How Black LGBQ Youths' Perceptions of Parental Acceptance and Rejection are Associated with their Self-Esteem and Mental Health

A Dissertation

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DEDICATIONS

First and foremost, I would like to dedicate this dissertation study to my family who has unconditionally supported me throughout all of my educational pursuits. Second, in the spirit of Ntozake Shange, this dissertation study is dedicated to all of the queer youth who have considered suicide, when the rainbow was not enough.

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ABSTRACT

How Black LGBQ Youths' Perceptions of Parental Acceptance and Rejection are Associated with their Self-Esteem and Mental Health
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Maureen Davey, PhD, LMFT

Parent-child relationships can both positively and negatively impact the psychological well-being and mental health of Black lesbian, gay, bisexual, and queer (LGBQ) youth and young adults. Yet, few studies have examined the role of parental acceptance and parental rejection among Black LGBQ youth. In order to fill this gap, this dissertation study examined the views of a convenience sample of 110 Black LGBQ youth (ages 14-21). Using Attachment Theory (Bowlby, 1969/1982), Intersectionality Theory (Crenshaw, 1989), and the Minority Stress Model (Meyer, 1995), the primary aim of this web-based, cross-sectional, prospective dissertation study was to understand how Black LGBQ youth and young adults' self-reports of parental acceptance and rejection are associated with their Black racial and LGBQ sexual identity development, and how they are associated with the following two mental health outcomes: 1) depressive symptoms and 2) self-esteem. The following two predictor variables were measured: 1) Black racial identity using the Cross Racial Identity Scale (CRIS); 2) Lesbian, Gay, Bisexual and Queer sexual identity using the Lesbian, Gay, and Bisexual Identity Scale (LGBIS). The proposed mediator, parental acceptance/rejection, was evaluated by assessing participants' perceptions of: 1) global parental acceptance/rejection using the Child Parental Acceptance-Rejection Questionnaire – Short Form (PARQ-C), and 2) sexual identity specific parental acceptance/rejection using the Perceived Parental Rejection Scale (PPRS). The two outcome variables were measured by: 1) depressive symptoms using the Center for Epidemiologic Studies Depression Scale (CES-D), and 2) self-esteem using the Rosenberg Self- Esteem Scale (RSES). A series of stepwise

regression analyses were conducted to examine how Black racial identity and LGBQ sexual identity, as well as salient demographic variables, were associated with depressive symptoms and self-esteem. A mediation analysis, using Preacher and Hayes' method (2008), was used to evaluate direct and indirect effects. Additionally, a series of t-tests and ANOVAs were conducted to examine the associations between depressive symptoms and self-esteem and salient demographic variables (age, gender, ethnicity, level of outness across three domains, family SES/class, and levels of parent's religiosity, as reported by youth). While participants' ages ranged from 14 to 21 years old, most were between 19 and 21 (n=75; 68.18%), most self-identified racially as either Black (79%), Biracial (14%) or Multiracial (5%), and most self-identified ethnically as African-American (76%). More than half were female (64%), and there was a relatively even percentage of sexual identities which included: 24.5% lesbian (n=27), 24.5% gay (n=27), 20% bisexual (n=22), 20% queer (n=22), and 12% other non-heterosexual (n=12). More than half (60%) reported being "completely out" to their families (or to at least to 1 parent/caregiver); approximately half (49%) reported they were not "out in their religious community (at church or place worship); and most (92%) were either "completely or somewhat out" in the world (in most all aspects of their lives). 40% identified as not religious/atheist/ agnostic, and 31% identified as Christian. Approximately half (55%) were either in college, had received "some college," or graduated college with either an Associate's or Bachelor's degree and 43.6% had some high school, or a high school diploma or General Education Development (GED, diploma equivalent). Participants' perception of *global* parental acceptance/rejection was not a significant mediator between racial or sexual identity, and depressive symptoms and self-esteem. Instead, *sexual identity-specific parental acceptance/rejection* was a partial, and in one model, was a full significant mediator for youth in the earlier pre-encounter self-hatred stage of

racial identity (having negative feelings about being Black), and the earlier acceptance concerns (worrying about being accepted as a LGBQ person) and identity uncertainty (being more unsure or insecure about one's sexual identity) of sexual identity development. Results suggest when Black LGBQ youth are in the *earlier sexual identity stages* of acceptance concerns and identity uncertainty, and perceive *more negative reactions from their mothers* about being LGBQ or more overall rejection of their sexual identities, they are *at increased risk of experiencing depressive symptoms and having lower self-esteem*. Thus, results suggest it is important to have at least one parent (mothers in this study) who is accepting of his or her child "coming out" as LGBQ, especially during the earlier stages of sexual identity development. Clinicians working with Black LGBQ youth, especially who present with depressive symptoms and/or lower self-esteem, should assess the youths' sexual identity stages, and partner with parents to help youth develop more positively. Clinicians need to ask about experiences at home for Black LGBQ youth and help them strengthen or repair attachment to their parents, especially during the "coming out" process. Family therapists and providers who are treating Black LGBQ youth and families should have more open conversations about the positive impact of acceptance and the potential detrimental impact of rejection. Future research should focus on transgender, gender non-conforming, genderqueer, gender variant, or otherwise non gender-binary (trans*) youth and their families. Future studies should survey larger samples of LGBQ youth and examine more outcome variables (e.g., suicidality, anxiety) and include LGBQ youth and their parents/caregivers. Specifically for Black and other families of color, future research should examine the role that religion and spirituality plays in the acceptance/rejection process of LGBQ youth. Finally, new measures should be developed, or existing measures revised, to better capture the complex identities for Black LGBQ youth growing up today.

CHAPTER ONE

INTRODUCTION

The field of Couple and Family Therapy (CFT) has the potential to lead the mental health field by conducting research with historically underserved populations using a relational and systemic perspective that considers the importance of the socio-political context. Prior research suggests parent-child relationships can both positively and negatively affect the well-being and mental health of Black young people, and specific to this study Black lesbian, gay, bisexual, and queer (LGBQ) youth and young adults. Yet, few CFT researchers have examined the role of parental acceptance and parental rejection among Black LGBQ youth. This dissertation study begins to fill this gap by surveying a convenience sample (n=110) of Black LGBQ youth (ages 14-21) to examine how youths' and young adults' perceived parental acceptance and rejection are associated with their racial and sexual identity development and their self-reported depressive symptoms and self-esteem.

Below, the prevalence of Black LGBQ youth living in the United States (US) is described, then the following three theoretical frameworks that informed the development of this cross-sectional, quantitative dissertation study with Black LGBQ youth (ages 14-21) are summarized: 1) Attachment Theory (Bowlby, 1969/1982), 2) Intersectionality Theory (Crenshaw, 1989), and 3) the Minority Stress Model (Meyer, 1995). Finally, a review of several bodies of literature that supported the importance of this dissertation study is provided. The first is a review of the parental acceptance and rejection literature, in particular, studies that examined the role of parental acceptance and rejection among Black LGBQ youth. Second, the extant literature on Black racial identity, LGBQ sexual identity is summarized. Finally, research is

summarized that examined the following two mental health outcomes among Black and LGBQ youth: 1) depressive symptoms and 2) self-esteem.

Prevalence of LGBQ Identity in Youth

Results from a 2012 Gallup poll reported younger Americans (ages 18-29) are three times more likely to identify as lesbian, gay, bisexual, or transgender (LGBT) compared to older Americans (6.4% of 18-29; 3.2% of 30-49; 2.6% of 50-64, and 1.9% of 65 and older). This report also noted gender-related differences consistent with prior studies, reporting that 8.3% of younger women (18-29yo) identify as LGBT, compared to 4.6% of younger men of the same age range (Gates & Newport, 2012). Statistics from other studies reported approximately 4.5% of youth identify as LGBT in high school and 4.5% identified as Questioning (Q). Taken together, these statistics suggest approximately 9% of youth in the U.S. identify as LGBT (Gates & Newport, 2012); however, this is likely an underestimation because of the societal stigma associated with self-reporting as LGBTQ in the U.S. Savin-Williams and Cohen (2010) noted that, "self-identified gay youth could conceivably represent as little as 10% of all youth who have same-sex attractions or who engage in same-sex behavior" (p. 31), yet we do not know if this is an accurate estimation.

In 2012, the Human Rights Campaign (HRC) released the results of their survey of over 10,000 young people ages 13-17, *Growing Up LGBT in America*. The purpose of this large cross-sectional self-report survey was to understand the social, cultural, ethnic, racial, family and safety experiences of LGBT youth in the U.S. LGBT youths' responses to this survey suggest many youth feel alienated from their families, communities, and peers. Sadly, many LGBT youth, compared to their heterosexual peers, reported they must leave their families and/or communities to live healthy and successful lives. LGBT youth are also among the most resilient;

many report facing these challenges with a sense of hope, optimism and a belief that "*it gets better*" (It Gets Better Project, 2010) eventually, however, for some it will take much longer (it is important to note that the *It Gets Better Project* ® has been critiqued by many LGBTQ activists and communities because it lacks diversity in LGBTQ experiences, perpetuating an upward mobility framework and ignoring class and culture-related differences – it gets better for whom, exactly?). Some of the most salient findings from the HRC's survey are summarized below:

- 42% of LGBT youth report living in a community that does not accept LGBT people
- 57% say their community's churches/ places of worship do not accept LGBT people
- 92% say they hear negative messages about being LGBT from school, internet, and peers
- 33% of LGBT young people say their family does not accept them, and just over half (56%) say they are out to their immediate family, 25% are out to extended family
- 46% of youth chose their family as a source where they most often hear negative messages about being LGBT
- 26% of youth said having a non-accepting family is the biggest problem they are facing, 21% said school/bullying problems, and 18% said the fear of being out or open
- 18% of youth reported the number one thing they would change right now would be people's understanding/tolerance/hate, 15% said their parent/family situation, and 9% said they would change where they lived or who they lived with
- LGBT youth are two times more likely to be verbally or physically assaulted at school than their non-LGBT peers (HRC, 2012).

Additionally, many researchers have suggested 20-40% of LGBTQ youth report having had suicidal thoughts (average 45%) and/or attempts (average 35%) (Youth Suicide Prevention Program [YSPP], 2011). Taken together, these findings suggest LGBTQ young people are in

need of more support and positive affirmation, which they sadly report not often finding in their extended communities (e.g., school, church), and may not find at home with their families. These studies and polls indicate a need to better understand how LGBTQ youth and their parents relate to each other, especially during youths' coming out process. If we can more fully understand why LGBTQ youth feel so disconnected from their families and communities, we can then clinically intervene, improve the safety of LGBTQ youth, and help families develop more accepting, nurturing, and affirming safe environments, even when the outside world is unsafe. Taken a step further, most research and polling that has been conducted has been too focused on White LGBTQ youth, or have not intentionally examined the experiences of youth of color and their families. Thus, this dissertation study fills a gap by understanding how these processes are similar or different in Black communities.

Theoretical Frameworks

The following three theoretical frameworks guided the development of this quantitative, cross-sectional web-based dissertation study: 1) Attachment Theory (Bowlby, 1969/1982), 2) Intersectionality Theory (Crenshaw, 1989), and 3) the Minority Stress Model (Meyer, 1995). Attachment theory (Bowlby, 1969/1982) provided the overarching conceptual framework for examining parental acceptance and rejection especially during the coming out process among Black LGBQ youth. Specifically, attachment theory was used to examine parent-child attachment during the process of adolescent sexual identity development and its associations with symptoms of depression and lower self-esteem among Black LGBQ youth and young adults.

Attachment Theory (Bowlby, 1969/1982) emphasizes the importance of accessibility and responsiveness between children, adolescents and their primary caregivers, which has been

linked to better social and emotional adjustment among children at any age (Bowlby, 1969/1982; Diamond, Diamond, Levy, Closs, Ladipo & Siqueland, 2012). Furthermore, Mohr and Fassinger (2003) suggested the coming out process (which for some, not all, is an important step in their sexual identity development), activates the parental attachment system. The authors noted that it is the strength of the attachment bond that can shield LGBQ youth from anti-gay prejudice, internalized heterosexism, and homonegativity. The developmental period of adolescence is a vulnerable stage for any young person, however, as a young person who is part of marginalized racial and sexual identity communities, having a strong and secure attachment to a parent or other primary attachment figure is especially important and has been linked to better psychological outcomes.

Second, Intersectionality Theory (Crenshaw, 1989) describes how multiple forms of oppression can affect individuals, couples, and families and lead to barriers to forming healthy relationships (Brooks, Bowleg & Quina, 2009; Dhamoon, 2011; Yuval-Davis, 2006). Salient contextual variables such as race/ethnicity, gender, sexual orientation, socioeconomic status (SES)/class, education level, ability, among others, are often viewed as separate socio-cultural demographic variables that rarely influence one another. Yet, intersectionality theorists contend that contextual variables intersect and influence one another (Brooks, et al., 2009; Crenshaw, 1989). Although, intersectionality has been conceptualized in many different ways, prior research suggests an individual's multiple identities interact and intersect to shape personal experiences (Crenshaw, 1991), and at times to form "intersecting oppressions… that work together to produce injustice" (Collins, 2000; p. 18). It is important to consider intersectionality in this study, because it was designed to examine variables such as race, gender, sexual identity, religion, and SES/class.

Third, the Minority Stress Model (Meyer, 1995) provides a basis for conceptualizing the impact of salient factors on mental health disparities among individuals who are considered "minorities" by mainstream societal standards and who tend to have higher levels of distress (Meyer, 2003, 2010). In recent years, the term *minority* has come under increasing scrutiny because of its pejorative connotation and how it tends to place individuals in a "less than" or disenfranchised position (Goldmann, 2001; Wilkinson, 2002). In this dissertation study the term *minority* was used to describe social locations for which barriers are constructed by dominant groups that prevent individuals from: 1) being treated with dignity and respect, 2) accessing health and mental health services, and 3) feeling safe in their relationships and in their communities. Additionally, this term was meant to discuss marginalized group affiliation, specifically as it relates to mental health disparities resulting from oppression and stress. Meyer (1995) defines minority stress as "psychosocial stress derived from minority status" (p. 38) that resides at "the juxtaposition of minority and dominant values and the resultant conflict with the social environment experienced by minority group members (p. 39). Prior research suggests prejudice and discrimination related to racism, sexism, and heterosexism all require adaptation because they negatively impact psychological well-being and mental health outcomes, and are experienced as stressful (Brooks, 1981; Clark et al., 1999; Cochran, 2001; Meyer, 1995).

Summary of the Literature

Next, several bodies of literature that have examined the following variables of interest are summarized: 1) family acceptance and rejection; 2) Black racial identity development; 3) sexual identity development; 4) mental health outcomes (depression and self-esteem); and salient demographic variables (age, gender, level of outness, SES/class, and youth and parental level of religiosity).

Family and Parental Acceptance and Rejection

Prior research suggests parental acceptance of a young person's LGBQ sexual identity is associated with increased parent-child communication and emotional closeness, two important domains found in secure parent-child attachments (Diamond et al., 2011; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Scholars have also recommended that more research examine the quality of adolescent and parent/caregiver attachment styles, particularly among LGBQ youth. The Family Acceptance Research Project (FAP; Ryan et al., 2009, 2010) has become the leading source of best practices among parents and families with LGBQ youth. Attachment-Based Family Therapy (ABFT; Diamond et al., 2010) has recently gained recognition as an evidence-based family therapy model that has promise for treating LGBQ adolescent depression and suicidal ideation, within the context of the family. Both models are described in more detail in chapter two.

Parental acceptance-rejection theory (PARTheory; Rohner, Khaleque, & Cournoyer, 2005, 2012) is a theory of socialization and lifespan development developed to explain major causes, consequences, and correlates of interpersonal, especially parental acceptance and rejection within the U.S. and worldwide. Yet little to no research has examined how PARTheory applies to families raising LGBQ children and youth. This dissertation study was informed by PARTheory, because it was hypothesized that parental acceptance is essential for the healthy development of Black LGBQ youth, while parental rejection is detrimental to Black LGBQ youth development and their psychological well-being.

Black Racial Identity Development

Many researchers have examined racial identity development, in particular racial and ethnic identity development among children and adolescents (Boyd-Franklin, 2003; Cross,

Parham, & Helms, 1991; Phinney, 1990; Stevenson, 1995; Thomas & Speight, 1999; Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001). Prior research has focused primarily on understanding family socialization processes, life experiences of Black college-age students, and more recently ethnic and racial identity development among young children and adolescents. Healthy Black racial identity development (Cross, 1991) has been historically described as an important aspect of resiliency and protection against race or ethnic-related prejudice and discrimination. In order to examine this construct, Cross' Nigrescence Model (1991) will be reviewed in more detail in chapter two, because the Cross racial identity measure was used to measure Black racial identity development in this study.

LGBQ Sexual Identity Development

Over the last several decades, several models of sexual identity development, and stages of coming out have been proposed (Bradford, 2004; Cass, 1979; Chapman & Brannock, 1987; Coleman, 1985; Fassinger & Miller, 1996; Minton & McDonald, 1984; Troiden, 1989; Weinberg, Williams & Pryor, 1994). In this study, sexual identity development is conceptualized as a dual process of *identity formation* (e.g., process of self-discovery, exploration, and awareness of one's emerging sexual orientation), and *identity integration (*e.g., acceptance and commitment to one's sexual identity and connecting to community) (Mohr & Fassinger, 2000; Rosario, Schrimshaw, & Hunter, 2008, 2011). Earlier models of sexual identity development were based on retrospective descriptions, from adults. These models suggested sexual identity formation is a developmental process that unfolds in sequential stages, rather than an evolving, and fluid multidimensional developmental process. Yet, recent research has started to recognize the importance of the fluid and changing nature of sexual identity over time and in different contexts. (Rosario et al., 2008). Few researchers have focused on sexual identity development

among racially or ethnically diverse LGBQ adolescents; this study fills an important gap by examining this construct in more detail with Black LGBQ youth and young adults.

Mental Health Outcomes

Depressive Symptoms

Family therapy is considered among the most effective and preferred treatments for child and adolescent depression (Diamond & Siqueland, 1995; Diamond, Reis, Diamond, Siqueland & Isaacs, 2002; Diamond et al., 2012; Shpigel, Diamond, & Diamond, 2012). Researchers have examined associations between parent-child attachment and depressive symptoms (Sund & Wichstrom, 2002), and between depression, depressive symptoms, and sexual minority status (Diamond et al., 2011; Lewis, Derlega, Griffin, & Krowinski, 2003; Marshal et al., 2011; Safren & Heimberg, 1999). Research examining the cause of increased depressive symptoms among LGBQ youth suggests youth tend to experience more fears of rejection, stigmatization, victimization, and/or humiliation by family and friends. Salient factors identified among LGBQ youth, as important contributors to the development of depressive symptoms include: 1) gay-related stress, 2) prejudice, 3) discrimination, 4) victimization, 5) internalized heterosexism and homonegativity, 6) perceived or actual rejection by family members upon coming out, and 7) remaining closeted or lack of disclosure of sexual identity.

Self-Esteem

Self-esteem is an important outcome variable to consider in this study, and was considered in the three theories that informed the development of this study (attachment, intersectionality, and multiple minority stress), as well as extant literature on racial and sexual identity development. Drawing from Attachment Theory (Bowlby, 1969/1982), the earliest development of self-esteem is associated with a healthier working model of self (Bowlby, 1973),

and one of the lasting negative outcomes of rejected children is lower self-esteem (Rohner et al., 2005, 2012). Prior research with Black populations (Constantine & Blackmon, 2002; Cross, 1991; Parham & Helms, 1985a, 1985b) reported that positive racial identity development, and family acceptance (secure attachment) are significantly associated with higher self-esteem, suggesting they are protective factors that help to prevent the development of depressive symptoms and suicidal ideation (Diamond et al., 2010; Ryan et al., 2010). Thus, self-esteem seems to have an important role in determining LGBQ youths' risks for increased mental health problems, and in this study is hypothesized to be mediated by family acceptance.

