Meidlinger and Hope defined coming out as a two part process of disclosure and concealment (2014). Disclosure refers to an active indication of one's sexual orientation, while concealment refers to an active avoidance of identity disclosure (Meidlinger & Hope, 2014).

The fear of coming out has led other LGBTQ+ people of color to actively hide their identity both at home and at school. After coming out, LGBTQ+ people often experience negative reactions that can have lasting effects. In one study comparing traumatic stress between LGB and heterosexual participants, LGB participants described family rejection after coming out as compromising the safety and security of their home life throughout their teenage years (Alessi et al., 2013). Gay Filipino and Latino men have described willingly hiding their sexual identity due to fear of rejection, feelings of shame, and internalized homophobia (Ocampo, 2014). Furthermore, LGB students of color reported that they did not feel safe being open about their identities at school, and did not feel safe being open about their identities at home, in fear of further rejection from family members (Ocampo, 2014).

Studies have shown that coming out for LGBTQ+ people of color can be detrimental to LGBTQ+ POC individuals' mental health. Even so, second generation immigrant LGB individuals shared a common theme of desiring to maintain their family relationships

(Ocampo, 2014). In one study of LGBTQ+ children of immigrants, one participant stated "No matter how much resentment I have toward my dad and mom, they're still my blood, and they're still part of me, even if it's good or bad" (Ocampo, 2014; p. 167). In attempts to repair conflict between their parents and themselves, both Filipino and Latino LGB participants reported increasing their efforts in school and work to appear self-sufficient and accomplished (Ocampo, 2014). This finding shows how family values may influence attitudes and outcomes related to outness.

Psychological Well-being

Studies regarding the psychological well-being of LGBTQ+ individuals have elicited mixed results. One study with older LGB adults found that, contrary to Meyer's Minority Stress theory (2003), LGB older adults self-reported better health than their heterosexual peers did (Nelson & Andel, 2020). Another study showed similar results in that people who identified as both LGB and racial/ethnic minority showed no differences in psychological well-being compared to those who only identified as LGB (Whitman & Nadal, 2015). Whitman and Nadal's study did find that LGB individuals who also identified as a gender minority had significantly lower scores of psychological well-being, regardless of racial/ethnic identity (2015).

In a comparison between bisexual, lesbian, and gay individuals, bisexuals had the lowest levels of well-being (Kertzner et al., 2009). Additionally, LGB individuals who identified as Latino had lower psychological well-being compared to White-identified individuals (Kertzner et al., 2009). While minority stress theory expects higher rates of stress due to increased discrimination (Meyer, 2003), one study on LGB well-being found that discrimination did not predict positive affect and life satisfaction (Douglass et al., 2017).

Psychological well-being relates to the mental health and daily stressors in children of immigrants (Kiang & Buchanan, 2014). For Asian American children of immigrants, second generation children reported higher levels of psychological well-being on a day-to-day basis compared to first generation Asian American children (Kiang & Buchanan, 2014). It is hypothesized that a high level of family closeness, as traditionally found in Asian cultures, is an additional factor that influences individual well-being (Kiang & Buchanan, 2014; Lieber et al., 2004). Further research is required to understand psychological well-being and LGBTQ+ individuals, especially for individuals who also identify as a racial/ethnic minority.

Purpose of Study

The purpose of this study was to address the gap in literature around LGBTQ+ persons who are children of immigrants. While past research has attempted to describe links to of LGBTQ+ POC and psychological well-being, there remains a lack of research regarding LGBTQ+ POC whose parents are immigrants (Ocampo, 2014). The LGBTQ+ identity alone predicts increased vulnerability to suicidal ideation and suicide attempt (Mayer, 2003). Furthermore, LGBTQ+ people have higher prevalence of mental health disorders (Meyer, 2003).

The additional identity of being a child of an immigrant adds another layer of complexity that requires more research to understand how this interacts with the LGBTQ+ identity and minority stressors. Research on children of immigrants suggests two opposing frameworks for understanding their mental health: the immigrant paradox and the acculturative stress framework (Harker, 2001; Berry, 1997). While both theories explain different facets of one’s experience, it is important to consider additional identities and how these may create nuanced understandings of what it means to live as an LGBTQ+ child of an

immigrant. Research on psychological well-being has also been limited to predominantly White samples (Whitman & Nadal, 2015), and samples of only LGB individuals but not trans and gender nonconforming individuals. Furthermore, a measurement tool for LGBTQ+ microaggressions and microaffirmations in families has not existed until recently (Sterzing & Gartner, 2020).

This research study allowed for examination, potentially for the first time, of the experiences related to having an LGBTQ+ and child of immigrant identity. Because of the detrimental outcomes often related to the navigation of multiple minority identities, it is imperative that counselors and researchers have a better understanding of how these identities intersect in the lives of LGBTQ+ children of immigrants. Increased understanding of these experiences will contribute to our knowledge of best practices when working with clients of different LGBTQ+ minority identities. Results from the current study will be instrumental in providing knowledge for practitioners, researchers, and helpers, who serve LGBTQ+ individuals who are children of immigrants.

CHAPTER II

METHODOLOGY

To be eligible for this study, participants must have been adults age 18 or older, must have identified as LGBTQ+, and must have disclosed their sexual orientation or gender identity to at least one parent or guardian. The participant must also have been born in the United States and have one or more parent or guardians who identified as an immigrant. The researcher recruited participants through online advertisements via social media platforms such as posting on the researcher's personal Facebook along with posting in Facebook groups targeted to the LGBTQ+ population such as LGBTQ Scholars of Color and Spectrum LGBTQ+ and allies. The researcher engaged in networking through personal contacts to recruit additional participants who qualified for the study. The researcher incentivized the study with the chance to win one of ten $20 visa gift cards upon completion of the survey.

Participants

Participants reported their age, race, gender identity, sexual orientation, and ethnicity. They also identified the nation of origin for each parent or guardian. For the purposes of this study, the researcher defined family as the parent(s) or guardian(s) of the participant. A total of 168 participants responded to the survey. Incomplete and ineligible responses were removed (n=59) for a total of 109 participants. The researcher conducted data analyses using Statistical Package for the Social Sciences (SPSS). Participants

identified as cisgender woman (61.5%, n=67), cisgender man (32.1%, n=35), transgender woman (2.8%, n=3), transgender man (3.7%, n=4), and gender fluid (2.8%, n=3). Some participants identified more than one gender, so the total (112) is higher than number of participants (109). Participants' ages ranged from 19 to 60, with a mean of 29 and a median of 26. Participants also identified as lesbian (38%, n=42), bisexual (33.9% n=37), polysexual (15.6%, n=17), gay (14.7, n=16), pansexual (4.6%, n=5), queer (2.8%, n=3) and asexual (0.9, n=1). Some participants selected more than one sexual orientation, so the total (121) is higher than the number of participants (109). Of the participants, 63.3 percent identified as White (n=69), 11.9 percent identified as American Indian or Alaskan Native (n=13), 8.3 percent identified as Black or African American (n=9), 6.4 percent identified as Asian American (n=7), 6.4 percent identified as more than one race (n=7), 2.8% identified as Hawaiian or Pacific Islander (n=3), and 1 percent identified as an identity not listed (n=1) Some participants selected more than one race, so the total (115) is higher than the number of participants (109). A total of 79.8 percent of participants identified as Hispanic/Latina/o/x (n=87) and 20.2 percent of participants identified as non Hispanic/Latina/o/x (n=22). The researcher removed participants with greater than 15 percent of missing data from the data set. Additionally, the researcher removed outliers by calculating Z-scores and removing any participants with a Z-score >3.

Table 1
Participant Demographics

Characteristics	**n**	**%**
Gender		
Cisgender Woman	67	61.5
Cisgender Man	35	32.1
Transgender Woman	3	2.8
Transgender Man	4	3.7
Gender Fluid	3	2.8
Two Spirit	0	0

Questioning	0	0
Agender	0	0
Identity Not Listed	0	0
Sexual Orientation		
Lesbian	42	38.5
Bisexual	37	33.9
Polysexual	17	15.6
Gay	16	14.7
Pansexual	5	4.6
Queer	3	2.8
Asexual	1	.9
Questioning	0	0
Identity Not Listed	0	0
Race		
American Indian or Alaskan Native	15	13.8
Black	11	10.1
Asian American	11	10.1
Hawaiian or Pacific Islander	3	2.8
White	73	67
Identity Not Listed	2	1.8
Ethnicity		
Hispanic/Latina/o/x	87	79.8
Not Hispanic/Latina/o/x	22	20.2

Procedures

Qualified participants completed an online survey (Appendix C) via Qualtrics. Participants were first presented with informed consent and asked to agree before continuing to the survey. Following informed consent, the researcher included screening questions to ensure participants were 18 years of age or older, identified as LGBTQ+, were born in the United States, had one or more parents who identified as an immigrant, and have disclosed their sexual orientation or gender identity to at least one parent. The researcher applied for funds through the School of Community Health Sciences, Counseling, and Counseling Psychology to provide compensation for participants taking the survey. Participants had the option to be entered to win one of ten $20 amazon gift cards upon completion of the survey.

Measures

LGBTQ Microaggressions and Microaffirmations in Families Scale

The LGBTQ Microaggressions and Microaffirmations in Families Scale was created by Sterzing and Gartner in 2020. The purpose of this scale is to measure the frequency of microaggressions and microaffirmations within family systems (Sterzing & Gartner, 2020). The scale consists of four subscales to measure interpersonal and environmental microaggressions and microaffirmations in one's family (Sterzing & Gartner, 2020). The four subscales include: interpersonal microaggressions, environmental microaggressions, interpersonal microaffirmations, and environmental microaffirmations (Sterzing & Gartner, 2020). The interpersonal subscales reflect messages from family that refer directly to the individual's LGBTQ+ identity, while the environmental subscales reflect messages that indirectly affect the individual by referring to LGBTQ+ identities as a whole.

In total, the LGBTQ Microaggressions and Microaffirmations in Family scale consists of 29 items (Sterzing & Gartner, 2020). Responses are recorded through a 4-point Likert-type scale ranging from "never" to "all the time," as well as an additional set of responses ranging from "not at all" to "extremely" (Sterzing & Gartner, 2020). Chronbach's alpha indicated good internal consistency for the microaggressions subscales: interpersonal at .90 and environmental at .90. Chronbach's alpha also indicated good internal consistency for microaffirmations subscales: interpersonal at .82 and environmental at .88 (Sterzing & Gartner, 2020). In error, the researcher omitted question five of the interpersonal microaggressions subscale "How often has a member of your family said or implied you were being overly sensitive for thinking you were being

treated poorly because of your sexual orientation or gender identity?” Without the item, Chronbach’s alpha remained high at .94. The environmental microaggressions subscale had a Chronbach’s alpha of .92, the interpersonal microaffirmations subscale had a Chronbach’s alpha of .91 and the environmental microaffirmations subscale had a Chronbach’s alpha of .91.