Purpose of Dissertation Study

Using Attachment Theory (Bowlby, 1969/1982), Intersectionality Theory (Crenshaw, 1989), and the Minority Stress Model (Meyer, 1995) as foundational frameworks, this cross-sectional, self-report online survey study was conducted to understand how Black LGBQ youths' and young adults' (ages 14-21) racial and sexual identity development are associated with each other and their depressive symptoms and self-esteem and whether these associations are mediated by youths' perceptions of parental acceptance and rejection.

This dissertation study addressed several gaps. Prior studies have examined LGBQ sexual identity development, parental acceptance/rejection, and symptoms of depression and self-esteem, however, very few Black LGBQ youth and their families have been included in these studies. This study addressed examined the experiences of Black LGBQ youth and young adults.

Second, this study examined youths' and young adults' perceptions of parental acceptance and rejection as a possible mediator between racial and sexual identity development and mental health outcomes as they are currently experiencing them. This is different from prior research which has relied more on adults' retrospective reports of childhood or adolescent

experiences. While most researchers have evaluated retrospective reports of childhood experiences, only the Family Acceptance Project (Ryan et al., 2009, 2010) has evaluated the role of parental acceptance and rejection as a mediator among these variables, but with a sample of Latino and White youth and their families living in California (FAP, 2012).

Third, few studies have used the PARTheory parental acceptance/rejection measure to evaluate mental health and well-being among LGBQ communities, and no researchers have used this measure with Black LGBQ samples of youth and young adults. In order to address this gap, the Parental Acceptance-Rejection Questionnaire – Child Short Form (PARQ-C; Rohner, 1984) was used to assess the relationships between youth and young adults and their mothers and fathers (or other primary caregivers).

Relevance to Couple and Family Therapy

Few CFT researchers have studied Black LGBQ youth. Furthermore, LGBQ youths' racial and sexual identity, as it relates to their perceptions of parental acceptance/ rejection, is a topic that has not been examined in the CFT field. It is important to address how these factors can affect Black LGBQ youth in the U.S. so the field can develop culturally relevant clinical interventions designed to facilitate healthier parent-child relationships and optimal clinical outcomes for LGBQ young people from diverse racial and ethnic backgrounds.

To summarize, this study addressed the following three gaps in the CFT literature: 1) examination of the experiences of Black LGBQ youth and young adults; 2) gathering prospective reports from Black LGBQ youth and young adults about current experiences, versus the more common retrospective reports from adults; and 3) understanding Black LGBQ perceptions of parental acceptance and rejection so culturally relevant interventions can be developed to

facilitate improved parent-child relationships. As Stone-Fish and Harvey (2005) have suggested, it is time for "family therapy transformed" (p. 41).

Self of the Researcher

As a Black, queer, cisgender, spiritual, now middle-class (but from a working class background), womanist/feminist scholar, I want to make my connection to this study clear – particularly regarding how my own intersecting, marginalized, and privileged identities have informed my personal beliefs throughout the various stages of conducting this research study (Alexander, 2003; Hardy & McGoldrick, 2008). I hold a special place in my heart for LGBTQ[1] youth, in general, but specifically for Black LGBTQ youth because of my own experiences, and understanding of the obstacles that are often presented to and experienced by them during adolescence – which will often continue, and maybe even intensify, through adulthood as a LGBTQ person of color. I believe that LGBTQ youth of color are among the most vulnerable populations in our society, who have historically been ignored, under-researched, and misrepresented. For example, being LGBTQ is not considered a minority status for most federal programs (although other inherent identities are such as race and disAbility status), and the health disparities among LGBTQ individuals and communities in the U.S. have only relatively recently gained the level of discourse and analysis that is necessary to appropriately begin to reduce them.

I have had a complicated experience with my own family of origin, as it relates to parental and family acceptance/rejection, and attachment to parents and primary caregivers. I am

[1] You will notice I use the acronym LGBTQ (referring to lesbian, gay, bisexual, trans*, and queer) in this section, as opposed to LGBQ (removing the T for transgender, gender-queer/variant/non-conforming) which is used throughout the rest of my dissertation. This is because trans* youth were not included as part of the sample (due to their unique experiences and the importance of not conflating sexual and gender identity) in this particular study, although I am referring to and addressing them and their experiences in this particular section.

the eldest daughter out of three siblings – a 21 year old brother, with whom I share a father; and a 15 year old sister, with whom I share a mother. My mother gave birth to me four days before her 16th birthday, and needless to say was ill-equipped to raise me on her own at that age. She was still in high school at the time, and living at home with her single mother in a household with two other siblings. I am unaware of the exact details, but there was some confusion regarding which of my grandparents would raise me, and because of my paternal grandmother's concerns about safety, I was raised by my paternal grandmother and (step) grandfather until my mom was established enough for me to move in with her. Although I did have an emotionally and physically "closer" relationship with my mother as an infant and toddler, it was not long before she left for college and our relationship changed. I recently went through an old photo album from my childhood, and counted numerous birthday and holiday cards from my mother in which she wrote "I'm so sorry I couldn't be there" or "Mommy wishes she was with you" or some other phrase recounting her desire, but inability to be physically with me. As an adult and as I think back retrospectively, I realize that this significantly influenced our attachment and relationship development. I did move in with her around age 11, at which time she was recently engaged and had stable employment, and we moved to Northern Virginia. I also moved with her because of increasing conflict with my grandmother – typical pre-teen developmental stage of defiance and attempts at establishing independence – and I thought that living with my mother *must* be better than continuing to live with my grandmother. It wasn't long after I moved that similar teenage developmental parent-child conflict begun with my mother. I believe that she and I clashed and disagreed so often because we are so similar and somewhat close in age, and because that bond and secure attachment was interrupted since my birth. Needless to say, throughout middle and high school, the similar feeling of "I can't wait to leave" emerged similar

to when I was finishing the 5th grade, living with my paternal grandmother and preparing to move with my mother. I think it was more or less typical adolescent independence and autonomy-seeking that characterized the last few years that I lived at home with my mother, but after I left for college a new barrier emerged between us.

My father and I have never had much of a relationship or connection to each other. He and my mother were never married, and at the time of my birth, he was serving in the military and was overseas. Thus, he was not present for my birth and did not see me for the first time until I was almost a year old. Our introduction to one another and failed attempt at "making up for lost time" has continued to be an experience that has shaped his participation (and my allowance of him) in my life. My father was also impaired by an alcohol addiction for much of my childhood, and though I lived with and was raised by his mother for about 11 years, I did not really "know" my father (nor did he really "know" me) or spend quality, sober time with him.

It was in the beginning of my sophomore year in college that I began dating my first girlfriend, but no one in my family found out until almost the end of that academic year, and not even through my own conscious decision. I was raised Baptist, Southern Baptist at that, with my paternal grandmother, and then was brought up in the African Methodist Episcopal once I moved with my mother. Both of these religious traditions are core denominations of the Black Church, and pretty religiously traditional and conservative. I had always dated boys when I was in high school, and when I came out at 18 while away at college, it was a shock to many in my family. My mother struggled the most with my "coming out" because she "just didn't agree, understand, it was against her religious beliefs, I was being manipulated by a White girl, I was too pretty for that, or I was experimenting or going through a phase." These are just a few of the many points

of denial or rationalizations that she came up with early on as she was trying to make sense of me and what I was going through, and going through her own process.

I am not surprised that my father and I have not, and do not speak explicitly about my queer identity, or my relationships. I also acknowledge that I am and always have been less concerned about gaining his acceptance or validation than I was of gaining my mothers' and grandparents' acceptance and validation. The closest that he has come to being direct about my identity and relationships are to say that, "he loves and supports me in whatever makes me happy." By the time he met my first girlfriend, I had already progressed to a place of no longer feeling the need to "come out," as I told myself that heterosexual people do not have to come out, declare, or announce their sexual identities to anyone, so neither do I. In addition to my mother and before I had reached that place of resolve, I did "come out" to my paternal grandmother and to my maternal grandmother, because I wanted them to understand that my girlfriend was not my "friend" and that they should treat her and ask about her in the same way they treated and asked about my previous boyfriend that I dated for three years during high school. I was then, and continue to be, the most surprised by both of my grandparents' reactions, which I can only describe as *whatever* or *nonchalant,* when I told them. I expected them to have the most difficulty with having a queer (then lesbian) granddaughter because they are the two most religious members of my family, and the ones that tried to keep both sides of my family grounded in the Baptist faith tradition. Perhaps, because I am not their child or because of their age and life experiences, my grandparents were able to express unconditional acceptance faster than my mother did.

My first relationship with a woman lasted for five years, and what made it even "worse" (according to some members of my family) was that she was a White woman. It was not until

about three years in that my mother would allow my girlfriend to visit home with me. I could go on with stories of my mother's rejection both verbally and nonverbally, covertly and overtly, but the comment that stands out most to me was made during my first graduate program, during which time my girlfriend and I had been together for four years and were living together. During one of the few long, intense conversations about her acceptance process, my mother said to me that "she wants to know about my life, just not that part" or something to that effect. I remember feeling in that moment that partial acceptance was not good enough, partial acceptance did not exist to me – it was either all or nothing. Either you accept all of me in my complexity, or you do not, because I could not and would not be split into parts for you to decide which identities you will "tolerate," and which you will reject. I have now reached somewhat of a different understanding of parental and family processes regarding coming to terms with having an LGBTQ child, and I am better equipped to hold nuance and complexity, as well as to show more patience than before. My personal experiences with this topic illustrate the importance of this work to me, and my passion about issues of race, class, sexual identity, religion/spirituality, and culture as a whole.

I recognize that my personal connection, and both my marginalized and privileged identities related to this dissertation study, may pose a limitation because of possible researcher biases (Alexander, 2003). If unacknowledged and ignored, this could lead me to report skewed results and draw erroneous conclusions. For example, my bias towards "healthy family functioning," narrowly defined in attachment terminology as being securely attached, may inadvertently lead me to misunderstand the function of attachment in a family that is not as close, or miss how they are securely attached differently than what I might consider healthy. As a clinician, researcher and human being, I am always striving to remain curious about and discuss

my personal biases, in order to expand my understanding of those who may first appear to be similar to or different from me. I prefer to make the implicit explicit, and am reflective and reflexive in all of the work that I do, in an attempt to make it less likely that my personal biases will obscure others' experiences. Throughout this dissertation study, I remained grounded and in touch with my own personal beliefs and experiences, while at the same time trying not to allow them to interfere with what the participants and the data were telling me about their beliefs and experiences, as well as about the research findings. My dissertation chair (M. Davey) helped me to keep my personal biases in check also by having ongoing consultations throughout the process to ensure that the voices of the participants were heard and documented in this study. I also journaled occasionally in order to remain curious and reflexive about feelings and thoughts that were coming up for me throughout the process, and those that were or were not based in the actual results and interpretations of the study.

CHAPTER TWO

LITERATURE REVIEW

Theoretical Frameworks

Attachment Theory (Bowlby, 1969/1982), Intersectionality Theory (Crenshaw, 1989), and the Minority Stress Model (Meyer, 1995) provided the theoretical foundations for this web-based, cross-sectional, self-report survey study. Attachment theory emphasizes the importance of close parent-child affectional bonds to help maintain a sense of safety and security from childhood through adulthood. Attachment theory also focuses on the importance of parents being emotionally and physically accessible and responsive, which is especially important for youth in the earlier stages of understanding and embracing a marginalized sexual identity (Bowlby, 1969/1982; Johnson, 2003; Mohr & Fassinger, 2003). The theory of intersectionality (Crenshaw, 1989) focuses on navigating multiple identities and holding positions of both subjugation and privilege. Intersectionality helps to explain and evaluate the lived experiences of individuals who have multiple minority or oppressed statuses, like Black LGBQ youth (e.g., sexual identity and racial identity) (Crenshaw, 1991; Dhamoon, 2011; hooks, 1981). Finally, the model of (multiple) minority stress (Bowleg et al., 2003; Meyer, 1995) builds on intersectionality theory and provides a larger context for understanding how mental health outcomes are affected (and lead to greater health disparities) among individuals who are multi-stressed because of their multiple minority or oppressed statuses (Meyer, 2003, 2010). Separately, these theories do not fully explain the experiences of Black LGBQ youth and their families, but together they provide a more contextually sensitive understanding of Black LGBQ youth who are often disenfranchised in our society (Meyer, 2010).

Attachment Theory

Attachment theory (Bowlby, 1969) provides the overarching conceptual framework for this study, examining parental acceptance and rejection as it relates to the coming out process among Black LGBQ youth. Attachment theory describes the importance of accessibility and responsiveness between children and adolescents, and their primary caregivers, which has been linked to better social and emotional adjustment among children at any age (Bowlby, 1969/1982; Diamond, Diamond & Hogue, 2007; Diamond, Diamond, Levy, Closs, Ladipo & Siqueland, 2012; Mohr & Fassinger, 2003, Moran, Diamond & Diamond, 2005). The developmental period of adolescence is a sensitive time for any young person, however, as a person of color *and* a LGBQ individual, experiencing parental acceptance and a secure parent-child attachment may be even more important. Mallon (1999) notes, "given the stigmatizing status that [an LGBQ identity] still holds for many in society, the family is one place where a gay or lesbian young person most needs to feel safe… [as] most gay and lesbian young people hope that their family, those who know them best, will see that they are the same persons they've always been (p. 70). Furthermore, Mohr and Fassinger (2003) reported that "the coming out process involves circumstances that are presumed to activate the attachment system [therefore] individuals' ability to effectively cope with manifestations of antigay prejudice and internalized homonegativity may be closely related to their level of attachment security" (p. 483). Next, the basic tenets of attachment theory are reviewed.

While links between attachment theory and family systems theory have emerged in the last few decades (Akister & Reibstein, 2004; Crittenden & Dallos, 2009; Hill, Fonagy, Safier, & Sargent, 2003; Liddle & Schwartz, 2002), Bowlby's theory of attachment (1969/1982, 1973) assumes infants develop cognitive representations (internal schemas), conscious and

unconscious, based on their very early experiences with mothers or primary caregivers. Strongly influenced by Piaget's (1954) theory of cognitive development and adaptive behavior, Bowlby (1973) suggested internal cognitive representations of the self in relation to attachment figures are a natural consequence of human behavior. Bowlby coined the term, *internal working model*, which describes how children create internal cognitive maps, representations, schemas, or scripts about themselves and their environment based on interactions with parents, caregivers, and significant others (Marrone, 1998). According to Bowlby (1969, 1973), infants' experiences with primary caregivers form the basis for internal working models of the self in relation to others. Internal working models of the self are important because they demonstrate to the infant/child how acceptable or unacceptable he or she is in the eyes of his or her primary attachment figures (Bowlby, 1973), leading to the first development of self-esteem. For example, a child who experiences attachment figures as unresponsive and dismissive is likely to develop an internal working model that mirrors these experiences (Bretherton, 1990; Marrone, 1998), resulting in lower self-esteem. In this example, the internal working model represents the self as undeserving or unacceptable.

Central Tenets of Attachment Theory

The central tenets of attachment theory are that: 1) attachment is an innate motivating force, 2) secure dependence complements autonomy, 3) attachment offers a safe haven, 4) attachment offers a secure base, 5) accessibility and responsiveness builds bonds, 6) fear and uncertainty activate attachment needs, 7) the process of separation distress is predictable, 8) a finite number of insecure forms of engagement can be identified, 9) attachment involves working models of self and other, and 10) isolation and loss are inherently traumatizing. (Bowlby, 1980, 1988; Johnson, 2003). These ten tenets of attachment theory informed this study by describing

the importance of parent-child attachment overall (parental acceptance and rejection as a hypothesized mediator), but in particular for racially and sexually marginalized youth during the often difficult period of coming out during adolescence and young adulthood.

Some of the key features of Bowlby's (1969/1982, 1973, 1980) theory of attachment are that attachment is a *reciprocal process* in which a parent/caregiver and his or her child work toward developing a secure bond. The critical period of attachment is between six and twenty four months, when it is crucial for a baby to bond with a primary caregiver. When a child is separated from his or her mother during infancy, Bowlby suggests serious developmental impairment can occur, which he referred to as *maternal deprivation*. *Monotropy* describes how babies tend to form one strong attachment, usually to the mother or primary caregiver, and is believed to occur during the first year of life. Thus, secure attachment to a primary caregiver is essential for positive future social, emotional, and intellectual development, and if this attachment is ruptured after it is formed, it can lead to negative development outcomes (e.g,. failure to thrive, insecure attachment style).

Quality of Attachment and Attachment Styles

Mary Ainsworth and her colleagues (1978) introduced the concept of different attachment styles, characterized as *secure, insecure, avoidant, ambivalent, or disorganized* (later a term coined by Main and Solomon, 1986). Ainsworth, Blehar, Waters, and Wall's (1978) groundbreaking study, the "Strange Situation," further advanced Bowlby's original work on attachment. In the "Strange Situation" experiment, researchers observed and videotaped twelve and eighteen month old infants as they responded to a brief period of separation from their primary caregivers and were then reunited with their mothers or primary caregivers. The

observational coding of the children's responses led to what we now refer to as the major styles of attachment.

Initially described as *secure*, *ambivalent-insecure*, and *avoidant-insecure*, there have been several iterations of attachment styles since Ainsworth et al.'s (1978) seminal study. Main and Solomon (1986) later added a fourth style*, disorganized-insecure* attachment. Since that time, several have supported Ainsworth's (1986) and Main and Solomon's (1986) attachment style classifications, suggesting attachment styles have a significant impact on behaviors and relationships later in life (Allen, Moore, Kuperminc, & Bell, 1998; Cooper, Shaver, & Collins, 1998; Kenny & Sirin, 2006; Kerns & Stevens, 1996; Lessard & Moreti, 1998; Nada-Raja, McGee, & Stanton, 1992; Papini & Roggman, 1992; Paterson, Pryor, & Field, 1995). This dissertation study focuses on the following attachment styles, described in further detail below: 1) *secure, 2) avoidant, 3) ambivalent/anxious,* and 4) *disorganized*.

Children who are *securely* attached are able to separate from their parent/caregiver because they have a secure base to return to, seek comfort from their parent when frightened, express positive emotion when their parent returns, and tend to prefer their parent over a stranger (Byng-Hall, 2008; Cooper et al., 1998). As adults, securely attached children know how to develop trusting and lasting close relationships, tend to have better self-esteem, are more empathetic toward others, are comfortable emotionally expressing themselves to others, and are able to seek social support when needed (Byng-Hall, 2008). In contrast, children with *avoidant* attachment styles tend to avoid parents/caregivers, are unable to seek comfort or contact from parents, and show little to no preference between their parent and a stranger (Byng-Hall, 2008; Cooper et al., 1998). Children who have *avoidant* attachment styles tend to develop into adults who have difficulty with intimacy and maintaining close relationships. As adults, they often

avoid close emotional connections, tend to not express much emotional investment, may be unable to support partners during stressful events, and often experience little to no distress upon ending a close relationship (Byng-Hall, 2008).

Characteristics of children who are *ambivalently or anxiously* attached include: 1) having an extreme suspicion of strangers, 2) exhibiting a considerable amount of stress when away from their parent and 3) not being easily reassured or affected upon their parent's return. An *ambivalently* or *anxiously* attached child could outwardly reject his or her parent at first by refusing comfort, or be aggressive toward his or her parent. As young adults, children with this attachment style tends to be overly clingy or dependent on others (peers or adults), and as adults are often reluctant to become close to others, and worries when his or her partner does not reciprocate feelings (Byng-Hall, 2008; Cooper et al., 1998).