Nebraska Outness Scale

The Nebraska Outness Scale (NOS) was developed by Meidlinger and Hope in 2014 to measure two constructs determining an individual’s level of outness: disclosure of sexual orientation and concealment of sexual orientation. For the purpose of this study, the NOS will be adapted to include gender identity. Each subscale will be adjusted to ask about both sexual orientation and gender identity. The NOS includes a 5-item subscale to measure disclosure (NOS-D) and a 5-tem subscale to measure concealment (NOS-C). Disclosure is defined as active indication of one’s LGBTQ+ identity, while concealment is defined as the active avoidance of a disclosure (Meidlinger & Hope, 2014). Participants respond using an 11 point Likert-type scale ranging from “None” to “All” for the NOS-D and “Never avoid” to “Always avoid” for the NOS-C (Meidlinger & Hope, 2014). Higher scores on the NOS-D represent less disclosure of one’s sexual orientation and higher scores on the NOS-C represent more concealment of one’s sexual orientation (Meidlinger & Hope, 2014). Chronbach’s alpha of the NOS showed good internal reliability at .89, while the NOS-D was .82 and the NOS-C was .80 (Meidlinger & Hope, 2014). For this study, Chronbach’s alpha of the NOS was .93, while the NOS-D was .87, and the NOS-C was .89.

Measure of Psychological Well-being

The Measure of Psychological Well-being was created by Choi and colleagues for use in a 2014 study on chronological age, felt age, and indicators of health. It includes seven items and requires participants to respond using a three-point Likert-type scale ranging from “agree not at all” to “agree a lot” (Choi et al., 2014). Higher scores represent a higher sense of well-being. The seven items measured in this scale include purpose in life, self-acceptance, personal growth, acceptance of living situation, perceived constraints, personal master, and self-efficacy (Choi et al., 2014). These seven psychological items were designed to reflect the psychological well-being measure used in a national study of health and well-being (Ryff et al., 2006). The Measure of Psychological Well-being showed good internal reliability with Cronbach’s alpha at .75 (Choi et al., 2014). For this study, Chronbach’s alpha was .84.

Analysis

Research question one asked how the variable family support, as measured by its four subscales (interpersonal microaggressions, environmental microaggressions, interpersonal microaffirmations, and environmental microaffirmations) predicted levels of outness in LGBTQ+ adult children of immigrants. Research question two asked how the variable family support, as measured by its four subscales, predicted levels of wellbeing in LGBTQ+ adult children of immigrants. Both of these research questions asked how multiple predictor variables relate to variance in a criterion variable, thus, a multiple regression was used to analyze the data. Multiple regressions are useful for describing and predicting the relationship between two or more predictor variables and one criterion variable (Hair et al., 1987).

The third research question asked whether or not family support, as measured by its four subscales, acts as a moderator in the relationship between level of outness and psychological well-being in adult LGBTQ+ children of immigrants. The researcher used a hierarchical regression to test for a potential moderator effect. Hierarchical regressions are best used to analyze two continuous variables, and can explain how much variance in the criterion variable is predicted by the interaction of the moderator (Heppner et al., 2008). This analysis produced two R^2 figures that allowed comparison between how much variance is explained by (a) the predictor and criterion variable combined, and (b) the predictor, criterion variable, and their interaction (Heppner et al., 2008). If there is significant difference between the first and second R^2 figures, then there is a moderation effect present (Heppner et al., 2008). G* power was used to calculate the appropriate sample size to achieve a power of 0.95. A total of at least 150 participants was sought for this study. A total of 168 participants responded to the survey, and after data cleaning, the researcher analyzed 109 participants' data.

CHAPTER III

RESULTS

Assumption Checks

The initial sample size included 168 online participants who lived in the United States. The researcher cleaned participant data to remove those who did not fit eligibility criteria, and those whose responses had greater than 15% missing data. In total, 59 participants' data were cleaned from the analyses. Out of the 59, 56 participants were identified as ineligible after completing the demographic questions, and an additional three participants were removed for greater than 15% missing data. The final sample size was 109.

The researcher used a multiple regression to address the first two research questions. The researcher created a scatterplot to assess for a linear pattern to ensure the assumption of linearity was met. The assumption of linearity was met for each research question 1a-d and 2a-d. Independence is assumed due to the nature of the test occurring at a single point in time. The researcher tested the assumption of homoscedasticity by plotting the standardized residuals and ensuring the residuals do not fan into a triangular pattern. Research question 1a-d did not meet the assumption, while research question 2a-d passed the assumption check. The researcher used a weighted least squares multiple regression in research question 1a-d to address the failed homoscedasticity assumption check. The researcher assessed the multicollinearity assumption by looking for

correlations greater than .8 between predictor variables. All variables met the assumption for multicollinearity. The final assumption checked for normal distribution of residuals by assessing the scatterplot of standardized residuals and predictor values and ensuring no pattern exists. The first research question (1a-d) failed the assumption check while the second research question (2a-d) met the assumption. To address the failed assumption, the researcher transformed research question 1a-d using the weighted least squares regression analyses.

The researcher ran initial descriptive statistics for each of the scales and found a mean score of 15.39 out of 21 for participants' well-being, with higher scores representing more well-being, and a mean score of 6.09 out of 10 for participants' level of outness, with higher scores representing a higher level of outness. Participants had a mean score of 3.22 out of 5 for environmental microaffirmations, 3.25 out of 5 for interpersonal microaffirmations, 2.99 out of 5 for environmental microaggressions, and 2.94 out of 5 for interpersonal microaggressions.

Table 2
Scale Descriptives

Measure	**Mean**
Psychological Well-being	15.39
Nebraska Outness Scale	6.09
Environmental Microaffirmations	3.22
Interpersonal Microaffirmations	3.25
Environmental Microaggressions	2.99
Interpersonal Microaggressions	2.94

Family Support and Outness

The first research question asked whether family support, as measured by environmental microaffirmations, interpersonal microaffirmations, environmental microaggressions, and interpersonal microaggressions, predicted level of outness in adult

LGBTQ+ children of immigrants. The research questions were as follows: Do (1a) environmental microaffirmations, (1b) interpersonal microaffirmations, (1c) environmental microaggressions, or (1d) interpersonal microaggressions predict level of outness in adult LGBTQ+ children of immigrants? Results of the multiple regression showed that none of the family support variables significantly predicted level of outness in adult LGBTQ+ adult children of immigrants (F(4, 104) = 1.647, p>.05) with an R^2 of .06.

Table 3
Research Question One Analysis

Effect	**Estimate**	**SE**	**95% CI**		***p***
			UL	**LL**	
EP	-.03	.10	.12	-.44	.27
IP	-.10	.12	.39	-.183	.47
EN	.04	.11	.36	-.13	.37
IN	-.03	.11	.07	-.43	.15

Note. EP = Environmental Microaffirmations, IP = Interpersonal Microaffirmations, EN = Environmental Microaggressions, IN = Interpersonal Microaggressions, SE = Standard Error, CI = Confidence Interval, UL = Upper Limit, LL = Lower Limit

Family Support and Well-being

The second research question asked whether family support, as measured by environmental microaffirmations, interpersonal microaffirmations, environmental microaggressions, and interpersonal microaggressions, predicted the level of psychological well-being in adult LGBTQ+ children of immigrants. The research questions were as follows: Do (1a) environmental microaffirmations, (1b) interpersonal microaffirmations, (1c) environmental microaggressions, or (1d) interpersonal microaggressions predict level of psychological well-being in adult LGBTQ+ children of immigrants? Results of the multiple regression showed that only one of the variables, environmental microaffirmations, significantly predicted level of psychological well-

being in adult LGBTQ+ adult children of immigrants while the other variables did not (F(4, 103) = 3.522, p<.05) with an R^2 of .12. Environmental microaffirmations was a significant predictor of the variance in psychological well-being (β = .57, p<.05),

Table 4
Research Question Two Analysis

Effect	**Estimate**	**SE**	**95% CI**		***p***
			UL	**LL**	
EP	1.51	.53	2.55	.47	.00
IP	-0.66	.54	.41	-1.73	.23
EN	-0.53	.47	.39	-1.46	.26
IN	0.32	.47	1.26	-.62	.51

Note. EP = Environmental Microaffirmations, IP = Interpersonal Microaffirmations, EN = Environmental Microaggressions, IN = Interpersonal Microaggressions, SE = Standard Error, CI = Confidence Interval, UL = Upper Limit, LL = Lower Limit

Family Support, Outness and Well-being

The final research question asked whether each of the four variables of family support, environmental microaffirmations, interpersonal microaffirmations, environmental microaggressions, and interpersonal microaggressions, acted as a mediator in the relationship between outness and psychological well-being for adult LGBTQ+ children of immigrants. A hierarchical multiple regression was used to analyze the relationship. Results of the analysis showed that environmental microaggressions was the only variable to produce a moderation effect on the relationship between outness and well-being (F (9, 98) = 3.579 , p< .05).

Table 5
Research Question Three Analysis

Effect	**Estimate**	**SE**	**95% CI**		***p***
			UL	**LL**	
Step 1					
Outness	1.04	.35	1.73	.35	.00
EP	1.67	.51	2.67	.66	.00
IP	-.77	.52	.27	-1.80	.14
EN	-.66	.45	.24	-1.55	.15

IN	.52	.46	1.43	-.40	.27
Step 2					
Outness	.61	.52	1.64	-.42	.24
EP	1.76	.51	2.77	.76	.00
IP	-.83	.52	.21	-1.86	.12
EN	-.44	.48	.51	-1.39	.36
IN	.19	.52	1.22	-.84	.71
Outness x EP	-.54	.52	.50	-1.58	.31
Outness x IP	.44	.63	1.70	-.81	.49
Outness x EN	-.90	.42	-.06	-1.73	.04
Outness x IN	.33	.35	1.03	-.37	.35

Note. EP = Environmental Microaffirmations, IP = Interpersonal Microaffirmations, EN = Environmental Microaggressions, IN = Interpersonal Microaggressions, SE = Standard Error, CI = Confidence Interval, UL = Upper Limit, LL = Lower Limit

CHAPTER IV

DISCUSSION

The goal of this study was to add to the research in understanding the experiences of LGBTQ+ adult children of immigrants. The first research questions 1a-d asked: Do (1a) environmental microaffirmations, (1b) interpersonal microaffirmations, (1c) environmental microaggressions, or (1d) interpersonal microaggressions predict level of outness in adult LGBTQ+ children of immigrants? Results suggested that family support (as measured by microaggressions and microaffirmations) was not a significant predictor of outness for LGBTQ+ adult children of immigrants. Much of the literature focused on family support of LGBTQ+ individuals focuses on children and adolescents, with fewer studies exploring family support and its influences on LGBTQ+ individuals later in life or longitudinally over time (Lytle et al., 2014; Sterzinger & Gartner, 2020; Willoughby et al., 2008;). The mean age of the current study was 29, with an age range of 19-60. Family influence may have less impact on outness of individuals in adulthood due to factors such as no longer living in close proximity with family of origin and having increased individual autonomy.