Characteristics of children with *disorganized* attachment styles include vacillating between avoidant and resistant attachment behaviors, and exhibiting behaviors suggesting that the child is dazed, confused or apprehensive toward his or her parent/caregiver (Byng-Hall, 2008; Cooper et al., 1998). Main and Solomon (1986) suggested inconsistent and ambivalent behavior from parents may be one of the main factors that lead children to develop an *insecure* attachment style. Main and Hesse (1990) later reported parents who tend to elicit both fear and reassurance (or other contradictory behaviors) in their children, do contribute to the development of a *disorganized-insecure* attachment style, because confusion results from children who are both afraid of *and* comforted by the same person.

Ambivalent/anxious, avoidant, and disorganized attachment styles are described as *insecure* attachment styles. In contrast to secure attachment, these styles do not foster a sense of protection, support, and a secure base. An *insecurely* attached child generally has difficulty

exploring the larger world, and consequently will have difficulty developing close relationships with others when those relationships require trust, friendliness, and sharing or taking turns. Children with *insecure* attachments to their primary caregivers also tend to be at a developmental disadvantage. There is some evidence that parents of children classified as insecure or disorganized tend to experience negative effects or undesirable outcomes (Minde, Minde & Vogel, 2006). For example, insecure mother-child attachment patterns have been associated with maternal depression and anxiety (Carlson et al., 1989; Minde et al., 2006; Easterbrooks, Biesecker, & Lyons-Ruth, 2000). Additionally, parents with insecure attachment styles tend to be more troubled or abusive (Belsky & Cassidy, 1994). Thus, an *insecurely* attached parent may react to his or her child's difficulties with a mixture of adaptive, caring responses and withdrawing, blaming, angry, or disparaging responses.

Parent-Adolescent Attachment

Bowlby (1980) reported attachment is necessary for the promotion of survival through safe, emotionally connected relationships and by providing a secure base from which children can more securely explore the world. Infants, children, adolescents, and adults with more secure attachments to their primary caregivers tend to explore the world more confidently, and are less anxious and vulnerable to negative mental health outcomes (Bowlby, 1980; Kobak, Cole, Ferenz-Gillies, Fleming & Gamble, 1993). Prior research suggests that what one learns or experiences during this early attachment period continues to shape an individual's internal working model as they move through adolescence and adulthood (Armsden & Greenberg, 1987). Consequently early parent-child attachments and the quality of interactions with primary caregivers influence the construction and maintenance of positive emotional and social development over time. Moreover, when considering the experiences of Black LGBQ youth,

primary caregivers impact how they see themselves, and how they will relate to others as they navigate the coming out process during adolescence and young adulthood.

The period of adolescence is one in which parent-child relationships undergo frequent and important transitions, such as a decrease in the amount of time spent with each other, and a gradual shift in parental roles from dependency to mutual reciprocity (Freeman & Brown, 2001; Hilburn-Cobb, 1996; Larson, Richards, Moneta, & Holmbeck, 1996). According to the International Children and Youth Care Network (2006) website, "adolescents benefit from parental support that encourages the development of autonomy development, yet ensures continued monitoring and emotional connectedness" (no pp.). Specific parenting skills that promote more secure attachments and autonomy during adolescence include psychological availability, active listening, warmth, behavior monitoring, limit setting, negotiating rules and responsibilities, and acceptance of individuality (Allen & Hauser, 1996; Allen et al., 1998; Karavasalis, Doyle & Margolese, 1999). Parental support during stressful developmental transitions (e.g., entry to high school; coming out as LGBQ) is associated with more positive adolescent adjustment and mental health outcomes. Positive social adjustment, as it relates to secure attachment during adolescence, is associated with fewer mental health problems, including depression, anxiety, and insecurity; less likelihood of engaging in substance abuse, antisocial and aggressive behaviors, and risky sexual activity; and better ability to manage transitions successfully, and enjoy positive relationships with friends and family (Cooper et al., 1998; Kerns & Stevens, 1996; Nada-Raja et al., 1992; Papini & Roggman, 1992; Paterson et al., 1995).

The quality of attachment to parents/primary caregivers plays an important role in youths' behavioral and emotional responses to social and environmental challenges, including

typical developmental milestones (e.g., school transitions) and non-normative life events (e.g., abuse) (Muris, Meesters, & van den Berg, 2003; Parade, Leerkes, & Blankson, 2010). A positive and secure attachment between an adolescent and his or her primary caregiver provides a secure base from which youth can explore his or her evolving identities, new situations, and environments independently while maintaining safety and support (Ainsworth et al., 1978). Conversely, a lack of trust or support from an unresponsive primary caregiver is a risk factor for future developmental challenges among adolescents (Papini & Roggman, 1992). We know that severe depression is a strong predictor for suicidal ideation, so addressing underlying parent-child attachment ruptures is especially important for LGBQ youth who are already at higher risk.

In addition to attachment in childhood and throughout young adulthood, other major identity development occurs during adolescence (Lee & Wicker, 1997; Meeus, 2011). Erik Erikson's (1950, 1968) theory of human development suggests during adolescence, individuals are typically negotiating the fifth developmental stage, *identity vs. identity confusion*. For Black LGBQ youth, *identity vs. identity confusion* is likely even more complicated because they have to examine not just their adolescent identity, but also their sexual and racial identities. Erikson (1968) noted the fifth stage of identity development, *identity vs. identity confusion,* is often a period of exploration when adolescents are figuring out who they are, what they are about, and where they are going in life. One of the main ways this is accomplished is through relationships with others (Stone-Fish & Harvey, 2005). If parents or caregivers do not accept a particular identity (e.g., sexual identity) their children are exploring, it may become internalized as a negative internal working model. Especially during adolescence, there is a greater potential for disrupting the developmental processes, which can lead to negative mental health outcomes, such as depressive symptoms and low self-esteem.

Closs (2010) reported autonomy is essential for healthy adolescent development, but is informed by White, heterosexual, Euro-American values. Different racial and ethnic groups who value interdependence or who do not have privileged status in the U.S. may have different beliefs about an adolescent's healthy transition into adulthood (Closs, 2010). As a coping mechanism in response to societal discrimination, Black LGBQ youth may maintain closer ties to their families of origin and communities to cope with prejudice and oppression (Closs, 2010). As described below, this can present a unique challenge for Black youth who are LGBQ when their communities reject them. Central to Bowlby's (1973) theory of attachment is the premise that the attachment system is triggered during times of real or perceived threat and anxiety. This felt or perceived threat triggers behaviors that encourage physical closeness to the primary attachment figure(s). Proximity seeking in times of perceived threat has important implications for LGBQ youth whose identities, friendships, and relationships are often the target of heterosexism, heteronormativity, and other forms of discrimination and sometimes in their own homes (Closs, 2010). When adolescents are not accepted in their own homes, it can become increasingly difficult to develop or maintain a secure attachment with their parents and primary caregivers (and thus, to learn how to develop secure attachments with others).

Intersectionality Theory

The second theory, Intersectionality, describes how multiple forms of oppression can affect individuals, couples, and families; limit access to resources; hinder the ability to form and maintain healthy relationships; and render them voiceless in policies and society at large, and also in research and theoretical literature (Anderson & McCormack, 2010; Brooks et al., 2009; Dhamoon, 2011; Diamond & Butterworth, 2008; Trahan, 2011; Walby, 2007; Yuval-Davis, 2006). Prior to discussions about intersectionality, "social categories such as race/ethnicity,

gender, and sexual orientation [were] often treated singly as if they operated independent of one another; for a large part, separate theories and bodies of research addressed racial identity, gendered identities, and sexual identity, as well as racism, sexism, and heterosexism" (Brooks, et al., 2009, p. 41), and oftentimes left people of color at the margins of racial, gender, and sexual identity groups. Intersectionality has been conceptualized in many different ways, but all with similar themes and assumptions. Crenshaw (1991) defined Intersectionality as, "the various ways in which race and gender interact to shape multiple dimensions of [individuals'] experiences" (p. 1244). Collins (2000) refers to it as "particular forms of intersecting oppressions… that work together to produce injustice" (p. 18), and McCall (2005) describes it as "the relationship among multiple dimensions and modalities of social relations and subject formations" (p. 1771).

Although intersectionality has been described in earlier seminal works (see Davis, 1981; hooks, 1981; Loewenberg & Bogin, 1976; Lorde, 1984), the term was coined in the late 1980s by Kimberlé Crenshaw as a critique of the mainstream feminist movement that largely excluded Black women's experiences from the dominant discourses on feminism, and implied that there was only one lived experience of women. In her classic book *Ain't I a Woman: Black Women and Feminism*, bell hooks (1981) deconstructed race, class, and gender typologies and paved the way for the emergence of intersectionality as a theory. Crenshaw (1989, 1991), Collins (2000) and McCall (2005), and other intersectionality theorists have argued that "the custom of theorizing and researching race, class, gender [and sexual orientation] as independent constructs that exert independent influences on outcome variables is not grounded in reality" (Trahan, 2011, p. 1). Moreover, the belief that we can measure the experience and extent of disadvantages and disparities in health, education, and career, for example, by simply adding up the effects of individual experiences of discrimination is challenged by intersectionality theorists. Instead,

"discrimination is far more multifaceted and diffuse than the simple arithmetic concept assumes" (Trahan, 2011, p. 2) and hybrid forms of oppression include a mix of structural and contextual components that result in qualitatively different realities and subjective experiences for individuals (Diamond & Butterworth, 2008; McCall, 2005).

The central tenets of Intersectionality Theory are: 1) forms of oppression can intensify when combined; 2) there are many types of oppression that structure an individual's evolving identity; and 3) these oppressive forces are mutually reinforcing (Anderson & McCormack, 2010). Intersectionality encourages a closer consideration of how certain identities are located within a *matrix of domination*, that is constructed at the intersections of social positions of privilege and subjugation (Collins, 2000) and are "unique, non-additive, and not reducible to the original identities that went into them" (Diamond & Butterworth, 2008, p. 366). Furthermore, viewing race, gender, class, sexual orientation, or any one social location, as an independent construct implies that individuals are either *pure oppressors* or *pure victims* (Collins, 2000, 2004), when in reality all people occupy places of subjugation and places of privilege simultaneously (Andersen and Collins, 2004, Burgess-Proctor, 2006; Collins, 2000, Daly and Stephens, 1995). Whether or not they recognize and take ownership of them (especially their privileged identities) is a different story.

There is a significant body of theoretical literature and research that suggests oppression tends to intensify when combined and individuals with intersecting marginalized identities often contend with multiple *systems of inequality* simultaneously (Anderson & McCormack, 2010; Harper, Jernewall & Zea, 2004; Trahan, 2011). Anderson and McCormack (2010) reported that "the bifurcation of Black and gay identities is strengthened by cultural [mis-]understandings of psychological models of [LGBQ] development, which seem to maintain that [same-sex

attraction] is 'a problem' for Whites only" (p. 950). Many LGB people of color report feeling pressured to choose between being LGB and being a member of their racial/ethnic group (Bonilla & Porter, 1990; Herek & Capitanio, 1995; Moore, 2011; Morales, 1989, 1990; Washington, 2001) because it has been suggested that these are identities that are in direct conflict with one another. Models, such as racial/ethnic identity formation models and sexual identity formation models, have previously described experiences of identity from an individual or conflicting standpoint, consequently discounting the experiences that are created at the intersections or when integration is attempted and achieved.

Another premise of intersectionality describes how several types of oppression play an important role in structuring an individual's evolving identity. Harper et al. (2004) states that "the interplay between oppressed and privileged statuses related to gender, race/ethnicity, social class, and sexual orientation has been shown to have differential effects on an individual depending on the composition and visibility of their oppressed and privileged statuses" (p. 190). Prior research has demonstrated the chronic and long-term psychological effects of sexual identity-based and race-based oppression, for example, social isolation/loneliness, low self-esteem, demoralization, guilt, suicide, and overall higher rates of psychiatric disorders (Diaz, Ayala, Bein, Henne, & Marin, 2001; Harper et al., 2004; Mays & Cochran, 2001; Meyer, 1995; Moore, 2011).

Yuval-Davis (2006) suggested identities are individual and collective lived answers to the question, "who am/are I/we?" However, our attempts to restrict and define identities in a comprehensive way may exacerbate the oppression of those who have multiple, intersecting and subjugated identities. The emotional and psychological benefits of developing a holistic and positive sense of self, specifically for LGBQ individuals, individuals of color, and LGBQ people

of color, have been well established. For LGBQ people of color, reaching an optimal level of identity integration can result in healthier functioning and improved well-being, as evidenced by higher levels of self-esteem, stronger social support networks, greater levels of life satisfaction, and lower levels of psychosocial distress (Crawford, Allison, Zamboni, & Soto 2002).

From an intersectionality perspective, we also understand oppressive forces and discrimination to be mutually reinforcing, particularly for LGBQ youth. One of the primary ways that heterosexism and racism affect LGBQ people's health and functioning is through acts of violence, which may be especially detrimental for LGBQ youth, as they are often subjected to bullying, harassment, and physical abuse in various settings including their neighborhoods, schools, and even homes (Harper et al., 2004; Ryan, Huebner, Diaz, & Sanchez, 2009). These types of victimization can take the form of overt and outwardly aggressive acts of violence, or more covert, insidious microaggressive acts of violence. Any form of victimization may have extremely detrimental effects on an individual's emotional and psychological wellbeing. Central to our beliefs about healthy adolescent development is having a family system in which one feels safe, loved, supported and nurtured. An early lesson for all children is learning which behaviors will be accepted and reinforced, and which behaviors will be rejected and punished. Children then become adolescents who have learned which behaviors (and identities) will be accepted, and those that will not, therefore, they have are socialized to only express the parts of themselves that will gain acceptance from others (Ecklund, 2012). We know that issues of race/ethnicity, culture, gender, sexual orientation, and faith practices are understood and developed within the context of the family, and using a systemic framework, family is considered a single unit with its own identity, one that also becomes separate from an individual's self-identity.

Ecklund (2012) suggests that intersectionality should be considered both an individual and family construct while working with children and adolescents, as a young person may have multiple intersecting identities, and family members each represent the intersectionality of identity within the larger family system. "Family members' intersecting identities result in a complex web of intersectionality that impacts family relationships and functioning… as a [youths'] various cultural identities, developmental status, identity salience, and valence (evaluative features of identity tied to self-validation) are prevalent and intersect with those of other family members, conflict may erupt" (Ecklund, 2012, p. 260). The intersecting identities of interest in this dissertation study were race, class, gender, sexual orientation, and religion. Intersectionality theory provides a framework to help us understand how Black families make sense of their race, ethnicity, and religious affiliation, and how it can influence the coming out process for a LGBQ young person in the family. This theory provides an additional conceptual understanding, beyond what attachment theory offers, to more fully describe the struggles of Black LGBQ youth and the processes that (presumably) Black parents and family members may navigate while coming to terms with a LGBQ young person in the family. Intersectionality theory, however, does not fully describe the emotional and psychological effects of possessing multiple, intersecting, marginalized identities, therefore, the theory of (multiple) minority stress also informs this dissertation study.

Minority Stress Model

The third and final theoretical model provides a conceptual framework for understanding mental health disparities among individuals who are considered "minorities" by mainstream society, and who often experience higher levels of social stress (Meyer, 2003, 2010). The term *minority* continues to be criticized (Goldmann, 2001; Wilkinson, 2002) because of its pejorative

connotation and how it tends to place individuals in a "less than" or otherwise disenfranchised position. Further, it obscures the felt impact of racial, gender, and other forms of discrimination by shifting the focus onto particular groups rather than on systemic oppression – the true culprit. In this study, the term *minority* was only used when referring to this model and describes social locations that create barriers for individuals, and that prevent them from being treated with dignity and respect, having equal access to services and spaces, and feeling safe in their relationships and communities. Such minority statuses include: racial (non-White[2]), gender (non-male[1]), sexual (non-heterosexual[1]), socioeconomic status (non-middle/upper class[1]), and religious (atheist, agnostic or otherwise non-Christian[1]).

Stress refers to physical, mental, or emotional factors that can cause pressure, strain, or tension in the body or mind (MedicineNet, 2013; Merriam-Webster, 2012). Ilan Meyer (1995), the founding theorist of the minority stress model, defines minority stress as "psychosocial stress derived from minority status [that resides at] the juxtaposition of minority and dominant values and the resultant conflict with the social environment experienced by minority group members" (p. 38-39), while Bowleg and colleagues describe multiple minority stress as experiences of sexism and heterosexism contextualized through the prism of racism (Bowleg et al., 2003). In the mental health literature, stressors have commonly been described as "events and conditions that cause change and that require an individual to adapt to a new situation or life circumstance" (Meyer, 2003, p. 675). Prior research suggests that prejudice and discrimination related to racism, sexism, and heterosexism can induce changes that require adaptation because they are experienced as stressful, and negatively affect mental health outcomes (Allison, 1998; Barnett,

[2] The terms non-White, non-male, non-heterosexual, non-middle class, and non-Christian are not used to center or substantiate these particular privileged identities. Instead, these terms are used to contextualize the minority communities that I am referring to, and analyzing in this study, in contrast to their majority counterparts.

Biener & Baruch, 1987; Bowleg et al., 2003 Brooks, 1981; Clark, Anderson, Clark & Williams, 1999; Cochran, 2001; DiPlacido, 1998; Meyer, 1995).

This program of research led to development of the earlier models of minority stress. Meyer's (1995) minority stress model specifically related to LGBQ individuals and was based on several sociological and psychological theories in an attempt to explain the adverse effect of social conditions (such as prejudice and stigma) on the lives of LGBQ individuals (Allport, 1954; Crocker, Major & Steele, 1998; Goffman, 1963; Link & Phelan, 2001). The minority stress model was developed as a framework for understanding how members of certain groups are at an increased risk for certain mental health difficulties because of their disadvantaged statuses, and associated chronic stress (Herek & Garnets, 2007). Meyer's (1995, 2003) research suggests that stigma, prejudice, and rejection create hostile and stressful environments that lead to mental health issues for sexual minority populations. Additionally, individuals who experience compounding stress and stigma may develop maladaptive coping mechanisms, which may resemble mental health symptoms referred to as "secondary deviance" (referring to the stage of deviant identity formation in which an individual internalizes the deviant identity by integrating it into their self-concept) (Lemert, 1967) or "traits due to victimization" (Allport, 1954).

The underlying assumptions of the minority stress model are that stress is: 1) unique and an addition to general stressors that are experienced by all people, which requires stigmatized people to develop adaptations above that required by others who are not stigmatized in the same way; 2) chronic, cumulative, and related to relatively stable underlying social and cultural structures; and 3) socially- or structurally-based, e.g. stemming from social processes, institutions, and structures beyond the individual (Meyer, 2003). Additionally, Meyer (2003) notes that the minority stress model relevant to LGBQ people involves three stress processes: 1)

external or objective stressful events and conditions; 2) the minority individuals' expectations of such events and the vigilance this expectation requires; and 3) the minority individuals' internalization of negative societal attitudes. In relation to the theory of intersectionality described above, it is important to be aware of the many ways that specific populations are stressed across and between their intersecting identities, and to understand the societal and structural reinforcements of those stressful situations that keep people in disadvantaged positions in society.