The coming out experience often takes place while LGBTQ+ individuals are living with family, regardless of whether family members are accepting or rejecting (Carastathis et al., 2017). One hypothesis for family support not being a significant predictor for outness may be that the adult participants of the current study were likely

not currently living with their parents or family who reared them. The researcher did not ask about this demographic in the present study so this may be an important demographic question to include in future research. Furthermore, while this study focused on immediate family support for children of immigrants, the experience of outness expands to social settings, the work place, and interactions with strangers. This may be due to individuals receiving community support, acceptance, or belonging outside of the family unit, which may offer individuals safe places to have higher levels of outness regardless of levels of immediate family support. Additionally, one measure not addressed in the current study was LGBTQ+ community support and chosen family support, which has been found to be a predictor of outness (Pastrana, 2016).

The second research question asked: Do (1a) environmental microaffirmations, (1b) interpersonal microaffirmations, (1c) environmental microaggressions, or (1d) interpersonal microaggressions predict level of psychological well-being in adult LGBTQ+ children of immigrants? Research question 2a-d results showed that one aspect of family support, environmental microaffirmations, significantly predicted psychological wellbeing in LGBTQ+ adult children of immigrants. This finding is in alignment with literature that suggests family support for LGB individuals has been linked to improved physical health, lower levels of depression, fewer suicide attempts, and less internalized homophobia compared to LGB individuals without family support (Rothman et al., 2012; Savin-Williams, 1998; Wong & Tang, 2004). Furthermore, one study looking at resiliency in LGBT individuals showed that identity affirmation is a protective factor that can come indirectly from marginalization and lead to positive health outcomes for older LGBT adults (Nelson & Andel, 2020).

Environmental microaffirmations, positive statements referring to LGBTQ+ identities as a whole, appear to relate to adult LGBTQ+ children of immigrant mental health. This finding supports previous literature showing positive attitudes towards one's LGBTQ+ identity may relate to self-acceptance, confidence, self-concept, and pride (Carastathis et al., 2017). Furthermore, environmental microaffirmations may relate to an overall positive worldview in an otherwise heterosexist society.

The final research question asked whether each of the four variables of family support (environmental microaffirmations, interpersonal microaffirmations, environmental microaggressions, and interpersonal microaggressions) acted as a mediator in the relationship between outness and psychological well-being for adult LGBTQ+ children of immigrants. Research question 3 results showed that only one aspect of family support, environmental microaggressions, moderated the relationship between outness and psychological well-being for LGBTQ+ adult children of immigrants. Individuals who experienced fewer environmental microaggressions from family had higher levels of outness and higher levels of psychological well-being. Conversely, individuals who experienced more environmental microaggressions from family had lower levels of outness and lower levels of psychological well-being.

For LGBT people of color with mental health diagnoses, family has been described as an important support network despite experiences of family members being ambivalent and microaggressive toward the individual (Holley et al., 2019). This finding adds to the literature on microaggressions experienced by LGBTQ+ individuals in their families by highlighting a relationship between outness and well-being that is potentially impacted by the experience of microaggressions within the family. This finding also

adds to previous research that has shown parental rejection can be related to weakened self-esteem, internalized heterosexism, and higher levels of depression compared to LGBT individuals who felt accepted by family (Carastathis et al., 2017; Willoughby et al., 2008). The current finding is also supported by previous literature that has noted the relationship between family rejection, feelings of isolation, and how the two may negatively impact one's psychological well-being (Yadegarfard, Meinhold-Bergmann, & Ho, 2014).

Implications for Practice

Few studies examine topics related to LGBTQ+ adult children of immigrants. Nor is there much literature that describes family support through the lens of microaggressions and microaffirmations. Findings from the current study may allow clinicians additional points of understanding or inquiry in their work with LGBTQ+ adult children of immigrants. Environmental microaffirmations was a significant predictor of adult LGBTQ+ children of immigrants' well-being, while environmental microaggressions was a moderator in the relationship between outness and well-being. The finding that different family support variables (environmental microaffirmations and environmental microaggressions) were significant highlights the complexity of support for LGBTQ+ identities and how it may be experienced. Both environmental microaffirmations and microaggressions relate to messages about LGBTQ+ topics not directly related to the LGBTQ+ individual themselves. For clinicians, this highlights the possibility that even indirect messages from family members about LGBTQ+ identities may be strongly influencing the well-being of the individual. In the clinical setting, practitioners should be mindful of the gravity of environmental or indirect comments

made by family members, and offer opportunity for the client to explore the impact of these experiences.

Furthermore, it may be important to note the family support variables that were not significant predictors or moderators of outness and well-being, such as interpersonal microaggressions and interpersonal microaffirmations, as additional areas to discuss with clients. Interpersonal microaggressions and microaffirmations are messages from family members that concern the client's LGBTQ+ identity itself. For clinicians, it is important to understand that microaggressions and microaffirmations can happen concurrently and come from the same family members, thereby sending mixed messages. In working with LGBTQ+ clients and those who are adult children of immigrants, the clinician should have an understanding that family support is not often experienced as a dichotomous all-or-nothing state. Rather, the experience of family support may be a living, fluctuating, and complex experience. Microaggressions and microaffirmations themselves may be a new idea or new language for the client. Therapists should provide patient, non-judgmental space for clients to explore how they may or may not have experienced microaggressions or microaffirmations. Additionally, there may be benefit to the therapist explicitly naming that clients can hold both love toward their family but also pain and anger.

For children of immigrants, clinicians should be mindful of cultural factors that may also influence the client's experience of family support and how it relates to their outness and well-being. In this study, participants were adults born in the United States (US) with at least one parent or caregiver whose nation of origin is outside of the US. One area of consideration for clinicians may be individualistic versus collectivistic values

and how those may influence the client's experience of family support. Values of multiple cultures may influence children of immigrants: the US culture, that of their parent/caregiver and their home country, and in a multiple parent/caregiver household, the culture of additional caregivers. The clinician can name and explore the different cultural values that may influence the client's experience of family support, outness, and well-being, as well as to provide space for the client to explore what it means to be an LGBTQ+ children of an immigrant.

Implications for Future Research

As previously noted, there is minimal research on LGBTQ+ adult children of immigrants and their experiences. The findings of the current study point to a need for continued research around LGBTQ+ children of immigrants to continue expanding our knowledge of their experiences. Microaggressions and microaffirmations are complex experiences that should be further researched in relation to LGBTQ+ identities. Researchers have conducted minimal research on microaffirmations, and continued research in this area may help create a strengths based approach to supporting the well-being of LGBTQ+ individuals.

Sterzing and Gartner noted that previous literature has not explored microaffirmations in LGBTQ family systems (2020). The authors also discussed that microaggressions and microaffirmations are distinct constructs that cannot be measured as opposite sides of a continuous spectrum (Sterzing & Gartner, 2020). One unexpected finding was that interpersonal microaggressions and interpersonal microaffirmations were not significant predictors of well-being or significant moderators in the relationship between outness and well-being. This may be an area for future research.

Other areas for future research include exploring a qualitative approach to allow LGBTQ+ children of immigrants to provide descriptive responses related to family support, outness, and well-being, especially within the realm of microaggressions and microaffirmations. This would enhance more knowledge related to microaffirmations and microinvalidations that are received in the external environment through social media, peers, and other areas. In addition, given that this study had a majority White sample, it would be beneficial to conduct research with other racial, ethnic, and immigrant groups. Research has found that the coming out process is a Western culture norm, thus coming out may look different cross-culturally (Szymanski & Sung, 2013). Additionally, given that the experience of gender diverse individuals is different from sexual minorities, future research can add to our understanding in this area by focusing solely on the experience of individuals with gender diverse identities. Finally, this was a small sample size (n=109) compared to the recommended power analysis (n=150) conducted for this study; therefore, future research needs to obtain bigger samples that are adequate in power.

Limitations

The current study advanced understanding related to family support as a predictor of psychological well-being and outness in LGBTQ+ adult children of immigrants, but it is not without its limitations. First, this study involved use of convenience sampling and use of self-report measures. By using an online survey, sampling becomes biased toward individuals who have means to access the internet, which may exclude participants from low socioeconomic status backgrounds or those whose abilities may limit computer use (Heppner et al., 2008). Due to the likelihood of excluding participants with limited

internet access, the generalizability of the findings is limited. Second, the survey used self-report measures that are vulnerable to distortions by the participant (Heppner et al., 2008). Whether intentional or unintentional, participants may have responded in a manner they believed would confirm the researcher's hypothesis, in a manner that made them appear socially desirable, or in a manner that made them appear more distressed than is truly the case (Heppner et al., 2008). Third, participants were given the option to select multiple social identities that resulted in sample characteristics presented in Table 1 that are not accurate of all the identities that participants chose. This limited the depth of analysis in regards to racial and ethnic identities of participants and how they may relate to findings. Analysis was also limited because there was no non-children of immigrant comparison group to assess how results may have differed between children of immigrants and non-children of immigrants. Fourth, online surveys are vulnerable to invalid participant responses due to incomplete surveys or multiple submissions (Riggle et al., 2005). The anonymity of the survey may have helped mitigate reporter bias that often originates after a participant has interacted with the researcher (Riggle et al., 2005). Fifth, there was researcher error of omitting an item in one of the family support subscales, which may have impacted the validity of the total mean scores for the scale. However, cronbach's alpha remained strong. Finally, the researcher screened data to ensure the removal of invalid surveys. Initially, there were 168 completed surveys; however, upon data cleaning the final sample was 109 participants. This resulted in the power of the study being reduced from the minimum 150 participants, which may increase the likelihood of obtaining a false conclusion. Future research may address this by obtaining a larger sample size.

Summary

This dissertation adds to the present literature exploring the mental health with the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) community. Specifically, this study examined the mental health implications for LGBTQ+ adult children of immigrants by examining family support as measured by interpersonal and environmental microaggressions and microaffirmations, and its relationship to levels of outness and well-being. The researcher found that no variables of family support significantly predicted levels of outness, while environmental microaggressions were a significant predictor of levels of well-being in LGBTQ+ adult children of immigrants. Additionally, the researcher found that family support moderated the relationship between outness and wellbeing. This study provides a preliminary understanding of the importance of environmental microaggressions and microaffirmations. Finally, this study supports the need for families, clinicians, researchers, and educators to create safe and supportive spaces that support an overall healthy sexual orientation identity that does not result in negative consequences.