Adolescents constantly look for and receive implicit and explicit messages that help to shape their perceptions of themselves. Burke (1991) suggested that feedback from external sources that is incongruent with one's own self-identity may cause distress in the form of *identity interruptions*, which may be especially true for LGBQ (particularly Black LGBQ) adolescents. Additionally, since we know that individual's conceptions of self are associated with their psychological well-being, "stressors that damage or threaten self-concepts are likely to predict emotional problems" (Thoits, 1999, p. 346). Similar to intersectionality, the salience, valence, and level of integration with an individual's other identities may create an additional or different type of stress because "the more an individual identifies with, is committed to, or has highly developed self-schemas in a particular life domain, the greater will be the emotional impact of stressors that occur in that domain" (Thoits, 1999, p. 352). Many models of identity formation, whether it is racial/ethnic identity, sexual identity, gender identity, or any other, tend to view the minority identity as more prominent; whereby the primary task becomes to fully accept and integrate one's minority status with other majority identities. Yet, this research also encourages consideration, through multiple minority statuses and intersections of identity, of how one can live at the intersections, fully embracing one's whole, integrated, and total identity.

During the developmental stage of adolescence, youth are expected to navigate different tasks, many of which involve an understanding of self – self in relation to other, self in relation to family, self in relation to peers, and self in relation to society – while simultaneously incorporating characteristics of self as they relate to race/ethnicity, gender, sexual identity, gender identity, and religion/spirituality (Consolación, Russell & Sue, 2004; Harter, 1990). We also know that most youth recognize their sexual orientations, whether heterosexual or LGBQ, early in adolescence, because of puberty and an increase in desires and attractions during this developmental stage (Pilkington & D'Augelli, 1995). Diamond (2000) suggests, however, that because many adolescents who engage in same-sex sexual behavior or who experience attractions to individuals of the same sex do not identify as LGBQ, it is difficult to conduct research with LGBQ adolescents that relies on this type of self-identification, solely. While we know about the psychological impact of multiple minority identities and stress on adults, as well as mental health outcomes of adolescents who identify as LGBQ, much less is known about the implications of multiple minority identities and its consequential stress on adolescents (Consolación et al., 2004).

Research suggests that individuals can hold several, even seemingly conflicting identities while maintaining a coherent unified sense of self (McAdams, 1997; Moore, 2011; Singer, 2004). This assertion conflicts with theories about the difficulty that people of color have integrating their racial/ethnic and sexual identities. Meyer (2010) suggested that there is a "misconception about LGB[Q] people of color [concerning] the management of racial/ethnic versus LGB[Q] identities" (pg. 444), whereby views have historically presented a *clashing, warring, conflicting,* or *competing* perspective. Meyer advocates for Collins' (2005) description of developing a progressive Black sexual politics, requiring an examination of "how racism and

heterosexism mutually construct [and reinforce] one another" (p. 89). Frost and Meyer (2009) reported that many Black LGBQ people reject the notion of identity conflict, and are able to make sense of their identities in a way that admits to the stress of homophobia and heterosexism, especially in the Black Church, but differentiates between the external sources of stress and internal identity cohesiveness. For some individuals, they are clear that rejection from anyone or any group does not cause them to doubt any of their multiple identities.

Resilience as a Residual of Stress

It is difficult to talk about minority stress, particularly as it relates to Black communities, without considering resilience and the residuals of slavery in the United States. Meyer states that "the study of stress and resilience has been central to our theoretical understanding of the mental health and well-being of LGB[Q] individuals" (Meyer, 2003, p. 691). Resilience has been conceptualized in many different ways, and is often difficult to measure; however, in extant risk and resilience literature it is most often viewed as a protective factor. For the purposes of this dissertation study, resilience was conceptualized as *a process, capacity, or outcome of successful adaptation, despite challenges, rejection, or stressful circumstances* (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Masten, Best & Garmezy, 1990). Meyer (2010) describes the effects of resilience as being threefold: 1) it may be understood as a sense of mastery whereas resilient people may be less threatened and therefore perceive less stress compared to less resilient people; 2) it may serve as a protective factor by creating a buffer against stress because of the strengths that resilient people tend to have; and 3) it may be viewed as a resource, having a direct effect on mental and physical health outcomes regardless of stress exposure. Myers (1982) describes the idea *urban stress* with a six-component model that examines how race and social class impact stress in minority populations (as cited in Miller, 1999). Research has shown that

occupying multiple minority statuses can increase experiences with discrimination (Bowleg et al., 2003; Herek & Garnets, 2007). However, if one is successful at integrating their multiple identities and understanding the complexities of intersectionality, his or her overall psychological resilience may be enhanced and access to resources for coping with societal stigma may be more available (Bowleg et al., 2003; Crawford et al., 2002).

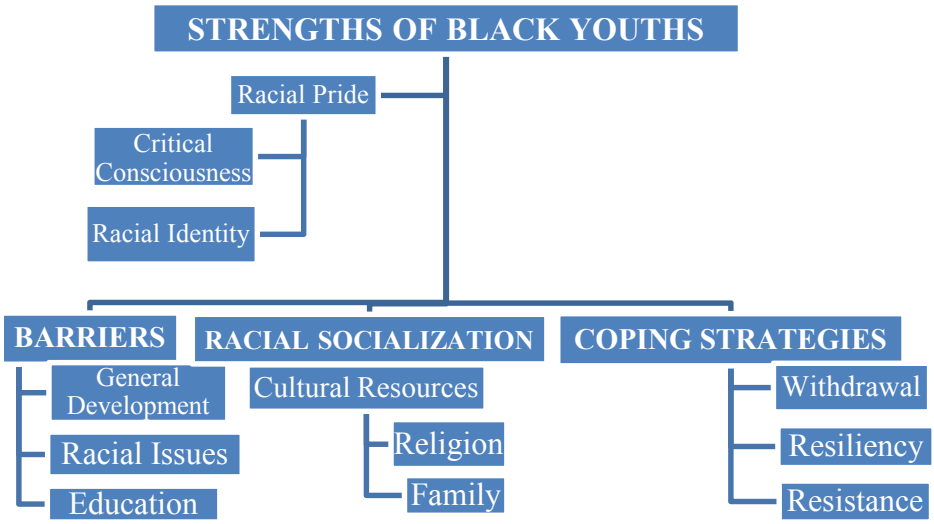
Black people and families have long been regarded as some of the most resilient (Bagley & Carroll, 1998; Brown, 2008; Denby, 1996; Greene, 1994; Hildreth, Boglin, & Mask, 2000; Hill, 1971, 1999; McAdoo, 1998; McCubbin & McCubbin, 1998; Meyer, 2003, 2010; Moradi et al., 2010; Nicolas et al., 2008) because of the persistence of African-centered traditions, beliefs, religions, and other practices among Black people despite attempts to subjugate and eradicate their racial and cultural identities in the U.S, principally through the transatlantic slave trade. Additionally, members of racial and ethnic minority groups often teach skills to their family members about how to thrive in the face of prejudice and discrimination (e.g., parental racial socialization), and how to cope with the stress that can be accompanied by racial and ethnic discrimination (Constantine & Blackmon, 2002; Evans et al., 2012; Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007; Hughes et al., 2006; McHale et al., 2006; Miller, 1999; Miller & MacIntosh, 1999; Neblett et al., 2008; Stevenson, 1995; Stevenson, Cameron, Herrero-Taylor, & Davis, 2002; Thomas & Speight, 1999).

Some researchers have used family stress and coping theory (Crosbie-Burnett, 1989) as a framework for understanding parental reactions, which suggests that family members' reactions to stressful experiences are contingent upon factors, such as: 1) the availability of family-based resources to manage the stress, 2) the meaning attached to the stressful event, and 3) the co-occurrence of multiple stressors, as they all influence parental reactions (Potoczniak et al., 2009;

Willoughby, Malik, & Lindahl, 2006; Willoughby et al., 2008). If we conceptualize a young person coming out as a stressful family event, then it would be useful to conceptualize the family's overall resilience, including the family-based resources, process of meaning-making, and ability to overcome previous family stressors in order to theorize a family's coping process and potential resilience. Other theories, specific to family therapy that could help families understand and accept an LGBQ child is Narrative Therapy (Long, Bonomo, Andrews, & Brown, 2006; Saltzburg, 2007) because of its focus on re-authoring stories; developing an empathic and supportive environment for people to gain access to other ways of knowing themselves, their families, and their lives to facilitate change; and its socio-political stance in recognizing power, privilege, and oppression in the world. Additionally, the power of family narratives used to socialize Black children to a world that discriminates against them due to their racial or ethnic group affiliation are just as important, effective, and relevant in socializing them to live in a world that will be hostile toward them due to their LGBQ sexual identity.

Black youth, in particular, develop strengths and resilience at the intra- and interpersonal and systemic levels (see Figure 1), and their strengths lie "in their abilities to analyze situations for race-related power imbalances and to negotiate the related challenges or barriers to optimal functioning from a position of pride in oneself, self-esteem, and affirmative self-agency throughout their development (Nicolas et al., 2008, p. 265). Many scholars and researchers believe that these same parenting practices may help parents of LGBQ youth learn how to deal with sexual identity-related discrimination, and improve their ability to cope with stress and develop resilience (Bowleg et al., 2003; Choi, Han, Paul, & Ayala, 2011; Ghavami, Fingerhut, Peplau, Grant, & Wittig, 2011; Herek & Garnets, 2007; LaSala & Frierson, 2012; Meyer, 2010).

Figure 1. A Strengths-Based Model for Black Youth



(Retrieved from Nicolas et al., 2008, p. 264)

Conclusion

The minority stress model (Meyer, 1995) suggests members of certain minority groups experience unique, chronic stressors which place them at an increased risk for some kinds of psychological or mental health difficulties. The minority statuses evaluated in this study were: racial (non-White), sexual (non-heterosexual), gender (non-male), socioeconomic status (non-middle class), and religious (atheist, agnostic or otherwise non-Christian). When an individual holds multiple minority statuses, the risk is exacerbated as he or she experiences compounding and oftentimes intersecting stressors that create unique problems, such is the case with Black LGBQ youth and young adults. Although the model of multiple minority stress is congruent with intersectionality, the theory of intersectionality focuses more explicitly on how oppression intensifies when multiple minority statuses exist within the same individual. Intersectionality also helps to augment our understanding of racial and sexual minority individuals' experiences, as they have historically been discussed and conceptualized separately. Many Black LGBQ

individuals have felt pressured to choose between their subjugated, seemingly conflicting identities, and to only align themselves with one or the other in certain situations or communities. Intersectionality allows for a way to discuss what happens at the intersections of these, and other, identity statuses.

This study attended to these multiple constructs and intersections of identities in the context of attachments between Black LGBQ youth and their parents or primary caregivers. A secure attachment, fostered through parental acceptance, has long been regarded as the ideal attachment style, associated with optimal development for children, the closest relationships between family members, and the best future relational and psychological functioning. Yet, because of the multiple stressors, intersecting identities, and rejection and discrimination described above, this level of attachment and acceptance is sometimes hard to obtain between LGBQ youth and their parent(s) or primary caregiver(s). Depending on how secure attachment is defined, this will likely look different for Black families in comparison to how middle-upper class White families develop secure attachments. The assumption guiding this study is that one way is not *better* or *healthier* than another, and should not be regarded as *preferable* or *right* in comparison to others. Attachment will vary in different cultures and communities.

LGBQ youth, in general, tend to report higher rates of depression, anxiety, self-injurious behavior, suicidal ideation and attempts, substance abuse and risky sexual behaviors (Ryan et al., 2009), and are disproportionately reflected in populations of homeless youth (Durso & Gates, 2012). We also know that there are different challenges White LGBQ youth face compared to Black and other LGBQ youth of color; that gay/bisexual/queer boys face compared to lesbian/bisexual/queer girls; that impoverished LGBQ youth face compared to LGBQ youth from affluent families; and that LGBQ youth from highly religious families face compared to

LGBQ youth from families who do not have or are not guided by a strong religious affiliation (Ryan et al., 2009, 2010). The primary purpose of this study was to better understand Black LGBQ youths' and young adults' racial and sexual identity development, and whether global and sexual identity specific parental acceptance/rejection mediates the association between racial and sexual identity and self-esteem and depressive symptoms.

Review of Prior Research

Next, I review several bodies of literature that have examined the following key constructs evaluated in this study: 1) parental and family acceptance and rejection; 2) Black racial identity development; 3) LGBQ sexual identity development; 4) mental health outcomes (depressive symptoms and self-esteem); and salient socio-demographic variables (age, gender, SES/class, religion/spirituality, among others).

Parental and Family Acceptance and Rejection

Parental acceptance of a young person's LGBQ sexual identity is associated with increased communication and emotional closeness, two main components of a secure parent-child attachment (Diamond et al., 2011; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). D'Augelli (2003) suggests that parental acceptance can buffer against the negative effects of LGBQ-related victimization in the U.S. These findings further suggest the need for more research that examines the quality of adolescent and parent/caregiver attachment, particularly for LGBQ youth. Yet, an often neglected but important consideration is the intersections of race and ethnicity, religious affiliation, SES/class, and other salient contextual variables. In this first section, I review family acceptance and family rejection and extant literature. In particular, I describe how parental and family acceptance and rejection are distinct constructs, summarize how prior research has focused more on negative experiences resulting from youth "coming out,"

and the lack of attention to parents' understanding, acceptance or rejection of their child, especially among Black families living in the U.S.

Responding to the dearth of literature that explicitly examined the associations between family reactions to their children's sexual orientation and subsequent health and mental health outcomes, Drs. Caitlin Ryan, Rafael Diaz, and a team of researchers at San Francisco State University conducted a seminal research study and intervention initiative known as the Family Acceptance Project (FAP). According to the FAP website:

> The Family Acceptance Project™ is the only community research, intervention, education and policy initiative that works to decrease major health and related risks for lesbian, gay, bisexual and transgender (LGBT) youth, such as suicide, substance abuse, HIV and homelessness – in the context of their families. We use a research-based, culturally grounded approach to help ethnically, socially and religiously diverse families decrease rejection and increase support for their LGBT children (FAP, 2012).

Since its development in 2002, the results from the initial FAP research has led to five peer reviewed publications, which are summarized below.

Family Rejection as a Predictor of Negative Health Outcomes in LGB Young Adults

The first publication, using the data from the FAP, explores the construct of family rejection as a predictor of health and mental health problems in a sample of LGBT young adults (Ryan, Huebner, Diaz & Sanchez, 2009). The original study utilized a participatory research design, involving the population of interest at all stages, and included a sample of 245 lesbian, gay, and bisexual, and transgender non-Latino White, and Latino young adults, ages 21 to 25 years old (however, only 224 outcomes were reported because only 21 of the participants identified as transgender). This retrospective self-report study required that the young person had

previously come out as LGB to at least one parent, guardian, or caregiver during adolescence (defined as between the ages of 13-19).

The construct, family rejection, was measured using a previously developed 51-item self-report assessment (the measure was developed based on an in-depth qualitative study with LGB youth). The researchers developed this self-report measure to assess the "presence and frequency of each rejecting parental or caregiver reaction to participants' sexual identity and gender expression when they were teenagers, creating at least three close-ended items for each type of outwardly observable rejection reaction documented in transcripts" (Ryan et al., 2009, p. 347). Dichotomized scores were summed up to create a total *family rejection score*, based on the young adults' recollection of their treatment during adolescence by family parents, guardians, or caregivers when they came out during adolescence. Based on the family rejection score, the sample was further divided into three subgroups: 1) low rejection, 2) moderate rejection, and 3) high rejection.

Several outcomes were measured in this study, including: 1) current depression, 2) suicidal ideation and lifetime suicide attempts, 3) substance use assessed as heavy alcohol intake in the past six months, 4) use of illicit drugs in the past six months and substance-use related problems in the past five years and abuse, and 5) sexual risk which was assessed by number, gender, and type of sexual partners in the past six months, type of sexual activity, and whether or not protection was used during sexual acts involving penetration (Ryan et al., 2009). The Center for Epidemiologic Studies Depression scale (CES-D) was the only standardized reliable and valid measure used to study levels of current depressive symptoms, while all other outcomes were measured by self-report questions that were developed by the researchers specifically for this study. The researchers reported the following results: 1) high rates of depression, suicidal

ideation and attempts, substance use, and sexual health risks; 2) lower levels of family rejection for non-Latino White women, and higher levels of family rejection for Latino men, as well as men reporting more rejecting reactions than women; and 3) greater experiences of family rejection correlated with poorer health outcomes in all but two of the nine outcomes measured. Specifically, "LGB young adults who retrospectively reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report illegal drug use, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers from families with no or low levels of family rejection" (Ryan et al., 2009, p. 349).

Family Acceptance in Adolescence and the Health of LGBT Young Adults

Data from this same retrospective, participatory research study was analyzed in a second published article; however, the primary focus was on the construct, family acceptance (Ryan et al., 2010). The focus of this paper described the dearth of research that has examined the role of the parent-adolescent relationship for LGB youth and how few researchers have examined the quality of family relationships among transgender youth. Ryan et al. (2010) maintains that "the role of family acceptance as a protective factor for LGBT adolescents and young adults has not been established" (p. 205), therefore, this study describes the associations between family acceptance and affirmation of LGBT youth, as well as positive adjustment and decreased mental and behavioral health risks in youth adulthood.

The construct of family acceptance was measured using the previously developed 55-item self-report measure (also developed based on a prior in-depth qualitative study) designed to assess for the presence and frequency of positive experiences from a parent, guardian, or primary caregiver. Each participant was asked to provide retrospective narrative accounts of experiences

in their families related to "gender identity and expression, sexual orientation, cultural and religious beliefs, family, school and community life, and sources of support" (Ryan et al., 2010, p. 207), and recall instances in which a parent, guardian, or caregiver showed support, affirmation, or acceptance of the young person's LGBT identity. Dichotomized scores were again summed up to create a total *family acceptance score*, based on the young adults' recollection of their treatment by family parents, guardians, or caregivers when they came out. Based on the family acceptance scores, the sample was again divided into three subgroups: 1) low acceptance, 2) moderate acceptance, and 3) high acceptance.

The specific outcomes described in this second paper included: self-esteem, social support, general health, depression, substance abuse, sexual risk, and suicidal ideation and attempts (Ryan et al., 2010). The three indicators of positive adjustment and health (e.g., self-esteem, social support, and general health) were measured using the 10-item valid and reliable self-report Rosenberg Self-Esteem Scale (RSES). Additionally, a mean was calculated from a 12-item self-report questionnaire about social support, and one question about participants' general health. In addition to the RSES, the CES-D was the other standardized measure used to study depressive symptoms, while the other negative indicators of adjustment (e.g., substance abuse, sexual risk, and suicidal ideation and attempts) were measured by self-report items developed for this study. Findings suggest that there are no statistically significant differences in the average levels of family acceptance based on sexual identity, gender, or gender identity.

Parental religiosity was significantly associated with family acceptance, with highly accepting families reporting lower religiosity and highly religious families reporting lower family acceptance. Additionally, a link was reported between social class and family acceptance, with highly accepting families having a higher socioeconomic status compared to those who

scored lower on family acceptance. In conclusion, their findings suggest that: 1) "family acceptance did not vary based on gender, sexual identity, or gender identity" – families are no more accepting of girls than boys, bisexual than lesbian/gay youth, or transgender than cisgender youth; 2) "family acceptance in adolescence is associated with young adult positive health outcomes and is protective for negative health outcomes," and 3) "the influence of family acceptance persists, even after control for background characteristics" (Ryan et al., 2010, p. 210).