REFERENCES

Alessi, E., Martin, J., Gyamerah, A., & Meyer, I. (2013). Prejudice events and Traumatic stress among heterosexuals and lesbians, gay men, and bisexuals. *Journal of Aggression, Maltreatment & Trauma*, *22*(5), 510-526. https://doi.org/10.1080/10926771.2013.785455

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology*, *17*, 163–174. https://doi.org/10.1037/a0023244

Berry, J. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology, 46*(1), 5-34. https://doi.org/10.111/j.1464-0597.1997.tb01087.x

Carastathis, G., Cohen, L., Kaczmarek, E., & Chang, P. (2017). Rejected by family for being gay or lesbian: Portrayals, perceptions, and resilience. *Journal of Homosexuality*, *64*(3), 289-320. https://dio.org/10.1080/00918369.2016.1179035

Centers for Disease Control and Prevention. (n.d.). Injury prevention and control: Data and statistics (WISQARS). www.cdc.gov/injury/wisqars/facts.html

Cochran, S., Greer Sullivan, J., & Mays, V. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*(1), 53-61. https://doi.org/10.1037/0022-006X.71.1.53

Conron, K., Mimiaga, M., & Landers, S. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health, 100*(10), 1953-60. https://doi.org/10.2105/AJPH.2009.174169

Davidson, C., & Wingate, L. (2011). Racial disparities in risk and protective factors for suicide. *Journal of Black Psychology*, *37*(4), 499-516. https://doi.org/10.1177/0095798410397543

Drazdowski, T., Perrin, P., Trujillo, M., Sutter, M., Benotsch, E., & Snipes, D. (2016). Structural equation modeling of the effects of racism, LGBTQ discrimination, and internalized oppression on illicit drug use in LGBTQ people of color. *Drug and Alcohol Dependence*, *159*, 255-262. http://dx.doi.org/10.1016/j.drugalcdep.2015.12.029

Douglass, R., Conlin, S., Duffy, R., & Allan, B. (2017). Examining moderators of discrimination and subjective well-being among LGB individuals. *Journal of Counseling Psychology, 64*(1), 1-11. http://dx.doi.org/10.1037/cou0000187

Frost, D., Meyer, I., & Schwartz, S. (2016). Social support networks among diverse sexual minority populations. *American Journal of Orthopsychiatry, 86*(1), 91-102. http://dx.doi.org/10.1037/ort0000117

Glick, J., Theall, Andrinopoulos, & Kendall. (2018). For data's sake: Dilemmas in the measurement of gender minorities. *Culture, Health & Sexuality*, *20*(12), 1362-1377. https://doi.org/10.1080/13691058.2018.1437220

Harker, K. (2001). Immigrant generation, assimilation, and adolescent psychological well-being. *Social Forces*, *79*(3), 969-1004. https://www-jstor-org.argo.library.okstate.edu/stable/2675615

Hair, J. F., Jr., Anderson, R. E., & Tatham, R. L. (1987). *Multivariate data analysis: With readings* (2nd ed.). New York: Macmillan.

Harris, A., Battle, J., Pastrana, A., & Daniels, J. (2015). Feelings of belonging: An exploratory analysis of the sociopolitical involvement of Black, Latina, and Asian/Pacific Islander Sexual Minority Women. *Journal of Homosexuality, 62*(10), 1374-1397. https://doi.org/10.1080/00918369.2015.1061360

Heppner, P. Paul., Bruce E. Wampold, and Dennis M. Kivlighan. Research design in counseling. 3rd ed. Belmont, CA: Thomson Brooks/Cole, 2008. Print.

Herek, G., & McLemore, K. (2013). Sexual Prejudice. Annual review of psychology, 64(1), 309-333. https://doi.org/10.1146/annurev-psych-113011-143826

Kertzner, R., Meyer, I., Frost, D., & Stirratt, M. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *American Journal of Orthopsychiatry*, *79*(4), 500-510. https://doi.org/ 0.1037/a0016848

Hershberger, S. L., & D'Augelli, A. R. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. Developmental Psychology, *31*, 65–74. https://doi.org/10.1037/0012-1649.31.1.65

Holley, L., Oh, H., & Thomas, D. (2019). Mental illness discrimination and support experienced by people who are of color and/or LGB: Considering intersecting identities. *American Journal of Orthopsychiatry, 89*(1), 16-26. http://dx.doi.org/10.1037/ort0000360

Juang, L. P., & Cookston, J. T. (2009). A longitudinal study of family obligation and depressive symptoms among Chinese American adolescents. *Journal of Family Psychology*, *23*, 396–404. https://doi.org/10.1037/a0015814

Kahn, S., Alessi, E., Kim, H., Woolner, L., & Olivieri, C. (2018). Facilitating mental health support for LGBT forced migrants: A qualitative inquiry. *Journal of Counseling & Development*, *96*(3), 316-326. https://doi.org/ 10.1002/jcad.12205

Kiang, L., & Buchanan, C. (2014). Daily Stress and emotional well-being among Asian American adolescents: Same-day, lagged, and chronic associations. *Developmental Psychology*, *50*(2), 611-621. https://doi.org. 10.1037/a0033645

Kim, J., Nicodimos, S., Kushner, S., Rhew, I., McCauley, E., & Vander Stoep, A. (2018). Comparing mental health of US children of immigrants and non-immigrants in 4 racial/ethnic groups. *Journal of School Health*, *88*(2), 167-175. https://doi.org/ 10.1111/josh.12586

Kosciw, J. G., Greytak, E. A., Palmer, N. A., & Boesen, M. J. (2014). The 2013 national school climate survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York, NY: GLSEN.

Lee, R., Su, J., & Yoshida, E. (2005). Coping with intergenerational family conflict among Asian American college students. *Journal of Counseling Psychology*, *52*(3), 389-399. https://doi.org/ 10.1037/0022-0167.52.3.389

Lieber, E., Nihira, K., & Mink, I. T. (2004). Filial piety, modernization, and the challenges of raising children for Chinese immigrants: Quantitative and qualitative evidence. *Ethos,* 32, 324 –347. https://doi.org/10.1525/eth.2004.32.3.324

Liu, R., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *American Journal of Preventive Medicine, 42*(3), 221-228.

Lytle, M., De Luca, S., & Blosnich, J. (2014). The influence of intersecting identities on self-harm, suicidal behaviors, and depression among lesbian, gay, and bisexual individuals. *Suicide and Life-Threatening Behavior*, *44*(4), 384-391. https://doi.org/ 10.1016/j.amepre.2011.10.023

Matsuno, E., & Israel, T. (2018). Psychological interventions promoting resilience among transgender individuals: Transgender resilience intervention model (TRIM). *The Counseling Psychologist*, *46*(5), 632-655. https://doi.org/10.1177/0011000018787261

Meidlinger, P. C., & Hope, D. A. (2014). Differentiating disclosure and concealment in measurement of outness for sexual minorities: The Nebraska outness scale. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 489-497. http://dx.doi.org/10.1037/sgd0000080

Meyer, I. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697. https://doi.org/ 10.1037/0033-2909.129.5.674

Meyer, I., Schwartz, S., & Frost, D. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine*, *67*(3), 368-379. https://doi.org/10.1037/0033-2909.129.5.674674

Mcconnell, E., Birkett, M., & Mustanski, B. (2016). Families matter: social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *Journal of Adolescent Health, 59*(6), 674-680. http://dx.doi.org/10.1016/j.jadohealth.2016.07.026

Mood, C., Jonsson, J. O., & Låftman, S. B. (2017). The mental health advantage of immigrant-background youth: The role of family factors. *Journal of Marriage and Family*, *79*(2), 419-436. http://dx.doi.org.argo.library.okstate.edu/10.1111/jomf.12340

Moracco, K., Runyan, C., Bowling, J., & Earp, J. (2007). Women's experiences with violence: A national study. *Women's Health Issues*, *17*(1), 3-12. https://doi.org/10.1016/j.whi.2006.03.007

Mulvaney-Day, N., Alegría, M., & Sribney, W. (2007). Social cohesion, social support, and health among Latinos in the United States. *Social Science & Medicine, 64*(2), 477-495. https://doi.org/10.1016/j.socscimed.2006.08.030

Nadal, K. L. (2008). Preventing racial, ethnic, gender, sexual minority, disability, and religious microaggressions: Recommendations for promoting positive mental health. *Prevention in Counseling Psychology: Theory, Research, Practice and Training*, *2*(1), 22–27.

Nelson, C., & Andel, R. (2020). Does sexual orientation relate to health and well-being? Analysis of adults 50 years of age. *The Gerontologist*. https://doi.org/10.1093/geront/gnz187

Ocampo, A. (2014). The gay second generation: Sexual identity and family relations of Filipino and Latino gay men. *Journal of Ethnic and Migration Studies*, *40*(1), 155-173. https://doi.org/10.1080/1369183X.2013.849567

Ocampo, A., & Soodjinda, D. (2016). Invisible Asian Americans: The intersection of sexuality, race, and education among gay Asian Americans. *Race Ethnicity and Education, 19*(3), 480-499. https://doi.org/10.1080/13613324.2015.1095169

Osborn, D., Killaspy, H., Tai, S., Semlyen, J., King, M., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry*, *8*(1), 70-70. http://www.biomedcentral.com/1471-244X/8/70

Patterson, J. M. (2002). Integrating family resilience and family stress theory. *Journal of Marriage and Family*, *64*, 349–360. https://doi.org/10.1111/j.1741-3737.2002.00349.x

Pastrana, A. (2014). It takes a family. *Journal of Family Issues*, *37*(6), 765-788. https://doi.org/10.1177/0192513x14530971Portes, A., & Zhou, M. (1993). The new second generation: Segmented assimilation and its variants. *Annals of the American Academy of Political and Social Science*, *530*, 74–96. https://doi.org/10.1177/0002716293530001006

Riggle, E. D., Rostosky, S. S., & Reedy, C. S. (2005). Online surveys for BGLT research: Issues and techniques. *Journal of Homosexuality*, *49*(2), 1-21. https://doi.org/10.1300/J082v49n02_01

Rothman, E., Sullivan, M., Keyes, S., & Boehmer, U. (2012). Parents' supportive reactions to sexual orientation disclosure associated with better health: Results from a population-based survey of LGB adults in Massachusetts. *Journal of Homosexuality*, *59*(2), 186-200. https://doi.org/10.1080/00918369.2012.648878

Ryff, C., Almeida, D. M., Ayanian, J. S., Carr, D. S., Cleary, P. D., Coe, C., & Williams, D. (2006). Midlife Development in the United States (MIDUS2), 2004–2006: Documentation of Scales, All Parts (ICPSR 4652) Inter-University Consortium for Political and Social Research. Ann Arbor, MI.