Family Acceptance Project Data Applied to School Experiences of LGBT Students

The authors' final three publications describe results from the FAP's original data and report the recalled experiences that LGBT youth had in school, including school victimization and psychosocial adjustment, and the effect that the presence of Gay-Straight Alliances (GSAs) had on youth well-being (Russell, Ryan, Toomey, Diaz & Sanchez, 2011; Toomey, Ryan, Diaz, Card & Russell, 2010; Toomey, Ryan, Diaz & Russell, 2011). It has been well documented that LGBT students report higher rates of verbal and physical harassment, abuse and victimization at school (Friedman, Marshal, Stall, Cheong & Wright, 2008; Human Rights Watch, 2001; Kosciw, Greytak, Diaz & Bartkiewicz, 2010; Williams, Connolly, Pepler & Craig, 2005), and often report feeling unsafe at school (Kosciw et al., 2010; O'Shaughnessy, Russell, Heck, Calhoun & Laub, 2004; Russell & McGuire, 2008). Negative school experiences have also been linked to long-term negative health and mental health outcomes (Rivers, 2001; Russell et al., 2011; Toomey et al., 2010), as well as decreased academic success (Kosciw et al., 2010). The findings from the FAP research adds to this body of literature by describing the detrimental effects of school victimization and lack of safety on a particular sample of LGBT students, as well as providing implications for school health, safety and policy changes. The major limitations of the original FAP study include: the retrospective design which relies on participants being able to recall past

experiences, the use of newer, invalidated measures for parental acceptance/rejection in particular, that do not have established reliability, and the lack of a diverse sample of LGBT youth which makes it difficult to generalize the study's findings to broader populations.

Overview of the Attachment-Based Family Therapy Model

Attachment-Based Family Therapy (ABFT) has recently gained recognition as a promising evidence-based family therapy model for effectively treating adolescent depression and suicidal ideation within the context of the family. ABFT is the only empirically-based family therapy model specifically designed to target individual and family processes associated with adolescent depression, suicide, and self-injurious behaviors (e.g., Diamond, Reis, Diamond, Siqueland & Isaacs, 2002; Diamond et al., 2010; Kissil, 2011; Shpigel, Diamond, & Diamond, 2012). More recently, ABFT has been evaluated with families of LGB adolescents who are struggling with depression and suicidal ideation (e.g., Diamond et al., 2012). Given that LGB adolescents report higher rates of victimization, discrimination, and rejection which often leads to lower levels of self-esteem and higher levels of depression, anxiety, isolation and hopelessness, ABFT may be a favorable treatment option that can help LGB young people process these feelings and heal attachment ruptures with their parents.

The original ABFT manual was first adapted in order to better address the unique challenges and cultural relevance necessary for use with LGB adolescents and their families, and then a treatment development study was conducted with this vulnerable population (Diamond et al., 2012). One significant change that Diamond and colleagues made was that parents needed much more time at the beginning of ABFT treatment to work through their own feelings of fear, shame, disappointment, and anger directed towards their LGBQ children and/or their child's sexual identity. The results of this preliminary study suggest strong support for ABFT as an

effective family-based treatment for depressed and suicidal LGBQ youth and their families. According to the findings, families reported feeling closer to one another because parents were able to overcome attachment barriers to their LGBQ child, parents became more accessible to their child, and children reported a decrease in their symptoms of depression and low self-esteem, and a decrease in suicidal ideation (Diamond et al., 2012).

As treatment recommendations for depressed and suicidal adolescents moved away from focusing primarily on the individual, and an understanding that the family system needed to be considered, more research and literature has focused on the links from "family factors to the development, maintenance, and relapse of child and adolescent depression" (Diamond et al., 2002, p. 1190). For example, disengagement between parents and children or weaker attachment bonds, higher levels of criticism and hostility, parental psychopathology, and ineffective styles of parenting (Kaslow, Deering, & Racusin, 1994; Sheeber, Hops, & Davis, 2001) were all identified as significant contributing factors to the development of depressive symptoms among children and adolescents. ABFT was first developed in 1995 as two researchers' response to the lack of family-focused treatment models specifically for adolescents struggling with depression (Diamond & Siqueland, 1995). ABFT draws on the following theoretical paradigms: Structural Family Therapy (Minuchin, 1974), Multidimensional Family Therapy (MDFT; Liddle, 1991, 1999), Contextual Therapy (Boszormenyi-Nagy & Sparks, 1984), Emotion-Focused Therapy (EFT; Greenberg & Johnson, 1988), and Attachment Theory (Bowlby, 1969/1982). Below, I describe the central tenets of ABFT, and then review the relevant literature of interest and focus on the constructs that were investigated in this dissertation study.

The underlying assumption of ABFT is that "poor attachment bonds, high conflict, harsh criticism, and low affective attunement can all lead to physical or emotional neglect, abuse, and

abandonment" (Diamond et al., 2002, p. 1191). Additionally, ABFT assumes that attachment injuries can be repaired, parents can become better caregivers, and adolescents can rebuild trust and communication with their parents. There are five treatment tasks in ABFT that are introduced sequentially, but may take several sessions (approximately one to three sessions each) to complete (Diamond et al., 2002, 2012; Diamond & Siqueland, 1995; Diamond, Siqueland, & Diamond, 2003; Shpigel et al., 2012).

The first task is the *Relational Reframe Task* which sets the foundation for the relational treatment by shifting the family's focus from "fixing" the child to improving family relationships and aims to reduce parental criticism and hostility. The second task, the *Adolescent Alliance-Building Task*, is developed individually with the child and focuses on engaging the child in the treatment, building hope, and identifying core parent-child conflicts. The third task is the *Parent Alliance-Building Task* and is developed individually with the parent(s) to explore his/her/their current stressors, understand the history of attachment injuries, and reduce parental distress in an effort to soften them and begin working on improving parenting practices. The fourth task is the *Reattachment Task*, in which the child will practice disclosing unexpressed anger about core conflicts to his or her parent(s) and begins to have a new, corrective experience as the parent(s) are able to respond in a more grounded, empathic, and supportive way. The fifth and final task is the *Competency –Promoting Task* which focuses on building self-esteem by promoting autonomy and competency, allowing the adolescent to explore being away from home knowing that the family is a secure base to help navigate life's impending challenges.

Attachment-Based Family Therapy for Depression and Suicidal Ideation

Since its inception in 1995, ABFT has been replicated in different research studies by the PI and his team (as well as a few unaffiliated clinical researchers), including three randomized

clinical trials (Diamond et al., 2002, 2003, 2010, 2012; Diamond & Liddle, 1999; Kissil, 2011; Shpigel et al., 2012). ABFT has also been used with several different presenting problems, including adolescent depression, anxiety, suicidal ideation, and self-injury (Diamond et al., 2002, 2003, 2010, 2012; Kissil, 2011; Shpigel et al., 2012). The first randomized control trial was conducted to develop the treatment manual and an adherence measure. Pilot data were collected over a two-year period from 32 adolescents (78% were female and 69% were Black) who met DSM-III criteria for major depressive disorder (MDD) (Diamond et al., 2002). Adolescents (between ages 13 to 17) and their families were randomly assigned to twelve weeks of ABFT treatment or to a six-week, minimal contact waitlist control group. Baseline assessments were taken at the beginning of treatment, and participants in the ABFT group were also assessed half-way through treatment (at 6 weeks), post-treatment (after 12 weeks), and some were evaluated during a six-month post-treatment follow-up. At post-treatment, 81% of the adolescents treated with ABFT no longer met criteria for MDD, compared to 47% of the adolescents in the waitlist control group. Adolescents who received ABFT showed a significantly greater reduction in both depressive and anxiety symptoms, as well as family conflict, compared to the waitlist control group (Diamond et al., 2002).

The second randomized control trial of ABFT was conducted in 2010 with 66 adolescents (83% were female and 70% were Black) between the ages 12 to 17 who were identified in primacy care and emergency departments, and met the criteria for clinical depression and/or had a certain score on a self-report measure of suicidal ideation (Diamond et al., 2010). The adolescents in this study were either enrolled in ABFT treatment with their families for three months (assessed at baseline, 6 weeks, 12 weeks, and follow up at 24 weeks) or received Enhanced Usual Care (EUC), including facilitated referrals to other providers. Results suggest

that participants who received ABFT demonstrated significantly greater rates of change in self-reported depressive symptoms and suicidal ideation at post-treatment evaluation, and these changes were maintained at follow up three months later (Diamond et al., 2010).

According to Diamond et al. (2010), when "compared with usual care in the community, youth treated with ABFT demonstrated significantly greater and more rapid reductions in suicidal ideation during treatment" (p. 129) and "ABFT provided more rapid relief from depressive symptoms than community care, an important advantage when youth are at risk for suicide" (p. 130). Limitations of these two randomized trials include: relatively small sample sizes; most participants were low-income Black girls and their families and results may not be generalizable to other populations; they did not clearly identify when family treatment may be contraindicated; and the relatively short follow-up time frames limited understanding of long-term ABFT treatment benefits. More recently Diamond and colleagues are conducting a NIMH funded R01 to examine the effectiveness of ABFT with suicidal youth and their families.

Attachment-Based Family Therapy for Suicidal LGB Adolescents: Preliminary Findings

ABFT was also adapted to assess its effectiveness with suicidal lesbian, gay, and bisexual (LGB) youth and to obtain preliminary data for the feasibility and acceptability of ABFT with this particular population of adolescents. During Phase I, a treatment development team modified ABFT in order to meet the unique needs of LGB suicidal youth. These adaptations to the ABFT manual included allowing for more individual time to work with the parents (approximately 1-3 more sessions compared to the original ABFT manual). Additional sessions with parents allowed them to first process their disappointments, pain, anger, and fears related to their child's lesbian, gay, or bisexual identity; to address the meaning, implications, and process of acceptance; and finally to work towards heightening parents' awareness of subtle yet hurtful and invalidating

responses to their child's sexuality (Diamond et al., 2012). During Phase II, 10 suicidal LGB youth ages 14 to 18 (5 Black, 2 White, 2 multiracial, and 1 "other") completed 12 weeks of ABFT-LGB, which was adapted to be more culturally sensitive. Adolescents' self-reports of suicidal ideation, depressive symptoms, and maternal attachment-related anxiety and avoidance were collected at baseline, 6 weeks, 12 weeks, and post-treatment. Results from Phase II suggest that LGB adolescents' self-reports of suicidal ideation and depressive symptoms significantly decreased over the course of ABFT treatment, as well as attachment-related anxiety and avoidance. These results "suggest this population can be recruited and successfully treated with a family-based therapy, evidenced by high levels of treatment retention and significant decreases in suicidal ideation, depressive symptoms, and maternal attachment-related anxiety and avoidance" (Diamond et al., 2012, p. 62).

Overview of the Parental Acceptance-Rejection Theory and Model

Parental acceptance-rejection theory (PARTheory) is an evidence-based theory of socialization and lifespan development that attempts to predict and explain major causes, consequences, and other correlates of interpersonal – especially parental – acceptance and rejection within the U.S. and worldwide (Rohner et al., 2005, 2012; Rohner & Britner, 2002; Rohner & Rohner, 1980). PARTheory was developed in response to research suggesting that "parental love is essential to the healthy social and emotional development of children," and over 2,000 empirical studies later, PARTheory concluded that "children everywhere need a specific form of positive response (i.e., acceptance) from parents and other attachment figures" (Rohner et al., 2005, p. 300). Evidence from PARTheory research suggests that about 26% of the variability in children's psychological adjustment can be explained by how much children perceive their parents or primary caregivers as accepting or rejecting (Rohner et al., 2005). My

dissertation study builds on the research base and implications of PARTheory, as I propose that parental acceptance is critical for the healthy racial and sexual identity development of Black LGBQ youth, while rejection can be detrimental to LGBQ youth development and place them at increased risk for experiencing more depressive symptoms and lower self-esteem.

PARTheory has traditionally focused on parental acceptance and rejection, however, in 1999 it underwent a paradigm shift from parental to interpersonal acceptance and rejection, but the sub-theories were unchanged (Rohner et al., 2012). This theory addresses five types of questions which are further divided into three sub-theories, including the: 1) personality sub-theory, 2) coping sub-theory, and 3) sociocultural systems model and sub-theory (Rohner et al., 2005, 2012). The personality sub-theory asks two general questions: 1) *do children everywhere – in different sociocultural systems, racial or ethnic groups, genders, sexual orientations, and the like – respond the same way when they perceive themselves to be accepted or rejected by their parents or other attachment figures*?, and 2) *to what degree do the effects of childhood rejection extend into adulthood and old age*? The coping sub-theory asks one basic question, *what gives some children and adults the resilience to emotionally cope more effectively than others with experiences of childhood rejection*? Finally, the sociocultural systems sub-theory asks two different types of questions, the first is *why are some parents warm and loving and others are cold, aggressive, and neglecting/rejecting*?; and the second is *in what way is society as a whole, as well as the behavior and beliefs of individuals within society, affected by the fact that most parents tend to either accept or reject their children*? These sub-theories will be described in detail below.

The empirical study of parental acceptance and rejection dates back to the late 1800s, but it was not until the 1930s that the research base, for which PARTheory is based, was widely

disseminated (Rohner, 2005; Rohner et al., 2005). Beginning in 1960, and following a long research history in the psychology field, Rohner began collecting data in his program of research that led to the eventual development of PARTheory and its associated measures. The measure that is relevant to this study is the Child Parental Acceptance-Rejection Questionnaire – Short Form (PARQ-C; Rohner, 1986). Each has three different versions that assess the following dimensions of acceptance and rejection: 1) children's perceptions of the degree of acceptance, rejection, and behavioral control they receive from their parents or caregivers; 2) parents' recollections of their childhood experiences of acceptance, rejection, and control by their parents; and 3) parents' perceptions of their own accepting, rejecting, or controlling behaviors as parents. While there have been several studies that confirm PARTheory, using these validated measures with diverse populations (e.g., African Americans, Asian Americans, and Latino Americans) (Gomez & Rohner, 2011; Khaleque & Rohner, 2002a, 2002b, 2011, 2012; Rohner & Khaleque, 2010; Rohner et al., 2005), no empirical studies have yet used PARTheory and its associated measures with families with LGBQ children, a central focus of this study.

Clinical Application and Dimensions of PARTheory

The three sub-theories of PARTheory provide the basis for understanding the consequences of acceptance and rejection for social, behavioral, cognitive, and emotional development of children, adolescents, and adults. It helps to explain how some individuals are able to cope better with the effects of perceived rejection by attachment figures, the major psychological, environmental, and maintenance systems that are antecedents of acceptance and rejection, and finally the issues regarding the sociocultural and expressive correlates of acceptance and rejection.

The personality sub-theory attempts to predict and explain major personality or psychological, especially psychosocial or mental health-related, consequences of interpersonal acceptance and actual or perceived rejection (Rohner et al., 2005, 2012). This sub-theory focuses on a constellation of personality characteristics that are believed to characterize rejected children and adults worldwide, including: dependence, healthy/defensive independence, emotional unresponsiveness, hostility, aggression, low self-esteem, negative worldview, and emotional instability. This sub-theory also postulates that rejected individuals will develop mental representations of themselves, of significant others, and of the world that leave them reactive to or avoiding certain situations or people – whether due to explicit or perceived rejection (Rohner et al., 2005, 2012). Central to this dissertation study, the personality sub-theory suggests that the emotional need for a positive or accepting responses from attachment figures is a powerful motivator, and when a young person's need is not adequately satisfied by their parents or caregivers, they are predisposed to respond emotionally or behaviorally in unhealthy ways.

The coping sub-theory examines how some rejected individuals are able to withstand and cope with rejection without suffering the negative consequences described above. Rohner et al. (2005, 2012) suggest that this is the least researched and least developed part of PARTheory, similar to most other bodies of research on the coping process. Yet, this sub-theory does focus on three parts: 1) self – an individual's mental activities along with other internal and external characteristics; 2) other – personal and interpersonal characteristics of rejecting attachment figures, along with form, frequency, duration, and severity of rejection; and 3) context – other significant people in the individual's life, along with social-situational and environmental characteristics. This sub-theory predicts that the capacity of individuals to cope with rejection is influenced by whether they have a clearly differentiated sense of self, a strong sense of self-

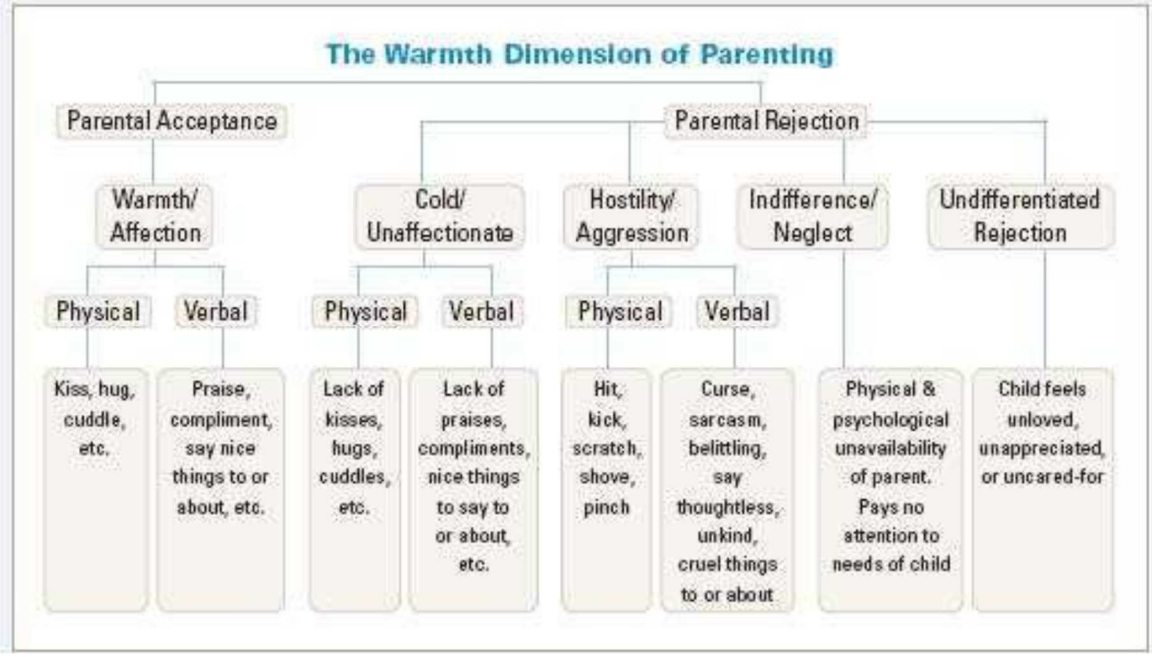
determination, and an ability to depersonalize and to develop in healthy ways despite the rejection (Rohner et al., 2005, 2012).

The sociocultural systems model sub-theory, "provides a way of thinking about the antecedents, consequences, and other correlates of parental acceptance-rejection within individuals and total societies" (Rohner et al., 2005, p. 317). These antecedents include the natural environment, and the maintenance systems of one's society (e.g., family structure, household and economic organization, systems of defense), which help to shape parental behavior. This sub-theory also suggests that the level of parents' accepting or rejecting behaviors directly affect their children's personality development and behavior, and vice versa. In addition to the maintenance systems, this sub-theory describes institutionalized expressive systems and behaviors as also contributing to children's development, and these systems include: religious traditions, artistic traditions, and other symbolic, non-utilitarian, and non-survival-related beliefs and behaviors (Rohner et al., 2005, 2012). This sub-theory attempts to predict and explain worldwide causes of parental acceptance and rejection, and even though expressive systems are human creations, they tend to shape future beliefs and behaviors.

In PARTheory, parental acceptance includes the *warmth/affection dimension of parenting,* which "has to do with the quality of the affectional bond between parents [or caregivers] and their children" (Rohner et al., 2012, p. 1). As Figure 2 shows, warmth can be exhibited through verbal expressions of affection, such as praise, compliments, and saying nice things, or through physical expressions of affection, such as kissing, hugging, and cuddling. Figure 2 also describes the dimensions that make up parental rejection, which include the: 1) *hostility/aggression dimension, 2) cold/unaffectionate dimension, 3) indifference/neglect dimension,* and the 4) *undifferentiated rejection dimension*. The hostility/aggression and

cold/unaffectionate dimensions can be exhibited in verbal (e.g., lack of praise, compliments, or nice things being said; and/or cursing, sarcasm, belittling, cruel/unkind language, respectively) or physical (e.g., lack of kisses, hugs, cuddling; and/or hitting, biting, scratching, shoving, pinching, respectively) ways. Indifference/neglect is generally shown through physical and psychological unavailability to children, or parents/caregivers not attending to the needs of their child. Finally, undifferentiated rejection is exhibited by encouraging the child to feel unloved, uncared for, or unappreciated (Rohner et al., 2005, 2012). Behavioral control, in PARTheory, is studied by examining perceptions of permissiveness or strictness that children experience from their parents or caregivers.

Figure 2. The Warmth Dimension of Parenting



(Retrieved from Rohner, Khaleque & Cournoyer, 2012, p. 3)

When parents act on their feelings of hostility, anger, resentment, or enmity, the resulting behavior is generally referred to as aggression. As suggested by PARTheory, aggression refers to any behavior where there is the intention of hurting someone, something, or oneself (physically

or emotionally). It is important to realize that neglect or the perception of neglect may be felt for a variety of different reasons, sometimes for well-intentioned reasons. PARTheory maintains that all hurtful behaviors, real or perceived, individually and collectively, are likely to encourage children to feel unloved or rejected. Additionally, even in the most loving and warm families, children are likely to at least occasionally experience hurt emotions or behaviors, therefore, acceptance and rejection can be studied from two perspectives: 1) the perceived or subjective experience by the individual (e.g., phenomenological perspective), or 2) the reports by an outside observer (e.g. behavioral perspective) (Rohner et al., 2005, 2012).

Most parental acceptance and rejection is symbolic or subjective, therefore, in order to understand why rejection has consistent negative effects on children, adolescents, and adults, one must understand its symbolic nature. In the context of ethnic and cross-cultural investigations, it is important to understand that what one racial, ethnic, or cultural group does that is labeled or pathologized as rejecting, another racial, ethnic, or cultural group may experience as an appropriate parental practice or healthy socialization. In other words, "even though parents everywhere may express, to some degree, acceptance (e.g., warmth, affection, care, concern) and rejection (e.g., coldness, lack of affection, hostility, aggression, indifference, neglect), the way they do it will vary and saturated with cultural or sometimes idiosyncratic meaning" (Rohner et al., 2012, p. 3).

Black Racial Identity Development

Many researchers have examined racial (and ethnic) identity development, in particular racial and ethnic identity development among children and adolescents (Boyd-Franklin, 2003; Burlew & Smith, 1991; Clark & Clark, 1947; Cross, 1991; Cross et al., 1991; Helms, 1990, 1993; Jackson, McCullough, Gurin, & Broman, 1991; Parham, 1989; Phinney, 1990; Phinney &

Rosenthal, 1992; Phinney & Rotheram, 1987; Smith, 1989, 1991; Spencer, 1984; Spencer & Markstrom-Adams, 1990; Spencer, Swanson, & Cunningham, 1991; Stevenson, 1995; Thomas & Speight, 1999; Vandiver et al., 2001). Prior research on racial identity development has primarily focused on understanding family socialization processes, life experiences of Black college-age students, and more recently understanding ethnic and racial identity development among young children and adolescents. Many models and normed scales of racial identity development have been developed using racial identity development theories. It is important to note that there are also many theories, models, and scales of racial and ethnic identity development, however, for the purpose of this dissertation study with Black LGBQ youth and their parents, I only briefly review Cross' (1991) Nigrescence Model.

The Cross Nigrescence Model of Racial Identity Development

Cross (1971) first introduced the field of Black psychology to Nigrescence theory in 1971 with his seminal work on the Negro-to-Black conversion experience (Cross, 1971). Twenty years later he revised his theory from a five-stage model to a four-stage model in his seminal book, *Shades of Black: Diversity in African American Identity* (Cross, 1991). Almost 10 years later, the model was expanded to include additional identities that clarified the stages of Black identity development (Vandiver et al., 2000, 2002; Worrell, Cross, & Vandiver, 2001). Nigrescence refers to "the process of becoming black," and the most current model (Worrell et al., 2001) includes the following four stages: 1) pre-encounter, 2) encounter, 3) immersion-emersion, and 4) internalization (see figure 3). The Cross model (1971, 1991) led to the development of the Cross Racial Identity Scale (CRIS; Vandiver et al., 2001), which is a reliable and valid measure that will be used in this dissertation study in order to examine Black racial identity development among LGBQ youth.

In the more recently expanded nigrescence model, the pre-encounter stage is further characterized by three identities: 1) assimilation, 2) miseducation, and 3) self-hatred (Worrell et al., 2001) and describes Black individual's assimilation of society's messages about race and dominant culture politics. Those with an assimilation identity have a pro-American reference group orientation (RGO) and do not consider race as important or salient to their identities. The miseducation identity describes the negative stereotypes that many Blacks have about Black communities, and the self-hatred identity, which is separate from the miseducation identity in the expanded model, is characterized by Blacks' internalization of negative messages and stereotypes that they have received about their race (Vandiver et al., 2002). Vandiver et al. (2002) also suggest that with the separation of the mis-education and self-hatred identities, a new relationship emerged between anti-Black and self-esteem, such that now a negative relationship only exists between self-hatred (not mis-education) and self-esteem. The encounter stage describes the process of reexamining one's RGO through the experience of an event or series of events that forces an individual to acknowledge the impact of racism in his/her life. This stage usually starts in early adolescence, and "if the cognitive and emotional discomfort produced by this re-examination is sufficiently intense, individuals move to the immersion-emersion stage" (Vandiver et al., 2002, p. 72).

The immersion-emersion stage continues to be characterized by the same identities as described in the revised model – intense Black involvement and anti-White politics – which describes the simultaneous desire to immerse oneself with symbols of one's racial (Black) identity and avoid symbols of Whiteness, even to point of demonizing Whites and White culture (Vandiver et al., 2002). In the revised model (Cross, 1991) and the expanded model (Vandiver et al., 2002), the internalization stage synthesizes the internalization (stage 4 – Black acceptance)

and internalization-commitment (stage 5 – activism) stages from the original model (Cross, 1971). The internalization stage describes one's development of security about his or her racial identity and subsequent ability to establish meaningful relationships with Whites without questioning his or her Blackness. The internalization stage in the expanded model is typified by the same three identities as the revised model (Cross, 1991), however the final identity stage has been divided into three categories: 1) Black nationalist, 2) biculturalist and 3) multicultural. "Black nationalists concentrate their energies on empowering the Black community" (Vandiver et al., 2002, p. 72); while the biculturalist integrates two elements, Black self-acceptance and an active focus on other identities (e.g., gender, sexual orientation, or nationality); and the multiculturalist is able to focus on two or more other salient identities. Thus, the expanded Nigrescence model includes eight Black racial identities; however, only seven are assumed to be measurable (see figure 3) (Vandiver et al., 2002).

Figure 3: The Cross Nigrescence Identity Model

TABLE 1

Cross's Nigrescence Stages and Identities

Model	Stage	Identity
1971 original model	Pre-Encounter	Pro-White/Anti-Black
	Encounter	
	Immersion-Emersion	Anti-White/Pro-Black
	Internalization	Humanist
	Internalization-Commitment	
1991 revised model	Pre-Encounter	Assimilation
		Anti-Black
	Encounter	
	Immersion-Emersion	Anti-White
		Intense Black Involvement
	Internalization	Black Nationalist
		Biculturalist
		Multiculturalist
2000 expanded model	Pre-Encounter	Assimilation[a]
		Miseducation[a]
		Self-Hatred[a]
	Encounter	
	Immersion-Emersion	Anti-White[a]
		Intense Black Involvement
	Internalization	Black Nationalist[a]
		Biculturalist
		Multiculturalist Racial
		Multiculturalist Inclusive[a]

[a]Subscale included in the Cross Racial Identity Scale.

(Retrieved from Worrell, Cross, & Vandiver, 2001, p. 202)

Parental Racial Socialization

In his seminal work, Peters (1985) defines racial socialization as "the tasks Black [or other racial minority] parents share with all parents – providing for and raising children - … but include the responsibility of raising physically and emotionally healthy children who are Black in a society in which being Black has serious negative consequences" (Peters, 1985, p. 161). Phinney and Rotheram (1987) added that it is a developmental process where children acquire behaviors, perceptions, values, and attitudes of a racial/ethnic group and learn how to see themselves and others as members of their respective racial/ethnic groups. Healthy socialization has historically been described as an aspect of resiliency or as a protective factor against race- or ethnic-related prejudice and discrimination. Families of Black children, specifically parents or primary caregivers, have the responsibility for providing this protective buffer by instilling resiliency in their Black children. Prior research has highlighted the connection between developing a sense of group identity to the socialization content, implying that those who were taught about racism and better prepared for how to manage racial and ethnic discrimination as children, often became healthier adults. They felt more connected to their Black identities and communities and were less likely to suffer in terms of their racial identity development (Edwards and Polite, 1992; Stevenson, 1994, 1995). The messages that Black young people have reported as contributing most to their experience of positive parental racial socialization include a focus on: 1) racial barriers, 2) self-development, 3) egalitarianism, and 4) racial/ethnic pride (Stevenson, 1995). Stevenson (1993) has proposed the following assumptions of racial socialization:

1. Racial discrimination is an unavoidable but fearful reality that many persons from every racial or ethnic group resist discussing openly.

2. The consequences of racial discrimination are different for some persons of color than they are for others, due to the differential exposure to a greater degree of discriminatory experiences of persons from low socioeconomic status environments, and thus influences racial socialization.
3. Both social oppression and cultural empowerment processes contribute to extended self-identity or reference group orientation and are channeled through family, peer, community, and societal contexts.
4. Extended self-identity is interpersonal, reflexive, and corporate but requires buffering and nurturance to mature. As a buffer, racial socialization is not always present [explicitly] but is necessary in multiple contexts. Without racial socialization, African American youth are more vulnerable to personal identity and reference group orientation maladjustment.
5. Racial socialization is direct/indirect, verbal/nonverbal, and proactive/protective.
6. Racial socialization processes are inclusive of behaviors and attitudes between families and youth, including adolescent perspectives on how families should raise children of African descent. These processes may be subject to gender, economic, and environmental contexts.
7. Racial socialization is multidimensional and precedes, coincides with, and contributes to racial awareness and racial identity development across the life span (as cited in Stevenson, 1995, p. 53).

It is also important to remember that Black parents' racial socialization in a society that privileges Whiteness may not resemble, warm, tender, and affectionate expressions of what we usually call love. Instead, to the culturally unaware eye, it may appear to be harsh, cold, non-

accepting, and un-loving. Positive racial identity development, the primary goal of racial socialization, has been linked to better psychological adaptation and higher self-esteem (Constantine & Blackmon, 2002; Parham & Helms, 1985a, 1985b), better scholastic achievement, and parental warmth/attachment (McHale et al., 2006). Unhealthy racial identity development has been linked to lower self-esteem, problems with adjustment, drug abuse, self-injurious behaviors (Constantine & Blackmon, 2002; Cross, 1991).

The Black Church: A Staple of Black Culture and Community

> "Racists used Christianity against Black people and then Black people turn around and use Christianity against gays. It doesn't make any sense to me." –
>
> (Jewelee Gomez, *Feminist Review*, Issue 34, 1990, p. 51)

In many Black families, the church is second only to the family in terms of its importance as a social institution, source of support, and an educational system. The Black Church has long been regarded as "vital in the lives of African peoples, providing them with a moral compass in their families and communities" (Griffin, 2006, p. 48), as well as a source of strength and resilience, a place to escape to and to combat racial discrimination, a place of worship and fellowship, a sense of understanding and gaining answers to life's tough questions, and a place to develop Black consciousness, and engage in political movements and social activism (Boyd-Franklin & Garcia-Preto, 2004; Boykin, 1997; Du Bois, 1903/2003; Lincoln & Mamiya, 1990; Shaw & McDaniel, 2007; Washington, 1964). Yet, for many Black people, the Black Church has also been a source of pain, grief, sadness, loss, and shame – a place where they felt, possibly for the first time, a sense of not belonging even among their own people.

For Black LGBQ people, the Black Church has historically been a place of painful and extreme rejection, although speculation persists that many members of the clergy, choir, and

congregation are not heterosexual themselves (Brown-Douglas, 1999; Comstock, 2001; Griffin, 2006; Moore, 2011; Schulte & Battle, 2004); or as Keith Boykin put it "The church might be the most homophobic and most homo-tolerant of any institution in the Black community" (Dade, 2012, p. 3). Moore (2011) titles a section in her book *Black Religion as Simultaneous Source of Condemnation and Strength,* which captures the complexity experienced by many Black LGBQ individuals struggling to integrate their religious identity, and by many Black families struggling to accept a LGBQ child.

Although attitudes regarding LGBQ sexual identities and religious beliefs, particularly among the Black Church, are changing, the change process has been slow. For example, in 2012, the NAACP (which connected to the Black Church, is a historical source of power and strength in Black communities) passed a resolution endorsing same-sex marriage as a civil right to be protected by the U.S. Constitution (Dade, 2012). In the interim, there are young people and families struggling to find peace, retain faith, and develop *all* of their identities in a healthy, integrative way. Several inclusive church denominations have emerged, such as the Metropolitan Community Church, American Baptist Churches, Society of Friends, Unitarian, Universalist Church, Unity Fellowship Church, Disciples of Christ/United Church of Christ, Anglican/ Episcopalian, and Christian/Religious Scientist (Dade, 2012; Shaw & McDaniel, 2007; Walker, 2013), who open their doors to "fulfill the needs that gays and lesbians have to retain their religious identity" (Buchanan et al., 2001, p. 441). Yet, for many Black religious individuals and parents of LGBQ youth, their connections to religion and/or to the Black Church may exacerbate their difficulties fully accepting and affirming their LGBQ child.

LGBQ Sexual Identity Development

Over the past several decades, several models of sexual identity development, and stages of coming out have been proposed (Bradford, 2004; Cass, 1979; Chapman & Brannock, 1987; Coleman, 1985; Fassinger & Miller, 1996; Minton & McDonald, 1984; Troiden, 1989; Weinberg et al., 1994). In my dissertation study, sexual identity development was conceptualized as the dual process of *identity formation* (e.g., process of self-discovery, exploration, and awareness of one's emerging sexual orientation), *and identity integration (*e.g., acceptance and commitment to one's sexual identity and connecting to community) (Mohr & Fassinger, 2000; Rosario et al., 2011). The earlier models of sexual identity development were based on retrospective descriptions given by adults, and suggested that sexual identity formation is a development process that unfolds in stages, rather than an evolving, potentially fluid multidimensional developmental process. Based on the findings of Herdt and Boxer's (1993) seminal research, Rosario et al. (2008) stated that, "potential changes in aspects of identity integration over time and potential variability in these changes remain unstudied" (p. 267).

In their study on the patterns of sexual identity development over time among LGB youth, Rosario and colleagues (2008) suggested that LGB youth often experience a diverse set of coming-out experiences, and no single pattern is typical. Instead patterns of identity formation, identity integration, and change in identity integration can and do occur over time. Patterson (2005) and Meeus (2001) additionally noted that during the developmental stage of adolescence sexual aspects of the self emerge and become increasingly central, and issues LGB youth often face become exacerbated. "Evidence indicates that not all LGB youth experience the same aspects of identity formation in the same way and the same time, and some of the hypothesized

stages (such as identity pride, which connotes a feeling of superiority over heterosexuals) may not be experienced at all" (Bregman, Malik, Page, Makynen, & Lindahl, 2013, p. 418).

Additionally, not all LGBQ people describe or label their identity using the same language, and some have recently begun to believe that LGBQ adolescents and young adults are "post-gay" and redefining their sexual orientations on their own terms (Russell et al., 2009; Savin-Williams, 2006). While this may be true to a certain extent (such as with the renewed popularity of identities such as queer or "no label"), an empirical investigation that examines this belief reported that the identities of lesbian, gay, and bisexual remain relevant even for contemporary young people (Russell et al., 2009). Therefore, it is important to be aware of the diversity in sexual identities when designing studies, developing paperwork, and interviewing LGBQ adolescents.

Several investigations that have focused on sexual identity formation have examined 'milestones' as indicators of sexual identity development among LGB youth, including age of awareness of sexual attraction (or doubting one's heterosexuality), age of self-labeling as lesbian, gay, or bisexual (or otherwise non-heterosexual), age acceptance of same-sex orientation, age of disclosure to others, and age of first same-sex sexual experience (D'Augelli, 1996; Floyd & Stein, 2002; Institute of Medicine [IOM], 2011; Russell, eta al., 2009; Savin-Williams & Cohen, 2010). The process of "coming out" is one that occurs within a social and historical context that frequently includes prejudice, stigma, and victimization. This may be especially challenging for young people who are integrating other parts of their identities, and even more so for racially and ethnically diverse young people. Little research has focused on sexual identity development among racially or ethnically diverse LGBQ adolescents, however, in one study Rosario, Schrimshaw and Hunter (2004) reported that "black youth were involved in fewer gay-related

social activities, were less comfortable with others knowing about their sexual identity, and disclosed their sexual orientation to fewer persons than their white peers" (p. 144). More recent research has suggested that racial/ethnic and sexual identity develops in a parallel fashion during adolescence, but that the processes were different and unrelated. Moreover, sexual identity development was described as a private process, while racial/ethnic identity development was viewed as a more public process (Jamil, Harper, & Fernandez, 2009), as it is an identity that is more visible to others.

Although not well-researched in LGBQ populations (Rosario et al., 2011), the broader identity literature (e.g., adolescent identity, racial/ethnic identity) suggests that identity processes have important implications for youth outcomes and that disrupted or unhealthy identity development is associated with poorer adjustment (Archer & Grey, 2009; D'Augelli, 2002; Floyd & Stein, 2002; Floyd, Stein, Harter, Allison, & Nye, 1999; Marcia, 1966; Meeus, 2011; Stone-Fish & Harvey, 2005). Rosario et al. (2011) reported results that were consistent with prior research, suggesting that:

> patterns of [sexual] identity formation (early vs. recent development) were not significantly related to psychological distress and self-esteem" (p. 11); [however], different identity integration groups were found to significantly differ on all four indicators of psychological adjustment (depression, anxiety, conduct, self-esteem), both cross-sectionally and over time… suggesting that identity integration has short-term and long-term implications for the psychological adjustment of LGB youths (p. 12).

What this suggests is that poorer psychological adjustment has been found among LGBQ youth compared to heterosexual youth, but it may only be relevant to those LGBQ youth whose identity integration process has been interrupted or stagnated.

One of the more comprehensive sexual identity models, however, was developed by Mohr and Fassinger (2000) and later revised by Mohr and Kendra (2011), and was the basis of the measure used in this study. The other salient model that is relevant to this study is Morales' (1989) model that specifically describes the experiences of racial and ethnic minority LGBQ individuals. Mohr and Kendra's (2011) model describes six dimensions of identity development, including: 1) internalized homonegativity – rejection of one's LGB identity), 2 concealment motivation – concern with and motivation to protect one's privacy as a LGB person), 3) acceptance concerns – concern with the potential for stigmatization or non-acceptance as a LGB person), 4) identity uncertainty – uncertainty or insecurity about one's sexual orientation identity), 5) identity superiority – favoring LGB people over heterosexual people, and 6) difficult process – experiencing the process of developing a LGB identity to be difficult (Bregman et al., 2013; Mohr & Fassinger, 2000; Mohr & Kendra, 2013).