Samari, G. (2016). Cross-border ties and Arab American mental health. *Social Science & Medicine, 155*, 93-101. http://dx.doi.org/10.1016/j.socscimed.2016.03.014

Savin-Williams, R. C., & Dube, E. M. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *Family Relations*, *47*, 7–13. https://doi.org/ 10.2307/584845

Silverschanz, P., Cortina, L. M., Konik, J., & Magley, V. J. (2008). Slurs, snubs, and queer jokes: Incidence and impact of heterosexist harassment in academia. *Sex Roles*, *58*(3–4),179–191. https://doi.org/10.1007/s11199-007-9329-7

Singh, A. (2013). Transgender youth of color and resilience: Negotiating oppression and finding support. *Sex Roles*, *68*(11), 690-702. https://doi.org/10.1007/s11199-012-0149-z

Sterzing, P., & Gartner, R. (2020). LGBTQ microaggressions and microaffirmations in families: Scale development and validation study. *Journal of Homosexuality*, *67*(5), 600-619. https://doi.org/10.1080/00918369.2018.1553350

Streed, C., Arroyo, H., & Goldstein, Z. (2018). Gender minority patients' mental health care. *Health Affairs*, *37*(6), 1014. https://doi.org/10.1377/hlthaff.2018.0548

Stryker, S., & Statham, A. (1985). Symbolic interaction and role theory. Lindzey & E. Aronson (Eds.), *Handbook of social psychology*. New York: Random House (pp.311–378).

Testa, R., Sciacca, L., Wang, F., Hendricks, M., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*, *43*(5), 452-459. https:doi.org/10.1037/a0029604

Whitman, C., & Nadal, K. (2015). Sexual minority identities: Outness and well-being among lesbian, gay, and bisexual adults. *Journal of Gay & Lesbian Mental Health*, *19*(4), 370-396. https://doi.org/10.1080/19359705.2015.1038974

Willoughby, B., Doty, N., & Malik, N. (2008). Parental reactions to their child's sexual orientation disclosure: A family stress perspective. *Parenting*, *8*(1), 70-91. https://doi.org/10.1080/15295190701830680

Wong, C., & Tang, C. S. (2004). Coming out experiences and psychological distress of Chinese homosexual men in Hong Kong. *Archives of Sexual Behavior*, *33*, 149–157. https://doi.org/10.1023/B:ASEB.0000014329.00994.b6

Xavier, J., Hitchcock, D., Hollinshead, S., Keisling, M., Lewis, Y., Lombardi, E., Williams, B. (2004). An overview of U.S. trans health priorities: A report by the eliminating disparities working group. National Coalition for LGBT Health. http://transequality.org/PDFs/HealthPriorities.pdf

Yadegarfard, M., Meinhold-Bergmann, M. E., & Ho, R. (2014). Family rejection, social isolation, and loneliness as predictors of negative health outcomes (depression, suicidal ideation, and sexual risk behavior) among Thai male-to-female transgender adolescents. *Journal of LGBT Youth*, *11*(4), 347–363. https://doi.org/10.1080/19361653.2014.910483

APPENDICES

APPENDIX A: An Extended Review of the Literature

The mental health of lesbian, gay, and bisexual (LGB) individuals has been well-documented by many researchers who have detailed the often negative outcomes associated with having an LGB identity (Alessi et al., 2013; Cochran et al., 2003; Meyer et al., 2008; Nelson & Andel, 2020). When compared to heterosexual people, LGBs have been found to experience higher rates of prejudice-related events throughout their lifetimes (Meyer et al., 2008). The heightened rate of negative experiences becomes a significant factor in the development of negative mental health outcomes, which can be explained by minority stress. Minority stress theory explains that individuals of minority identities often experience conflict between the dominant social group, expectation of hostile interactions, and a lack of social institutions supporting their minority identity (Meyer, 2003). Meyer's meta-analysis of studies on LGB mental health showed that LGB individuals are at higher prevalence of mental disorders compared to heterosexual people (2003).

In line with Meyer's minority stress model, researchers have found evidence that supports the prevalence of discrimination harassment, and mental health issues throughout LGB people's lives. When compared to heterosexual people LGB participants

reported having more experiences with assault, harassment, and prejudice related to their sexual orientation or physical appearance (Alissi et al., 2013). The same study also found that LGB participants had increased rates of non-life-threatening challenges such as unemployment, frequent moving, switching schools, and asking family for money (Alissi et al., 2013). Both life-threatening and non-life threatening events put forth challenges that may be detrimental to LGB mental health when experienced throughout one's lifetime.

Research on mental health disorders in the LGB community show the severity in which mental health concerns occur. Gay and bisexual men have been found to be three times more likely to meet criteria for major depression and panic disorder than heterosexual men (Cochran et al., 2003). In addition, lesbian and bisexual women met criteria for generalized anxiety disorder more often than heterosexual women, and were more likely to be diagnosed with two or more mental health disorders (Cochran et al., 2003). In additional to higher rates of mental health disorders and experiences of discrimination, LGB persons are more vulnerable to suicidal ideation and suicide attempts when compared to heterosexual people (Meyer, 2003). Furthermore, LGB individuals have reported higher rates of self-directed violence and self-harm (Liu & Mustanksi, 2012; Lytle et al., 2014).

Not only do LGB persons have increased expectations of stigma compared to heterosexuals (Meyer et al., 2008), but also report symptoms similar to Post Traumatic Stress Disorder as a result of childhood physical abuse, physical assault, and harassment (Alessi et al., 2013). In one study that sampled LGB and heterosexual people living in New York, White LGB people were more likely than White heterosexual people to report at least one prejudice-related PTSD qualifying event (Alissi et al., 2013). Furthermore,

despite experiencing disturbing events, LGB persons often downplay the severity of experiences of discrimination when interviewed (Ocampo & Soodjinda, 2016). This finding may limit conclusions that can be drawn from participant LGBTQ+ samples.

The pervasiveness of LGB health issues extends to physical health as well. Lesbians have been found to have higher rates of diabetes, while poor general health conditions were found to exist among all sexual minorities when compared to health conditions of heterosexual people. (Conron et al., 2010). Asthma was also found to exist at higher rates in sexual minorities, and may be attributed to higher rates of smoking in LGB individuals (Conron et al., 2010). One study on mental health disorders and substance use found LGB individuals as 1.5 times more likely to misuse substances compared to heterosexual individuals (Osborn et al., 2008). Binge drinking has been found to be more common in bisexual women, while gay and lesbian individuals have reported higher rates of drug use, current smoking, and former smoking when compared to heterosexual people (Conron et al., 2010).

Despite the prevalence of negative outcomes related to LGB mental and physical health, researchers have found many positive factors related to resilience and well-being for LGB people (Harris et al., 2015; Holley et al., 2019). In one study on mental illness support for LGB communities, LGB participants reported that receiving support for their sexual orientation increased feelings of normality while decreasing symptoms of depression (Holley et al., 2019). For LGB women of color who identify as Black, Latina, or Asian/Pacific Islander, research has shown that engagement in sociopolitical groups was an important factor in supporting their intersectional identities (Harrest et al., 2015). This finding supports past research suggesting that civic engagement is a form of coping

for people with multiple marginalized identities (Balsam et al., 2011). Connecting with others who identify as LGBTI can provide benefits such as creating a safe place to explore sexuality, challenge negative stereotypes, and increase feelings of normality (Carastathis et al., 2017).

Social support has been a well-documented protective factor for LGB people vulnerable to negative mental health outcomes (Carastathis et al., 2017; Mcconnell et al., 2016). One longitudinal study examined social support from family, peers, and significant others from the time an LGB participant was age 16 to when they turned 20 years old (Mcconnell et al., 2016). Results found that LGB youth who reported higher levels of support from family members experienced less distress throughout adolescence and young adulthood, compared to those who reported less family support (Mcconnell et al., 2016). Family support was also found to be a significant factor of mitigating distress during adolescence, separate from peer support and support from a significant other (Mcconnell et al., 2016).

Although LGB youth with less family support experienced greater distress throughout adolescence, they gradually showed lower levels of distress and higher resilience over time (Mcconnell et al., 2016). This is consistent with previous research that has found LGB individuals to frequently overcome family rejection and develop a strong sense of self and positive psychological well-being (Carastathis et al., 2017). Strong self-acceptance of one's own sexuality has also been related to fewer mental health issues for LGB youth aged 15-21 (Hershbeger & D'Augelli, 1995). Researchers have posited that self-acceptance becomes an important protective factor when LGB youth and young adults experience family rejection (Carastathis et al., 2017). Strong self-

acceptance is thought to alleviate psychological distress by allowing LGB youth to view their own perception of themselves as more important than what others think (Carastathis et al., 2017).

Trans and Gender Diverse Health

Research on topics related to transgender and gender nonconforming individuals is often limited due to surveys conflating gender and sex demographics or limiting gender to binary categories of man or woman (Glick et al., 2018). The findings of limited research have suggested transgender and gender diverse individuals experience some of the same mental and physical health concerns as LGB individuals. This includes higher rates of victimization and harassment as well as higher rates of self-harm and suicidal ideation in comparison to cisgender people (Lui & Mustanski, 2012). Gender nonconformity was also found to be a specific risk factor for risk of self-harm (Liu & Mustanski, 2012). For this study, gender nonconformity was measured by assessing stereotypical boyhood behaviors and self-perceptions along with effeminate behaviors and self-perceptions (Liu & Mustanski, 2012).

Depression and anxiety disorders have also been found to occur at higher rates among gender minority individuals (Streed et al., 2018). This may be in part due to negative experiences perpetuated throughout school environments, which are often hostile towards students who deviate from their respective gender norms (Ocampo & Soodjinda, 2016). Cultural expectations of heterosexuality and masculinity also add pressure for students to "prove" they are not transgender (Herek & McLemore, 2013). This is often exemplified by individuals engaging in antigay behavior by expressing prejudice towards other sexual and gender minorities (Herek & McLemore, 2013). Outcomes of prejudice towards gender minorities can also lead to increased anxiety and loss of self-

esteem, resulting from perceived inability to meet cultural standards for one's gender (Herek & McLemore, 2013).

Physical victimization has also been found to occur at higher rates towards trans individuals (Testa et al., 2012). One study that surveyed 40 trans women and 30 trans men found that almost half of the participants reported experiencing past incidents of physical and sexual violence (Testa et al., 2012). Furthermore, the same study found no significant difference in the rates of reported violence across race, age, or socioeconomic status (Testa et al., 2012). Only 10% of trans participants who experienced violent incidents reported going to the police (Testa et al., 2012). This is consistent with previous research that suggests trans individuals fear "secondary victimization," in which a police officer is both the designated helper and the perpetrator (Xavier et al., 2004).

Similar to the LGB population, trans and gender diverse individuals have been shown to find resilience through social support (Singh, 2013). In Singh's 2013 study regarding transgender youth of color, participants described the ability to connect with a community of other LGBTQ youth as an important factor in increasing resilience. This is supported by Matsuno and Israel's 2018 study that described group resilience as a buffer between minority stressors for transgender individuals. The connection to group-level support, such as family acceptance and community belonging, was found to help transgender individuals gain access to positive role models and cope with minority stress (Matsuno & Israel, 2018).