Table 1: Fassinger Model of Gay and Lesbian Identity Development

	Awareness	Exploration	Deepening - Commitment	Internalization – Synthesis
Trajectory 1 Individual Identity	Recognition of difference from heterosexual 'norm'	Discovery of sexuality and attraction to same-sex others	Increased self-awareness and sense of consistency in feelings about sexuality	Solidification of sexual identity and integration of sexual identity into overall identity
Trajectory 2 Group Member Identity	Recognition that different sexual orientations and identities exist	Clarification of position in relation to lesbian or gay reference group	Involvement in lesbian or gay community and awareness of oppression	Integration of identity as a member of an oppressed group into overall identity

Information above is adapted from Fassinger & Miller, 1996 and McCarn & Fassinger, 1996

Fassinger and her colleagues developed a model of sexual identity formation describing four phases of development that are progressive, continuous, and circular, as opposed to linear

stages (Fassinger & Miller, 1996; McCarn & Fassinger, 1996). These four phases are outlined in terms of individual sexual identity and group membership identity development (see Table 1).

DeVine (1984) and later LaSala (2010), have described the identity formation process for families adjusting to the coming out of a LGBQ family member. Their respective family identity formation processes are described and contrasted below in tables 2a & 2b.

Table 2a: DeVine Theory of Family Coming Out Process		Table 2b: LaSala Theory of Family Adjustment	
Subliminal Awareness	Child's sexuality is suspected due to noticing certain behaviors or avoiding certain topics of conversation	Family Sensitization	Awareness of the child's 'differentness'
Impact	Suspicions are confirmed and the child declares his or her sexuality	Family Discovery Youth Comes Out	Youth comes out to family, may experience intense anxiety
Adjustment	Family grapples with maintaining homeostasis and the child is pressured to change or hide his or her sexuality	Family Discovery Parents React	Parents react to youth's coming and may assume the anxiety
Resolution	Family discards their heterosexual image of the child and adopt a new LGBQ identity	Family Recovery	Parents work through their 'grief' toward an acceptance process
Integration	Family shifts their values and ideas about LGBQ sexual identities	Family Renewal	Parents shift to a stance of acceptance and affirmation of their child's identity

Information above is adapted from DeVine, 1984 and LaSala, 2010

Identity Development in LGBQ People of Color

> "African culture has no place for homosexuality as a way of life because it does not fit with the view that humans should reproduce in order to be remembered for eternity… [those] promoting homosexuality in Africa [should] take a hike; let them stick to their cultural traditions and respect ours" –
>
> (Ifa Kamau Cush, *New African*, 2010, p. 76)

Despite this powerful quote from Ifa Kamau Cush (2010), few researchers have examined the experiences of identity formation among racial/ethnic minorities (or people of color) who also identify as LGBQ (Dubé & Savin-Williams, 1999; Gallor & Fassinger, 2010; Gilmore, 1994; Greene, 1994; Johnson & Henderson, 2005; Mays, Chatters, Cochran, & Mackness, 1998; Morales, 1990; Moore, 2011; Parks, 2001; Somerville, 2000). The few peer-reviewed theoretical and research journal articles that exist describe the difficulties that many racial/ethnic minorities experience during the "coming out" process, for example: 1) maintaining relationships with family members and friends; 2) connecting with racial/ethnic communities *and* simultaneously connecting with LGBQ communities; and 3) maintaining a sense of religiosity or spirituality (if previously held). Most scholars describe the experiences of LGBQ people of color as similar to a "*don't ask, don't tell"* policy, suggesting that Black LGBQ individuals are more likely to be accepted as long as they do not openly proclaim their sexual orientations to family members or to the community.

For LGBQ people of color, the "coming out" process often challenges their identity formation and their loyalties to one community over another. Morales (1990) hypothesized that racial/ethnic minority gay men and lesbians "need to live within three rigidly defined and strongly independent communities: 1) the gay and lesbian community, 2) the [racial/]ethnic minority community, and 3) the society at large" (p. 217). LGBQ people of color often report feeling pressured to choose one community as their primary identity or group allegiance, as opposed to reaching a level of integration that privileges all parts of themselves, and embraces the complexity that exists when individuals have multiple identities. Morales (1990) additionally noted that because each of these groups have their own social norms, expectations, and styles, LGBQ people of color must balance oftentimes conflicting challenges and pressures.

Morales' (1990) model of sexual identity development was the first to theorize about the process of sexual identity development in racial and ethnic minorities. People of color sometimes deny that lesbian women and gay men are part of their communities and have often asserted that being LGBQ is, as Morales (1990) puts it, a "White thing" or "White people's problem" (p. 225); however, unlike White LGBQ individuals who blend in with larger society, LGBQ people of color are a "visible minority" (p. 225) and therefore more easily identified across all segments of society. This makes people of color, those who are also LGBQ and those who are not, an easier target for discrimination and racist practices in the U.S. Discrimination does not solely exist within people of color communities, as Luna (1989) termed, "*gay racism"* (as cited in Parks, 2001, p. 44) is persistent throughout LGBQ communities as well. LGBQ people of color often do not feel accepted by others, and report overt and covert discrimination experiences from White LGBQ individuals (Gallor & Fassinger, 2010; Harris, 2009; Lewis et al., 2003; Morales, 1990; Washington, 2001).

Additionally Parks (2001) suggests that *gay racism* is even visible in political organizations, social settings, and more generally as evidenced by the sexual stereotyping of Black LGBQ young people. Morales' (1989) model was developed to address the importance of race and ethnicity that many prior models of sexual identity formation neglected. The five *states* that Morales describes reflect the experiences of many people of color who may experience several different *states* at one time, versus resolving only one *stage* at a time and progressing to the next. Morales' (1989, 1990) identifies the following 5 states: 1) denial of conflicts, 2) bisexual vs. gay/lesbian conflicts, 3) conflict in allegiances, 4) establishing priorities in allegiance, and 5) integrating various communities (Morales, 1989; see Table 3).

Table 3: Morales Identity Formation Model for Ethnic Minority Gays and Lesbians	
Denial of Conflicts	An individual tends to minimize the validity and reality of the discrimination they experience as a person of color; sexual orientation may or may not be defined; they may feel that their personal and sexual preferences have little consequence in their life
Bisexual vs. Gay/Lesbian Issues	A preference for some gays and lesbians of color is to identify as bisexual; upon examining sexual desires and sexual identities, there may be no difference between self-identified bisexual, gay, or lesbian individuals and communities
Conflicts of Allegiances	Simultaneous awareness of being a member of a marginalized racial/ethnic group as well as being gay or lesbian presents anxiety and a need to keep those identities separate; increasing anxiety about betraying one's racial/ethnic or gay/lesbian community
Establishing Priorities in Allegiance	Primary identification to the racial/ethnic community prevails in this state and feelings of resentment emerge due to lack of integration among communities; feelings of anger and rage develop from experiences of rejection by the gay community due to race and/or ethnicity
Integrating the Various Communities	The need to integrate one's life and identities and develop a multicultural perspective becomes a major concern; adjustment to the reality of limited options for gay and lesbian people of color heightens anxiety leading to feelings of isolation and alienation

Information above is adapted from Morales (1989, 1990)

Some scholars suggest that Blacks' and African Americans' difficulty accepting LGBQ individuals may be associated with slavery (and persistence of White supremacy), racial and sexual oppression, and internalized racism that is still a part of U.S. Black communities (Greene, 1994; Harris, 2009; Johnson & Henderson, 2005; Somerville, 2000). While others suggest that religion, specifically the Black Church, plays a significant role in the continued difficulty for LGBQ people of color to gain acceptance (Comstock, 2001; Douglas, 1999; Griffin, 2006; Harris, 2009; Johnson & Henderson, 2005; Moore, 2011; Somerville, 2000). We know that heterosexism and heteronormativity within Black communities is multiply determined, and we also know that reaching a level of integration that feels validating for each individual is important for healthy identity development, regardless of what identity is being developed.

Gilmore's (1994) commentary, *They're Just Funny That Way: Lesbians and Gay Men and African-American communities as Viewed Through the Privacy Prism*, as the title suggests, describes one way that many Black communities have negotiated the presence of lesbians and gay men within the culture – through a comedic lens. However, unfortunately many of these ways of negotiating are derogatory and reinforce stereotypes of what it means to be lesbian or gay. This commentary describes the relationships between LGBQ individuals of African descent and Black communities through the following lenses, which highlight some of the major myths that Black people tend to have about LGBQ people: 1) the significance of religion in Black communities, 2) the belief that lesbian and gay men women will destroy Black communities by masculinizing Black women and emasculating Black men, 3) the perception that LGBQ identification is solely about sex and the reluctance of Black communities to talk about sex, and 4) the perception that LGBQ communities, which is almost always perceived as being White and male, are trying to connect themselves to the Black civil rights movement in order to achieve civil rights for themselves (Gilmore, 1994; Washington, 2001). Washington (2001) also describes this belief in her article entitled, *Who Gets to Drink from the Fountain of Freedom?: Homophobia in Communities of Color*, which describes the incongruence that exists when a group who had to fight so hard to secure full civil rights, now supports the denial of civil rights to another minority group, especially when there are members within their own community.

"To live as a minority within a minority leads to heightened feelings of isolation, depression, and anger centered around the fear of being separated from all support systems, including the family" (Morales, 1990, p. 219). Morales and Eversley (1980) and Morales and Graves (1983) described the persistence of racial/ethnic discrimination within LGBQ communities and suggest that the institutionalized and systematic racism that exists in

mainstream society also exists within LGBQ communities. Yet few researchers have included significant numbers of Black gay, lesbian, bisexual, or queer participants in their research studies (Bass-Hass, 1968; Bell & Weinberg, 1978; Gallor & Fassinger, 2010; Mays et al., 1998; Mays & Cochran, 1988). Mays and Cochran's (1988) research concluded that: 1) lesbian women were more likely to maintain involvement with their families, to have children, and to depend more on family members or other Black lesbians for support, as compared to White lesbians; 2) Black men were less likely to benefit from the White gay community compared to their White counterparts; 3) Black lesbian women and gay men were more likely to experience tension and loneliness, but were less likely to seek outside professional help; 4) Black lesbian women and gay men preferred and felt safer disclosing their sexual orientation to women in their families; and 5) LGBQ people of color experienced greater satisfaction with overall support than with support specifically related to their sexuality.

Parks (2001) additionally reminded us that little attention has been given to racially and ethnically diverse LGBQ youth, who face a number of inter- and intrapersonal issues simultaneously: 1) racial identity development, 2) sexual identity development, 3) coping with heterosexism within Black heterosexual communities, 4) combating heterosexism and racism within White heterosexual communities, 5) *gay racism* within White LGBQ communities, and 6) the realities associated with the AIDS epidemic. Dubé and Savin-Williams (1999) investigated whether race/ethnicity was a salient context that can help us better understand the development of sexual identity among youth. Based on findings from their study, they reported that the following areas are the most challenging for youth: 1) level of disclosure, 2) internalized homophobia, 3) integration of sexual and ethnic identities, and 4) intimate relationships. This dissertation study focused on many of the interpersonal issues identified above.

Mental Health Outcomes

Depressive Symptoms

Diamond and Siqueland (1995) reported until the late 1980s, clinicians and researchers did not believe children and adolescents experienced symptoms of depression. It was not until Rutter's (1986) seminal book, *Depression in Young People: Developmental and Clinical Perspectives,* was published that symptoms of depression among youth began to receive widespread attention in the mental health field. Although recovery is possible and can be long-standing, youth have a high risk for recurrent depressive episodes (Garber, Kriss, Koch, & Lindholm, 1988; Weissman et al., 1999), and to have episodes concurrent with other psychiatric disorders (Mitchell, McCauley, Burke, & Moss, 1988), and to experience decreased school performance, social isolation, increased family conflict, and increased risk of suicide (Diamond & Siqueland, 1995). When there is an insecure parent-child attachment, the risks of severe depressive symptoms significantly increases (Sund & Wichstrom, 2002). Over the last several decades, family therapy has been well documented as the most effective and preferred treatment for child and adolescent depression (Diamond & Siqueland, 1995; Diamond et al., 2002; 2012; Kaslow et al., 1994; Shpigel et al., 2012; Sund & Wichstrom, 2002).

Over the past twenty years, there has also been a growing body of research literature examining the link between depression and depressive symptoms and LGBQ identity (Diamond et al., 2011; Lewis et al., 2003; Marshal et al., 2011; Safren & Heimberg, 1999). Exploring the causes of increased depressive symptoms (and risk of suicidality) among LGBQ youth has gained greater attention, suggesting that many fear rejection, stigmatization, victimization, or humiliation by family and friends. Extant literature on LGBQ youth also suggest that youth often report feelings of intense isolation, shame, and confusion during the sexual identity development

process, and for many without a supportive community or family environment in which to share these feelings, youth may turn those feeling inward which can lead to symptoms of depression.

Salient factors that have been identified, specifically among LGBQ youth, as contributors to depressive symptoms include: 1) LGBQ-related stress, prejudice, discrimination, and victimization (Almeida, Johnson, Corliss, Molnar & Azrael, 2009; Bontempo & D'Augelli, 2002; Diamond et al., 2011; Lewis et al., 2003; Meyer, 1995, 2003), 2) internalized homonegativity (McGregor et al., 2001), 3) perceived or actual rejection by family members upon coming out (Goldfried & Goldfried, 2001; Rotheram-Borus, Hunter, & Rosario, 1995; Ryan et al., 2009), and 4) remaining closeted or lack of disclosure (Ayala & Coleman, 2000; Lewis et al., 2003). In one of the first studies examining *how* LGBQ adolescents understand what causes their depressive (and suicidal) symptoms, Diamond et al. (2011) noted that adolescents reported the following three primary causes: 1) family rejection of sexual orientation, 2) extra-familial LGBQ-related victimization, and 3) non-LGBQ-related negative family life events.

Rates of depressive symptoms and effect sizes for LGBQ youth can be difficult to ascertain from the empirical literature because of the pervasive methodological and sampling limitations. These include, but are not limited to the following: 1) unaccounted for gender differences, 2) bisexuality status, and 3) different measures for sexual orientation (e.g., same-sex sexual behavior vs. self-identity as LGBQ). Marshal et al. (2011) examined depression and suicidal ideation disparities that exist between LGBQ youth and heterosexual youth. In their meta-analytic review, they identified twelve depression studies with 51 different effect size estimates, however, after further examination and exclusion of some studies, the re-estimated effect sizes ranged from .28 to .36 and depression was found to be a significant moderator of the association between sexual orientation/identity and depression. They suggest that "results from

this meta-analysis provide strong evidence that [LGBQ] youth are at a substantially heightened risk for suicide and depression, [therefore] depression in [LGBQ] youth should be treated aggressively with empirically supported interventions" (Marshal et al., 2011, p. 121).

Self-Esteem

Self-esteem is an important outcome variable and has been operationalized in this study using the definition described in the PARTheory literature:

> Self-esteem is the global emotional judgment individuals make about themselves in terms of worth or value… feeling that one likes oneself; that one approves of, accepts, and is comfortable with oneself; that one is rarely disappointed in oneself; and that one perceives oneself to be a person of worth and worthy of respect (Rohner, 2005, p. 13).

Drawing from attachment theory (Bowlby, 1969/1982), we know that the earliest development of self-esteem is associated with a healthier working model of self and the development of a secure attachment with a parent or a primary caregiver. Also, one of the lasting negative outcomes of rejected (non-securely attached) children is low self-esteem (Rohner et al., 2005, 2012). The theories of intersectionality (Crenshaw, 1989) and minority stress (Meyer, 1995) also suggest that one of the long-term psychological effects of sexuality-based, and race-based oppression is lower self-esteem (Harper et al., 2004; Meyer, 1995). The development of a positive racial identity has also been linked to increased psychological adaptation and higher self-esteem, and conversely, stagnated or unhealthy racial identity development has been associated with lower self-esteem (Constantine & Blackmon, 2002; Cross, 1991; Parham & Helms, 1985a, 1985b). Prior research with LGBQ populations suggests that family acceptance and attachment are significantly associated with higher self-esteem and can serve as protective factors in the development of depression (Diamond et al., 2010; Ryan et al., 2010).

Other researchers have documented the associations between stress, victimization, and micro-aggressions in the development of self-esteem in youth, in particular with samples of LGBQ youth (Hershberger & D'Augelli, 1995; Nadal et al., 2011; Rosario et al., 2005; Savin-Williams, 1989; Wilburn & Smith, 2005). Both Diamond et al. (2010) and Nadal et al. (2010) examined the effects of microaggressions, or "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 et al., 2010, p. 235), on LGBQ youth. Experiencing microaggressions on a consistent basis, in particular from parents or members of one's own family, had a significant negative effect on LGBQ youths' development of a positive self-identity and higher self-esteem. Despite prior research having linked "coming out" to parents with higher self-esteem (Savin-Williams, 1989), many scholars suggest that this association is complex and multifaceted due to its association with real or perceived harassment and victimization (Hershberger & D'Augelli, 1995).

Hershberger and D'Augelli (1995) studied the effects of victimization on the mental health and self-acceptance of LGBQ youth, and suggested that "self-acceptance of a lesbian, gay, or bisexual identity, in addition to the support of others, provide a buffer against the deleterious effects of victimization," (p. 67). Similarly, Wilburn and Smith (2005) suggested that self-esteem is affected by appraisals of how one is perceived by others, as well as self-evaluation, which both influence perceived levels of stress and potential suicidal ideation. A major finding in their research was that a significant degree of covariance was found between self-esteem and stress in the prediction of suicidal ideation, but self-esteem explained a greater degree of variability of suicidal ideation than did stress. In other words, "the stress adolescents experience when support from family is perceived to be low can significantly lower their self-esteem and increase the

level of stress and risk of suicide" (Wilburn & Smith, 2005, p. 40). This finding was corroborated by Rosario et al. (2005) who reported that "youths who attempted suicide subsequently reported fewer psychosocial resources (self-esteem and social support) and more negative social relationships than youth who neither attempted nor ideated (p. 158). We can ascertain from prior research that self-esteem plays an important role in determining an LGBQ youths' risk for unhealthy psychosocial functioning, and is likely mediated or moderated by family acceptance, secure attachments, low levels of stress, and healthy identity formation.

Salient Socio-demographic Variables

Sexual identity development and experiences of LGBQ youth varies across a number of demographic covariates, including gender, sexual orientation, age, and ethnicity (Bergman et al., 2013). For this study, I focused on how the following demographic variables affect the associations among Black racial identity, LGBQ sexual identity, perceived parental acceptance and rejection, and depression and self-esteem: 1) age, 2) gender, 3) ethnicity, 4) degree of outness across three domains [family, religion, world], 5) education level, 6) family SES/class, 7) youth and family religious affiliation, and 8) family level of religiosity (as reported by youth).

Prior research on sexuality and sexual identity have primarily relied on the retrospective reports of White adult gay men, however, as an increasing number of studies have included women and bisexual individuals, important gender differences have been described. Additionally, it has been my experience that gay, bisexual, or queer boys often experience greater harassment and victimization (Williams, et al., 2005), and to a certain extent rejection from their families, as compared to lesbian, bisexual, or queer girls. Girls may be protected by experiences of more tolerance in regard to female sexuality (Bostwick, Boyd, Hughes, & McCabe, 2010), but there often tends to be a sexualization aspect at play here. Youths' age,

SES/class, degree of outness, and parental religiosity, are also expected to influence the experiences of Black LGBQ youth and their parent's process of acceptance or rejection.