LGBTQ+ POC

Having an LGBTQ+ identity is a significant factor in mental health outcomes even before taking into account a second minority identity such as being a racial or ethnic minority. Research has documented higher rates of negative mental health

outcomes between LGBTQ+ people of color (POC) and White heterosexual individuals (Lytle et al., 2014; Meyer et al., 2008). Black and Multiracial students without an LGB identity have reported more suicide attempts when compared to their White peers (Lytle et al., 2014). Furthermore, the same study found that Asian, Black, and Multiracial LGB emerging adults have increased risk of attempting suicide when compared to their White peers (Lytle et al., 2014).

People who have both a racial/ethnic minority identity as well as an LGBTQ+ identity are at greater risk of exposure to prejudicial stressors when compared to White heterosexual men (Meyer et al., 2008). These stressors may originate from both the interpersonal level, involving relationships and interactions, as well as the systemic level, involving environmental factors such as residence location and school. Social isolation of ethnic groups has been identified as an additional risk factor in feelings of burdensomeness and thwarted belongingness (Davidson & Wingate, 2011). Social support is often sought to reduce feelings of isolation and burdensomeness (Davidson & Wingate, 2011), but may be difficult to find with LGBTQ+ POC, who report seeking "comfort zones" with people who share the same ethnic and sex/gender minority identities (Holly et al., 2019).

In one study of young transgender adults of color, participants described being unable to separate their racial/ethnic identity from their gender identity (Singh, 2013). The same study found that the development of both their racial/ethnic identity and their gender identity was found to be an important theme in the development of trans POC resilience (Singh, 2013). While the development of both racial/ethnic and gender identity may be an important factor, this development may be obstructed when one's surrounding

environment has limited opportunity to find others with similar identities (Singh, 2013). LGB people who identify as multiracial have also been found to have increased rates of self-directed violence (Lytle et al., 2014). This may be an important factor to consider when assessing how multiple minority identities affect one's well-being.

Consistent with minority stress theory, racial/ethnicity minority identity added substantial vulnerability to stress exposure for participants who also had a sexual minority status (Meyer et al., 2008). These findings suggest that extra resources and support may be required for mitigating and protecting LGB POC from potential mental health consequences of substantial stress. A study of LGB Latino people found they reported higher levels of depressive symptoms combined with lower levels of psychological well-being when compared to White LGB people, supporting Kertzner and colleagues' hypothesis of added burden stress (2009). Another study using online surveys of LGBTQ+ POC found that LGBTQ+ POC are at increased risk of using illicit drugs as a coping mechanism for internalized oppression (Drazdowski et al., 2016). This internalized oppression was found to be rooted in heterosexist ideals, where LGBTQ+ lives are invalidated and lack representation in interpersonal and environmental settings (Drazdowski et al., 2016). These conclusions detail only some of the increased mental and physical health stressors that LGBTQ+ POC may experience.

One component of the added stress may be attributed to the process of negotiating between identities. In a study of LGBT students of color, Ocampo and Soodjinda found that finding support through school Gay Straight Alliances (GSA) was often difficult as students had to decide between organizational values that supported their race or organizational values that supported their sexual identity (2016). The fear of retaliation

against boys who deviate from gender norms created an additional fear in joining LGBT-related school groups (Ocampo & Soodjinda, 2016). Additionally, one qualitative sample of 13 transgender students of color documented that 100% of participants described their schools as being unsupportive of both their racial/ethnic and gender identities (Singh, 2013).

In predominantly White settings, finding community can also be a challenge for LGBTQ+ POC. One study that surveyed people in public venues in NYC found that LGB POC most often found support not only from other LGB individuals, but from LGB individuals who were of the same race/ethnicity as themselves (Frost et al., 2016). Additionally, LGB POC were also found to have fewer members in their social support network and less dimensions of everyday support when compared to White LGBs (Frost et al., 2016). Singh's study of transgender students of color found that a critical aspect of resilience included both finding a "place" within the LGBTQ+ community as well as finding other transgender people of color to validate their experiences of both racism and to affirm their "whole" self (2013). A lack of access to community support was found to increase feelings of self-doubt for transgender students of color who experienced both racism and prejudice towards transgender people (Singh, 2013).

Second Generation Mental Health

Research on the mental health of children of immigrants has supported two perspectives: the immigrant paradox and the acculturative stress frameworks (Harker, 2001). The immigrant paradox suggests that people who transition from one country to start life in a new country are generally healthier compared to non-immigrants (Harker, 2001). Alternatively, the acculturative stress framework suggests that immigrant youth

tend to have higher rates of mental health problems when compared to non-immigrant youth, due to higher exposure to economic disadvantage and discrimination (Berry, 1997). The support for these two distinct theories highlights the importance of understanding intersectionality within LGBTQ+ children of immigrants.

For children of immigrants, research has shown that their mental health experiences are nuanced depending on the child's race/ethnicity and the type of mental health issue (Kim et al., 2018). Asian American and Latino children of immigrants have shown higher rates of parent-adolescent conflict, family dysfunction, and poor mental health when the child assimilated to the new culture at a faster rate than their parent (Lee et al., 2005). In addition to one's race/ethnicity, research has also shown differences in mental health for children with one immigrant parent when compared to children of two immigrant parents. For Asian American and Pacific Islanders, adolescents whose parents were both immigrants reported higher rates of depression and disruptive behavior symptoms when compared to children of immigrants with one immigrant parent and one US-born parent (Kim et al., 2018). It is hypothesized having one parent who was born in the United States may alleviate stressors related to parenting practices that are non-normative in families native-born to the United States (Kim et al., 2018).

In support of the immigrant paradox, research has shown that Black and African American children of immigrants show lower levels of disruptive behavior when compared to Black and African American children of non-immigrants (Kim et al., 2018). A hypothesis from Portes and Zhou suggests that immigrant families may attempt to shelter their offspring from the consequences of socioeconomic discrimination and socioeconomic disadvantage (1993). This may manifest as parents maintaining a tight

knit community around their child and close parental monitoring, and has been shown to be advantageous when integrating into the new culture (Portes & Zhoue, 1993). This hypothesis is in line with the more recent findings showing that family closeness in immigrant families is a protective factor against immigrant-related stressors (Patterson, 2002).

Language is yet another factor that may contribute to the mental health and support of LGBTQ+ POC, especially for those with parents who are immigrants. In one study looking at Latino mental health at the national level, support from friends was a significant predictor of self-rated mental health when the participant and their friend were able to speak with the same level of fluency in the same language (Mulvaney-Day et al., 2007). Alternatively, having supportive friends was not a significant predictor of self-rated mental health when the participant and their friend did not speak the same language at the same level of fluency (Mulvaney-Day et al., 2007). An extrapolation of this finding might be applied to other LGBTQ+ POC who speak a language other than English or whose first language may not be English. Further research is needed to examine LGBTQ+ POC who may speak a different first language than their parents, and how differing communication levels may affect support for LGBTQ+ POC children. These findings may be important considerations when assessing what factors may help mitigate minority stress and negative health outcomes predicted by dual minority identities.

Family Relationships

Family support has been associated with positive health outcomes for LGB people such as better physical health, lower levels of depression, fewer suicide attempts, and less internalized homophobia compared to LGB peers who did not receive family support

(Rothman et al., 2012; Savin-Williams, 1998; Wong & Tang, 2004). Alternatively, LGB individuals who were rejected by family members have been shown to experience higher levels of depression and distress (Rothman et al., 2012; Willoughby et al., 2008), more frequent suicide attempts, and homelessness (Savin-Williams, 1998).

Outcomes related to family support have also been found to last well into adulthood for LGB individuals. One study about family reactions to stressors looked at parental reactions to a child's coming out found that the level of parental acceptance predicted depression levels of LGB individuals into adulthood (age 52) (Willoughby et al., 2008). Family support or lack of family support can take various forms. Blatant forms of rejection may include verbal and physical abuse, punishment, disownment, condemnation, and direct statements showing disgust, dissatisfaction or unacceptance of one's LGB identity (Carastathis et al, 2017). In one study on LGBTQ+ children of immigrants, participants of rejecting parents reported being taken to conversion therapy, or being threatened that they would be sent back to the parent's native country (Ocampo, 2017). More subtle forms of rejection may appear passive and covert, such as invalidation, denial, withholding comfort and care, and withholding expressions of love (Carastathis et al., 2017).

Overt forms of discrimination toward LGBTQ+ individuals, such as bullying, physical abuse, and hate crimes, are more commonly studied than microaggressions (Kosciw et al., 2014). Alternatively, microaggressions have been less studied, and include more subtle forms of racism. Microaggressions are defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults

toward members of oppressed groups" (Nadal, 2008). Microaggressions concerning heterosexist harassment have been associated with higher levels of depression and anxiety in undergraduate students (Silverchanz et al., 2008). In relation to family support, feelings of rejection toward LGB children have been associated with internalized heterosexism, weekend self-esteem, increased depression, and increased alcohol and drug use (Carastathis et al., 2017; Willoughby et al., 2008).

When studying the influence of family support, it is important to look at the positive aspects alongside the negative. While microaggressions help explain negative interactions, microaffirmations help to explain positive interactions. Similar to microaggressions, they are subtle in nature, but show affirmations and acceptance rather than rejection. Minimal research exists regarding microaffirmations, especially within the context of family systems and LGBTQ+ POC children (Sterzing & Gartner, 2020). Both microaggressions and microaffirmations warrant further study, as past research has shown that LGBTQ adolescents often experience both rejection and acceptance within the same family system (Sterzing & Gartner, 2020). This finding suggests that family support can be complex and nuanced for each individual. The examination of mental health outcomes related to LGBTQ+ POC who experience both acceptance and rejection requires further study.

Family Support for LGBTQ+ Children of Immigrants

Family support for LGBTQ+ POC requires more research to deepen our understanding of outcomes related to the intersection of racial/ethnic minority identities and family support. Many studies regarding family support for LGB people often pull from predominantly White samples or fail to include specifiers for identities other than

White (Cochran et al., 2003; Willoughby et al., 2008). Research on the Latino experience with LGB support suggests that individual-level connections from family and friends explain more positive health-related outcomes than do community-level connections (Mulvaney-Day et al., 2007). This shows the importance of looking further into family influence on LGBTQ+ people of color, as well as family influence on LGBTQ+ children of immigrants.

For Latino and Filipino second generation Americans, participants of one study reported parents' initial responses to their identity disclosure ranged from conditional acceptance to explicit rejection (Ocampo, 2014). In Ocampo's 2014 study on family reactions to coming out, participants described the overt ways in which their families rejected their LGBTQ+ identity. One participant stated that his parents brought him to counseling in an attempt to make him straight (Ocampo, 2014). Another participant reported that his mom would go as far as throwing out a cup the participant had drank from, and washing the sheets if the participant had laid on her bed (Ocampo, 2014).

Many second generation LGB participants reported that their immigrant parents' perceptions about gay men stemmed from mainstream stereotypes (Ocampo, 2014). These stereotypes included White, privileged gay men who often partied and used drugs (Ocampo, 2014). When seeing LGB people portrayed on TV, one participant reported his parents would be disgusted, and use derogatory language to describe the gay identity (Ocampo & Soodjinda, 2016). However, not all second generation LGB participants reported experiencing rejection after disclosing their LGB identity. One participant reported that his parents immigrated to the United States at a young age, and therefore had more exposure to openly gay people and reacted in a calm and supportive manner

when he came out (Ocampo, 2014). Because immigrant family experiences are nuanced, more research is required to understand how family support may look for LGBTQ+ POC children of immigrants.

Outness

For many LGB individuals, the process of coming out often includes anxiety and fear related to the expectation of possible rejection and the possibility of disrupting family relationships (Carastathis et al., 2017). In their development an Outness measurement, Meidlinger and Hope defined coming out as a two part process of disclosure and concealment (2014). Disclosure refers to an active indication of one's sexual orientation, while concealment refers to an active avoidance of identity disclosure (Meidlinger & Hope, 2014). After coming out, LGBTQ+ people often experience negative reactions that can have lasting effects. In one study comparing traumatic stress between LGB and heterosexual participants, LGB participants described family rejection after coming out as compromising the safety and security of their home life throughout their teenage years (Alessi et al., 2013). Gay Filipino and Latino men have described willingly hiding their sexual identity due to fear of rejection, feelings of shame, and internalized homophobia (Ocampo, 2014).

The fear of coming out has led other LGBTQ+ people of color to actively hide their identity both at home and at school. Asian American students reported maintaining heterosexual relationships to avoid being gossiped about as being gay (Ocampo & Soodjinda, 2016). Other LGB students of color described hiding their identity as a tool to evade bullying, which they regularly witnessed towards classmates who were feminine and gay (Ocampo & Soodjinda, 2016). Furthermore, LGB students of color reported that

they did not feel safe being open about their identities at school, and did not feel safe being open about their identities at home, in fear of further rejection from family members (Ocampo, 2014).

Despite fear of rejection and possible compromise of personal safety, one study found that 100% of Filipino and Latino LGB participants desired coming out to their parents (Ocampo, 2014). However, a common theme between second generation participants was that coming out represented "moral collision" between immigrant parents and their gay sons (Ocampo, 2014). One participant described family rejection as the main source of his depression after coming out to his parents, while another reported that his parents treated him so poorly he wanted to kill himself (Ocampo, 2014).

Studies have shown that coming out for LGBTQ+ people of color can be detrimental to LGBTQ+ POC individuals' mental health. Even so, second generation immigrant LGB individuals shared a common theme of desiring to maintain their family relationships (Ocampo, 2014). In one study of LGBTQ+ children of immigrants, one participant stated "No matter how much resentment I have toward my dad and mom, they're still my blood, and they're still part of me, even if it's good or bad" (Ocampo, 2014; p. 167). In attempts to repair conflict between their parents and themselves, both Filipino and Latino LGB participants reported increasing their efforts in school and work to appear self-sufficient and accomplished (Ocampo, 2014). This finding shows how family values may influence attitudes and outcomes related to outness.

Psychological Well-being

Research has shown a relationship between level of outness and psychological well-being (Whitman & Nadal, 2015). Furthermore, psychological well-being has been

associated with biological, genetic, and personality characteristics as well as life events and social context (Kertzner et al., 2009). Kertzner and colleagues suggest that psychological well-being is also significantly tied to individual rather than social resources (2009). This may be an important consideration when attempting to understand how family support, race/ethnicity, and level of outness relate to LGBTQ+ psychological well-being.

Studies regarding the psychological well-being of LGBTQ+ individuals have elicited mixed results. One study with older LGB adults found that, contrary to Meyer's Minority Stress theory (2003), LGB older adults self-reported better health than their heterosexual peers did (Nelson & Andel, 2020). Another study showed similar results in that people who identified as both LGB and racial/ethnic minority showed no differences in psychological well-being compared to those who only identified as LGB (Whitman & Nadal, 2015). Whitman and Nadal's study did, however, find that LGB individuals who also identified as a gender minority had significantly lower scores of psychological well-being, regardless of racial/ethnic identity (2015).

Additional studies have documented the mixed outcomes of LGB mental health and psychological well-being. In a comparison between bisexual, lesbian, and gay individuals, bisexuals were found to have the lowest levels of well-being (Kertzner et al., 2009). The same study found that LGB individuals who identified as Latino had lower psychological well-being compared to White-identified individuals (Kertzner et al., 2009). While minority stress theory expects higher rates of stress due to increased discrimination (Meyer, 2003), one study on LGB well-being found that discrimination did not predict positive affect and life satisfaction (Douglass et al., 2017). Further

research is required to understand psychological well-being and LGBTQ+ individuals, especially for individuals who also identify as a racial/ethnic minority. An additional concern is that studies often have a small sample size of individuals who are transgender or gender queer, limiting statistical outcomes and interpretations (Whitman & Nadal, 2015).

Psychological well-being has also been connected with the mental health and daily stressors in children of immigrants (Kiang & Buchanan, 2014). For Asian American children of immigrants, second generation children reported higher levels of psychological well-being on a day-to-day basis compared to first generation Asian American children (Kiang & Buchanan, 2014). It is hypothesized that a high level of family closeness, as traditionally found in Asian cultures, is an additional factor that influences individual well-being (Kiang & Buchanan, 2014; Lieber et al., 2004). One study that examined mental health outcomes in Chinese American adolescents found that high levels of family assistance and family helping behavior were associated with decreasing depressive symptoms (Juang & Cookston, 2009).

APPENDIX B: Informed Consent

You are being invited to participate in a research study examining the experiences of LGBTQ+ children of immigrants. This research study will ask you to disclose information about your sexual orientation, gender identity, and family experiences.

This study is being conducted by Christine Fuston, M.S., under the direction of Dr. Julie Koch from School of Community Health Sciences, Counseling, and Counseling Psychology
Christine Fuston is a current doctoral student at Oklahoma State University, and the data collected from this research study will be used in her doctoral dissertation. The outcomes of this study may help researchers and clinicians explore the needs of LGBTQ+ children of immigrants.

We will implement procedures to protect the confidentiality of your information. Due to the personal nature of the questions, the researchers will not ask for your name. Computer IP addresses will not be collected. Demographic information collected (such as age, race, etc.) will be reported in summaries in order to protect individual identifiable information.

Please note that the survey will be conducted through Qualtrics, which has specific privacy policies of its own. You should be aware that this web service may be able to link your responses to your ID in ways that are not bound by this consent form and the data confidentiality procedures used in this study, and if you have concerns you should consult these services directly. Qualtrics' privacy statement is provided at: http://qualtrics.com/privacy-statement

Data collected will be password protected and only accessible to the researchers and those responsible for research oversight as identified in this document. Data collected from the study will be destroyed after 5 years.

The researchers have not identified any risks from participating in this study beyond difficult reactions or emotions that might arise as the result of reflection on your identity as an LGBTQ+ person who is a child of an immigrant.

By participating in this research study, you acknowledge that you understand the information provided in this document. You also affirm that you understand the type of information being collected and the benefits and risks of participating in this study. As a participant, you also have the right to discontinue this survey at any time and for any

reason. Please contact the researchers or the researcher's supervisors with any concerns or questions. If you would like a copy of the completed study, please contact the researchers.

Researcher's Contact Information:
Christine Fuston, M.S.
School of Community Health Sciences, Counseling, and Counseling Psychology
416 Willard Hall
Oklahoma State University
Email: christine.fuston@okstate.edu

Research Advisor Contact Information

Advisor: Julie Koch, Ph.D.
School of Community Health Sciences, Counseling and Counseling Psychology
Oklahoma State University
434 Willard Hall
Stillwater, OK 74078
Office Phone: (405) 744-6040
Email: julie.koch@okstate.edu

By checking the box below, you affirm that you understand the information in this document and would like to participate in the research. If you do not wish to participate, please exit this page and do not continue.

□ Yes, I understand and wish to continue

APPENDIX C: Online Questionnaire

<u>Age</u>
####

<u>Gender Identity</u>

Female □, Male □, Transgender □, Genderqueer/Nonbinary □, Agender □, Questioning □, Identity not listed ___________□

<u>Sexual Orientation</u>

Heterosexual □, Gay □, Lesbian □, Bisexual/Pansexual □, Asexual □, Queer □, Questioning □, Identity not listed___________□

<u>Race</u>

American Indian/Alaska Native □, Asian American □, Black/African American □, Native Hawaiian/Pacific Islander □, White □, Biracial/Multiracial/Mixed □

<u>Ethnicity</u>

Hispanic Latina/o/x □, Not Hispanic/Latina/o/x □

<u>Birth Location of Primary Care Givers</u>

Country of birth for primary care giver #1
####

Primary care giver #1's relationship to you
Mother □, Father □, Grandmother □, Grandfather □, Guardian □, Other_____________□

How long has primary care giver #1 lived in the United States?

Country of birth for primary care giver #2
####

Primary care giver #2's relationship to you
Mother □, Father □, Grandmother □, Grandfather □, Guardian □, Other_____________□

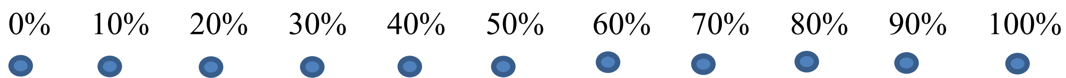
How long has primary care giver #2 lived in the United States?

Nebraska Outness Scale

What percent of the people in this group do you think are aware of your sexual orientation or gender identity (meaning they are aware of whether you consider yourself straight, gay, transgender etc.?

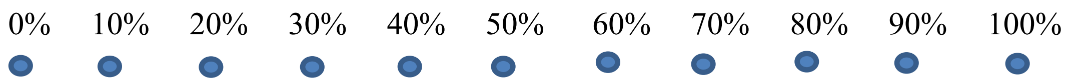
1. Members of your immediate family (e.g., parents and siblings)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



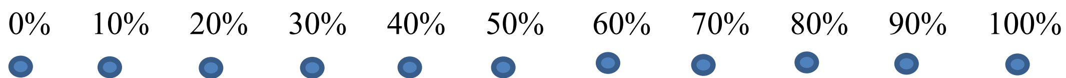
2. Members of your extended family (e.g., aunts, uncles, grandparents, cousins)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



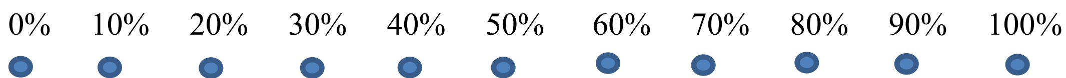
3. People you socialize with (e.g., friends and acquaintances)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



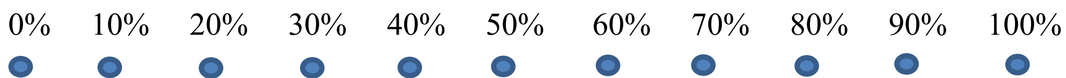
4. People at your work/school (e.g., coworkers, supervisors, instructors, students)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



5. Strangers (e.g., someone you have a casual conversation with in line at the store)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



How often do you avoid talking about topics related to or otherwise indicating your sexual orientation or gender identity (meaning they are aware of whether you consider yourself straight, gay, transgender, etc)?

6. Members of your immediate family (e.g., parents and siblings)

None Half of the Time Always

7. Members of your extended family (e.g., aunts, uncles, grandparents, cousins)

None Half of the Time Always

8. People you socialize with (e.g., friends and acquaintances)

None Half of the Time Always

9. People at your work/school (e.g., coworkers, supervisors, instructors, students)

None Half of the Time Always

10. Strangers (e.g., someone you have a casual conversation with in line at the store)

None Half of the Time Always

Nebraska Outness Scale

(NOS-D) What percent of the people in this group do you think are aware of your sexual orientation (meaning they are aware of whether you consider yourself straight, gay, etc)?

	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Members of your immediate family (e.g., parents and siblings)	○	○	○	○	○	○	○	○	○	○	○
Members of your extended family (e.g., aunts, uncles, grandparents, cousins)	○	○	○	○	○	○	○	○	○	○	○
People you socialize with (e.g., friends and acquaintances)	○	○	○	○	○	○	○	○	○	○	○
People at your work/school (e.g., coworkers, supervisors, instructors, students)	○	○	○	○	○	○	○	○	○	○	○
Strangers (e.g., someone you have a casual conversation with in line at the store)	○	○	○	○	○	○	○	○	○	○	○

(NOS-C) How often do you avoid talking about topics related to or otherwise indicating your sexual orientation (e.g., not talking about your significant other, changing your mannerisms) when interacting with members of these groups?

	Never					Half of the Time					Always
Members of your immediate family (e.g., parents and siblings)	○	○	○	○	○	○	○	○	○	○	○
Members of your extended family (e.g., aunts, uncles, grandparents, cousins)	○	○	○	○	○	○	○	○	○	○	○
People you socialize with (e.g., friends and acquaintances)	○	○	○	○	○	○	○	○	○	○	○
People at your work/school (e.g., coworkers, supervisors, instructors, students)	○	○	○	○	○	○	○	○	○	○	○
Strangers (e.g., someone you have a casual conversation with in line at the store)	○	○	○	○	○	○	○	○	○	○	○

Questions will be adapted from "What percent of the people in this group do you think are aware of your sexual orientation (meaning they are aware of whether you consider yourself straight, gay, etc.)?" to "What percent of the people in this group do you think are aware of your sexual orientation or gender identity (meaning they are aware of

whether you consider yourself straight, gay, transgender etc.)?" and "How often do you avoid talking about topics related to or otherwise indicating your sexual orientation (e.g., not talking about your significant other, changing your mannerisms) when interacting with members of these groups?" to "How often do you avoid talking about topics related to or otherwise indicating your sexual orientation or gender identity (e.g., not talking about your significant other, changing your mannerisms) when interacting with members of these groups?"

Measure of Psychological Well-Being

To what extent do you feel the following statements are true?

1. My life has meaning and purpose.
   □ Agree not at all
   □ Agree a little
   □ Agree a lot

2. I feel confident and good about myself. □ Agree a little
   □ Agree a lot

3. I gave up trying to improve my life a long time ago. (Mark One)
   □ Agree not at all
   □ Agree a little
   □ Agree a lot

4. I like my living situation very much. (Mark One)
   □ Agree not at all
   □ Agree a little
   □ Agree a lot

5. Other people determine most of what I can and cannot do (Mark One)
   □ Agree not at all
   □ Agree a little
   □ Agree a lot

6. When I really want to do something, I usually find a way to do it. (Mark One)
   □ Agree not at all
   □ Agree a little
   □ Agree a lot

7. I have an easy time adjusting to change. (Mark One)
   □ Agree not at all
   □ Agree a little

□ Agree a lot

LGBTQ Microaggressions and Microaffirmations in Families Scale

1. How often has a member of your family said positive and supportive things about LGBTQ people?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

2. How often has a member of your family treated LGBTQ people with respect?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

3. How often has a member of your family encouraged others to be accepting of LGBTQ people?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

4. How open is a member of your family to learning about the LGBTQ community?*

   □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

5. How supportive is a member of your family towards same-sex marriage*

   □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

6. How often has a member of your family stopped others from using negative LGBTQ words (e.g., that's so gay, fag, dyke, he/she, tranny)?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

7. How often has a member of your family welcomed your LGBTQ friends to your home, family events, or activities?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

8. How often has a member of your family said supportive things about your sexual orientation or gender identity?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

9. How loving and caring was a member of your family after learning about your sexual orientation or gender identity?*

   □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

10. How often has a member of your family stood up for you when you've been mistreated because of your sexual orientation or gender identity?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

11. How often has a member of your family encouraged others to be respectful of your sexual orientation or gender identity?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

12. How often has a member of your family knowingly gone with you to an LGBTQ organization or event?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

13. How welcoming has a member of your family been to your LGBTQ dating partner?*

   □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

14. How often has a member of your family said being LGBTQ is a choice that can be changed?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

15. How often has a member of your family made offensive comments about LGBTQ people?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

16. How often has a member of your family said or implied that being LGBTQ is a sin?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

17. How often has a member of your family said negative comments about same-sex marriage?

   □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

18. How often has a member of your family said or implied that being LGBTQ is the result of something that went “wrong” during someone’s childhood(e.g., bad parenting, childhood sexual abuse)?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

19. How often has a member of your family said or implied that LGBTQ people are overly sexual?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

20. How often has a member of your family said or implied LGBTQ people are “sick?”

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

21. How often has a member of your family said or implied that your sexual orientation or gender identity was “just a phase?”

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

22. How often has a member of your family said or implied that you should not tell others about your sexual orientation or gender identity?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

23. How negative or rejecting was a member of your family after learning about your sexual orientation or gender identity?*

    □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

24. How often has a member of your family asked you to dress or act more masculine or more feminine because of your sexual orientation or gender identity?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

25. How often has a member of your family said or implied you were being overly sensitive for thinking you were being treated poorly because of your sexual orientation or gender identity? ow often has a member of your family called you mean names like “fag,” “he/she,” “tranny,” or “dyke”?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

26. How often has a member of your family made offensive comments about your sexual orientation or gender identity without realizing they were being offensive?

□ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

27. How often has a member of your family acted as if you are straight or identify with your assigned birth sex even after telling them about your sexual orientation or gender identity?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

28. How often has a member of your family changed the topic of conversation when your sexual orientation or gender identity comes up?

    □ Never, □ Rarely, □ Occasionally, □ Frequently, □ All the time

"A member of your family" will be replaced with "a primary caregiver."

*Use alternate responses: □ Not at all, □ A little bit, □ Somewhat, □ Quite a bit, □ Extremely

APPENDIX D: Debriefing Statement

Thank you for your participation in this study. In this study, the researchers studied possible reasons why people use this helpline, and how effective the helpline is in reducing distress. If you would like a copy of the final results of this study or have any further questions, please contact the researchers or researcher's advisors.

If the questions in this study were distressing in any way or if you are considering seeking additional telehealth services, please contact the following:

National Suicide Prevention Lifeline
1-800-273-8255

Trans Lifeline
1-877-565-8860

The Trevor Project
1-866-488-7386

Researcher's Contact Information:
Christine Fuston, M.S.
School of Community Health Sciences, Counseling, and Counseling Psychology
Oklahoma State University
416 Willard Hall
Stillwater, OK 74078
Email: christine.fuston@okstate.edu

Research Advisor Contact Information

Advisor: Julie Koch, Ph.D.
School of Community Health Sciences, Counseling and Counseling Psychology
Oklahoma State University
434 Willard Hall
Stillwater, OK 74078
Office Phone: (405) 744-6040
Email: julie.koch@okstate.edu

Thank you for your participati

APPENDIX E: Institutional Review Board Approval Letter

Oklahoma State University Institutional Review Board

Date:	05/25/2021
Application Number:	IRB-21-240
Proposal Title:	Family Support: A Predictor of Outness and Psychological Well-being in LGBTQ+ Adult Children of Immigrants
Principal Investigator:	Christine Fuston
Co-Investigator(s):	
Faculty Adviser:	Julie Koch
Project Coordinator:	
Research Assistant(s):	
Processed as:	Exempt
Exempt Category:	

Status Recommended by Reviewer(s): Approved

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in 45CFR46.

This study meets criteria in the Revised Common Rule, as well as, one or more of the circumstances for which continuing review is not required. As Principal Investigator of this research, you will be required to submit a status report to the IRB triennially.

The final versions of any recruitment, consent and assent documents bearing the IRB approval stamp are available for download from IRBManager. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be approved by the IRB. Protocol modifications requiring approval may include changes to the title, PI, adviser, other research personnel, funding status or sponsor, subject population composition or size, recruitment, inclusion/exclusion criteria, research site, research procedures and consent/assent process or forms.
2. Submit a request for continuation if the study extends beyond the approval period. This continuation must receive IRB review and approval before the research can continue.
3. Report any unanticipated and/or adverse events to the IRB Office promptly.
4. Notify the IRB office when your research project is complete or when you are no longer affiliated with Oklahoma State University.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact the IRB Office at 405-744-3377 or irb@okstate.edu.

Sincerely,
Oklahoma State University IRB

VITA

Christine M. Fuston

Candidate for the Degree of

Doctor of Philosophy

Dissertation: FAMILY SUPPORT: A PREDICTOR OF OUTNESS AND PSYCHOLOGICAL WELL-BEING IN LGBTQ+ ADULT CHILDREN OF IMMIGRANTS

Major Field: Counseling Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2022.

Completed the requirements for the Master of Science in Educational Psychology at Oklahoma State University, Stillwater, Oklahoma in 2018.

Completed the requirements for the Bachelor of Arts in Psychology at Wichita State University, Wichita, Kansas in 2017.

Experience:

APA-Accredited Doctoral Internship at University of Florida
Graduate Assistant at OSU Student Health Services
Doctoral Practicum at Wichita State University Counseling Center
Doctoral Practicum at OSU-Tulsa Counseling Center
Doctoral Practicum and Counseling and Counseling Psychology Clinic

Professional Memberships:

McNair Scholars Program