Kirkpatrick and Morgan (1980) were among the first to question whether LBQ sexual identity for women was a mirror image of GBQ sexual identity for men. Since then, many researchers have tried to answer the question "Are female and male sexual minorities more alike on the basis of sexual orientation than they are different on the basis of gender?" (Savin-Williams, 2000, p. 611). Prior research suggests that girls are more likely to engage in identity-centered development (and label themselves as LGBQ *before* pursuing same-sex sexual contact), to de-emphasize the role of explicit sexual feelings or same-sex sexual contact in their process of sexual identity development (whereas boys tend to over-emphasize these roles), to experience sexual identity development as an emotionally-oriented process (whereas for boys it is tends to be more sexually oriented), and more likely to experience their first same-sex sexual contact within the context of a romantic relationship (Savin-Williams & Diamond, 2000). Additionally, women are more likely than men to exhibit situational and environmental plasticity in sexual attractions, behavior, and identifications (Diamond, 2005), and are more likely to identify as bisexual and to vacillate between identity labels (e.g., express more fluidity in their sexuality) (Diamond, 2007). Savin-Williams and Diamond (2000) concluded that it is extremely valuable to "assess the context, timing, spacing, *and* sequencing of sexual identity milestones when investigating gender differences in sexual identity development" (p. 620).

Age also has been identified as a salient factor related to sexual identity development, and several researchers have reported that youth who disclose at younger ages tend to experience greater comfort with their sexual orientations (Floyd & Stein, 2002; Floyd et al., 1999). The first study to explore the development of adolescent lesbian and gay identity in depth included 202

LGB adolescents, more than half of whom were youth of color (Herdt and Boxer, 1993). The mean age of self-identification as gay or lesbian was 16 years for girls and 16.7 years for boys. Lesbian or bisexual women, on average, became aware of same-sex attraction at about age 10, and the average age for gay or bisexual men was 9. Research subsequent to Herdt and Boxer's earlier work reported comparable ages of first awareness of sexual attraction (approximately age 10) (D'Augelli, 2006; D'Augelli & Hershberger, 1993; Rosario et al., 1996; Savin Williams & Cohon, 2010; Telingator & Woyewodzic, 2011). For girls, self-labeling tends to occur about three years after the initial same-sex attraction, whereas for boys it may take up to five years post-attraction (Telingator & Woyewodzic, 2011). We know that parental influence decreases during adolescence, as youth are seeking autonomy and independence and perhaps being more influenced by peers outside of the family. However, age remains important and should be explored as a moderator of the effects of family and peer support when a research sample includes adolescents (Mustanski Newcomb & Garofalo, 2011). Additionally, many researchers have examined the *degree of outness* among LGBQ youth, and have suggested that there are better mental health outcomes among youth and young adults who are out *and* accepted with their families, peers, and communities.

Prior research also suggests that psychosocial factors may be part of the causal pathway linking socioeconomic status (SES)/class to health outcomes, such as depression (Adler, Boyce, & Chesney, 1994; Anderson & Armstead, 1995; Goodman & Huang, 2002; Wilkinson, 1999). We know that higher rates of not only physical health, but also mental health problems exist in lower-income or lower-SES populations, which is why it was such an important covariate to explore in this study. Wilson, Foster, Anderson, and Mance (2009) stated that "African American adolescents living in low-income neighborhoods are more likely to be exposed to

chronic stressors such as overcrowding, substandard housing, parental discord, and daily conflicts" (p. 103), and the effects of this type of economic hardship places adolescents at heightened risk for social and psychological difficulties. Grant et al. (2004) expanded on the research and reported that poverty affects urban adolescents' interpersonal stressors, making them more susceptible to depression, violence and victimization, and substance abuse. "As living in poverty is a form of stress, poverty has been shown to affect the psychological health of [Black] adolescents" (as cited in Wilson et al., 2009, p. 104).

It has been suggested, and subsequently corroborated through research, that Black people have very high rates of theism (Billingsley & Caldwell, 1991; Whitley, 2012). Prior research has also found links between levels of parental religiosity (or theism) and parental acceptance (Ryan et al., 2010); with highly religious parents exhibiting less accepting behaviors (and more rejection) and parents who reported lower religiosity exhibiting more accepting behaviors (and less rejection). Oftentimes, parents struggling with some aspect of their religious beliefs that they believe to be non-accepting of LGBQ sexual identities, may suggest or force their child into some form of sexual reorientation therapy (a term used to collectively describe conversion therapy, reparative therapy, or any type of sexual orientation change efforts) or ex-gay camp (Walker, 2013). The detrimental effects of these kinds of experiences, similar to the detrimental effects of a lack of parental and family acceptance, may include the following: reinforced external and internalized homonegativity; self-hatred, low self-esteem, depression, suicidal ideation and/or attempt (regardless of presence before therapy); drug and alcohol abuse and other high risk behaviors (i.e., unprotected sex, other forms of self-harm); sexual dysfunction; increased family problems; alienation, loneliness or social isolation; rejection by LGBQ and heterosexual communities, religious harm or complete denunciation, developmental delays, and

misinformation (Beckstead & Morrow, 2004; Green, 2003; Morrow & Beckstead, 2004; Ryan et al., 2009, 2010 Shidlo & Schroeder, 2002; Walker, 2013).

Summary

Some CFT scholars have examined parent's and family member's reactions when a child first comes out as lesbian, gay, bisexual, or queer (LGBQ) and the parental or family acceptance process (DeVine, 1984; LaSala, 2010; LaSala & Frierson, 2012; Stone-Fish & Harvey, 2005). Yet, in general, the field of family therapy has produced little literature with Black LGBQ youth using relational and systemic frameworks and theories. This study begins to fill the following gaps in the literature: 1) most prior research about LGBQ individuals, and specifically youth, have included relatively small numbers of Black participants using qualitative studies; 2) most prior research has included retrospective reports with adult samples, requiring participants to report from memory what their childhood and adolescence was like; and 3) little research has included Black LGBQ youths' views of their parents accepting/ rejecting attitudes towards them as LGBQ individual.

More studies are needed that examine the experiences of Black LGBQ youth and young adults and, including but not limited to, their experiences with depressive symptoms and self-esteem. Most research on LGBQ identity, parental acceptance, parental rejection, symptoms of depression and self-esteem have included very few Black LGBQ youth. This is not new in research, as many studies across various disciplines have not included a significant number of participants of color. Furthermore, in research specific to sexual identity development, there has been a long history of studying White LGBQ individuals, and attempting to apply results to LGBQ people of color; as well as researching gay males, and attempting to attribute findings to

lesbian women, or to bisexual, queer, or otherwise non-heterosexual individuals. This study explored how the processes of racial and sexual identity development are related to each other.

Additionally, this study helped us better understand Black LGBQ youth (ages 14-21) and young adults in real time (e.g., as they are presently experiencing them). Most prior research that has examined sexual identity development and/or the coming out process has been retrospective reports with samples of primarily LGBQ adults and not youth. In most prior studies, youth have been asked to report, from memory, how their parents or families reacted to their coming out, how they came to terms with their sexual identity, and how they felt during the coming out process. This study is one of few prospective reports of Black LGBQ youths' and young adults' current experiences of parental acceptance and rejection.

Purpose of Dissertation Study

Using Attachment Theory (Bowlby, 1969/1982), Intersectionality Theory (Crenshaw, 1989), and the Minority Stress Model (Meyer, 1995), the primary aim of this web-based, cross-sectional, prospective dissertation study was to understand how Black LGBQ youth and young adults (ages 14-21) self-reports of parental acceptance and rejection are associated with their Black racial and LGBQ sexual identity development, and how they are associated with the following two mental health outcomes: 1) depressive symptoms and 2) self-esteem. This study examined the following research questions and hypotheses:

Research Questions

Question #1*:* Is there an association between stage racial identity development and sexual identity development in Black LGBQ youth? More specifically, do the developmental processes of racial identity and sexual identity development seem to occur along a similar trajectory?

Hypothesis #1*:* The processes of racial identity development and sexual identity development will occur along a similar trajectory, and the stage of racial identity development will be positively associated with stage of sexual identity development.

Rationale #1*:* Prior research has suggested that racial identity and sexual identity development are both central tasks in adolescence. Research specific to sexual identity development among racial and ethnic minorities has provided conflicting results, however, with some suggesting that the processes are different and unrelated, and other research concluding that these processes occur simultaneously.

Question #2*:* Is there an association between youths' stage of racial identity development and perceived level of parental acceptance/rejection?

Hypothesis #2*:* Racial identity development, a byproduct of parents' and caregivers' racial socialization practices, will not be associated with youths' perceived level of parental acceptance/rejection.

Rationale #2*:* Prior research suggests that race and ethnicity play a crucial role in Black LGBQ youths' fears and anxiety about coming out to parents, however, results have suggested that it is not only race or ethnicity, per se, that explains parental accepting or rejecting behaviors. Instead, other culturally-based variables may be more influential, such as adherence to traditional roles and expectations or connection to religion, in particular the Black Church.

Question #3*:* Is there an association between youths' stage of sexual identity development and their perceived level of parental acceptance/rejection?

Hypothesis #3*:* There will be an association between stage of sexual identity development and youth's perceived level of parental acceptance/rejection. Specifically, youth who are "more out"

or further along in their sexual identity development will view their parents as more accepting and less rejecting.

Rationale #3*:* Prior research has consistently suggested that coming out, particularly among adolescents, is an important step in sexual identity development and results in LGBQ youth reporting better overall mental health and wellbeing, and additionally feeling more connected to their parents and families. The minimal research exploring parents reports of their experiences have suggested that with time and resources, they were able to redefine their experiences and adapt to their new identity as a parent of a LGBQ child.

Question #4*:* Is there an association between the perceived level of parental acceptance/rejection and youths' symptoms of depression and levels of self-esteem?

Hypothesis #4*:* A negative association will be found between perceived level of parental acceptance/rejection and youths' symptoms of depression, and a positive association will be found for self-esteem. That is, higher levels of perceived parental acceptance/lower level of perceived parental rejection will be associated with lower levels of depression and higher levels of self-esteem.

Rationale #4*:* Prior research has consistently reported associations between parental acceptance and parental rejection on adolescent's reports of depression and self-esteem. In many research studies, adolescents have scored higher on measures of depression, and lower on measures of self-esteem when they perceive their parents as being rejecting of their sexual identity. Parental acceptance has been shown as a protective factor for these outcomes.

Question #5a*:* Is there an association between age of coming out and youths' symptoms of depression and levels of self-esteem?

Hypothesis #5a: An association will exist between youth's age and their self-reported reports of symptoms of depression and levels of self-esteem. Specifically, I hypothesize that youth who come to terms with their sexual identities and who come out younger ages will show more positive adjustment and have lower levels depression and higher self-esteem.

Rationale #5a: Prior research has identified age as an important factor related in identity development, broadly and specifically regarding sexual identity. Extant literature has reported that youth who can positively reach identity formation, and subsequent integration tend to experience greater comfort with their sexual identities, and tend to report lower levels of depression and higher self-esteem.

Question #5b*:* Is there an association between youth's gender and symptoms of depression and levels of self-esteem?

Hypothesis #5b: An association will exist between youth's gender and symptoms of depression and levels of self-esteem. Specifically, I hypothesize that lesbian, bisexual, or queer female youth will report less symptoms of depression and higher self-esteem, as compared to gay, bisexual, or queer male youth. I also predict that youth who self-report that they are out more with their families will report less symptoms of depression and higher self-esteem compared to youth who are not out with their families.

Rationale #5b: It has been my experience, which has also been corroborated in relevant literature, that gay, bisexual, or queer males often experience greater harassment, victimization, and less parental and family acceptance, as compared to lesbian, bisexual, or queer females. Prior research suggests that females tend to embrace and exercise greater levels of sexual fluidity, and may be protected by experiences of more tolerance in regard to female sexuality and less stigma associated with the idea of two females being involved romantically or intimately. Additionally,

research has also shown that, specifically for Black families, the role of masculinity is particularly shaming for Black gay, bisexual, or queer males, as stereotypes about hyper-masculinity still persist.

Question #5c*:* Is there an association between the family's SES/class and youth's symptoms of depression and levels of self-esteem?

Hypothesis #5c: An association will exist between the youths' family's SES/class and the adolescents reports of depression and self-esteem. Specifically, I hypothesize that youth who come from families of lower SES/class will report more symptoms of depression and have lower levels of self-esteem.

Rationale #5c: Prior research also suggests that psychosocial factors may be part of the causal pathway linking SES/class to health outcomes, such as depression. It is important to note that this association is not as direct as one would assume, as there are many reasons that people from lower SES/class backgrounds may experience worse mental health outcomes. The stress associated with being in a lower SES/class often results in difficulty getting basic needs met as a family, and providing basic needs to a child. This stress has been found to be a strong predictor of depressed mood, more so than the actual income level. Additionally, adolescents living in lower-income neighborhoods are more likely to be exposed to chronic stressors such as overcrowding, substandard housing, and daily conflicts, which can increase their risk for psychological difficulties.

Question #5d – Is there an association between parent's religiosity (as reported by the youth) and youth's symptoms of depression and levels of self-esteem?

Hypothesis #5d **–** An association will exist between parent's religious affiliation and level of religiosity (as reported by the youth) and youth's symptoms of depression and levels of self-

esteem. Specifically, I hypothesize that family's rated as exhibiting higher religiosity will result in more symptoms of depression and lower their self-esteem in youth.

Rationale #5d – Prior research has suggested that parental religiosity is significantly associated with family acceptance, with highly accepting families being less religious, and highly rejecting families being more religious. It is also important to note that religious fundamentalism, and specifically the Black Church, has a history of overt rejection, harsh criticism, and righteous judgment directed specifically at LGBQ individuals and communities.

The following direct effects were also examined:

Question #6a: Is racial identity associated with symptoms of depression and self-esteem in Black LGBQ youth?

Question #6b: Is sexual identity associated with symptoms of depression and self-esteem in Black LGBQ youth?

Hypothesis #6: Racial and sexual identity development will both be significantly associated with the outcome variables. That is, youth who are in earlier stages of identity development will report more depressive symptoms and as they progress, depressive symptoms will decrease; and youth who are in earlier stages of identity development will report lower self-esteem and as they progress, self-esteem will increase.

Rationale #6: Current research suggests that identity processes have important implications for youths' outcomes and that stagnated identity development is associated with poorer adjustment. This is true for adolescent development broadly, and includes racial and sexual identity development.

The following mediators (see diagram below) were also evaluated:

Question #7a*:* Is youths' perceived parental acceptance/rejection a significant mediator between racial identity and youths' symptoms of depression and levels of self-esteem?

Question #7b*:* Is youths' perceived parental acceptance/rejection a significant mediator between youths' sexual identity and their symptoms of depression and levels of self-esteem?

Hypothesis #7*:* Perceived parental acceptance/rejection will mediate the associations between youths' racial and sexual identity processes depressive symptoms and level of self-esteem.

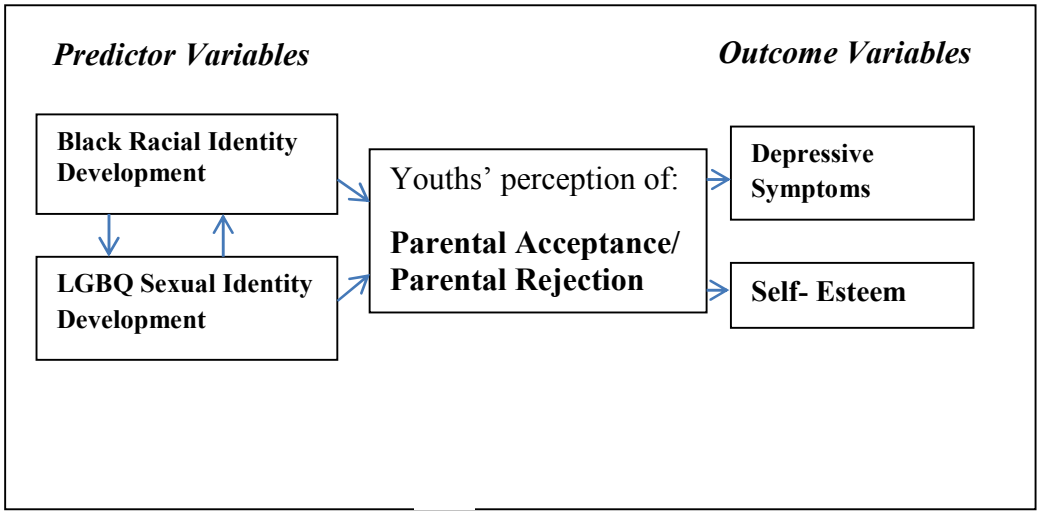
Rationale #7*:* Prior research suggests that higher levels of parental acceptance are associated with less depressive symptoms and higher self-esteem in LGBQ youth. Conversely, higher levels of parental rejection are associated with more depressive symptoms and lower self-esteem in LGBQ youth.

Below is a diagram that describes the quantitative study hypotheses and predicted associations between study variables (see Figure 4).

Figure 4: Diagram of Study Hypotheses

Covariates

1. Age
2. Gender
3. Outness
4. Education
5. SES/class
6. Parental religiosity



CHAPTER THREE

METHODOLOGY

Research Design

A cross-sectional, self-report, quantitative research design was used to examine the experiences of a convenience sample of Black LGBQ youth (ages 14-21). The worldviews of pragmatism, and cultural humility and safety informed this study. Pragmatism emphasizes valuing both objective and subjective knowledge, and approaching research through a "what works" stance (Creswell & Clark, 2007). Pragmatism assumes that the research questions are more important than the methodology; therefore, researchers employ the methods that will be most useful for the study. Cultural humility and cultural safety highlights the value of the community's voice and the importance of attending to the multiple social locations of participants by the researcher (Doherty & Mendenhall, 2006), and attending to the social, historical, political and economic circumstances that help to create power differences and inequalities in health during clinical or research encounters (Kirmayer, 2012).

This study examined the following six constructs among Black LGBQ youth and young adults (ages 14-21): 1) *perceived parental acceptance/rejection, 2) Black racial identity, 3) LGBQ sexual identity*, 5) *depressive symptoms* and *6) self-esteem*. A total sample of 110 Black LGBQ youth (N=195 non-completers) completed the survey using either an online survey or a paper version of the survey, including the six self-report measures which are described in more detail below.

Sample

The study population and sampling frame were Black LGBQ youth and young adults (ages 14-21) who could be reached by word-of-mouth in local community and agency networks,

national LGBQ organizations, local and regional pride parade celebrations, list-serves on the world wide web, and advertisements on popular LGBQ social media outlets. The following local community centers and agencies served as recruitment sites (and submitted letters of support to the IRB): the Attic Youth Center, Mazzoni Center, Gay and Lesbian Latino AIDS Education Initiative (GALAEI), Youth Health Empowerment Program (YHEP), True Colors: Sexual Minority Youth and Family Services of MA, Ali Forney Center of NY, and Supporting and Mentoring Youth Advocates and Leaders (SMYAL) of DC. The following national LGBQ organizations promoted the research study through their various outlets: National Black Justice Coalition (NBJC), National Youth Pride Services (NYPS), Parents, Families, and Friends of Lesbians and Gays (PFLAG), the Trevor Project, and YouthLink. The following list-serves also circulated the survey to their members: American Family Therapy Academy (AFTA), National Council on Family Relations (NCFR), American Psychological Association (APA) Division 44, Society for Psychotherapy Research (SPR), the Center for Lesbian and Gay Studies (CLAGS), Teaching College Sexuality, and Qstudy-L Digest. Finally, I regularly posted my dissertation flyer and survey link on the following social media outlets, and specifically in groups and pages frequented by Black and LGBQ youth and young adults: Facebook, Twitter, and Tumblr.

The study sample included Black LGBQ youth and young adults who fit specific study inclusion criteria and who agreed to volunteer for the study. The specific inclusion criteria for the study were: 1) between the ages of 14-21; 2) self-identify as a Black male or female; 3) self-identify as lesbian, gay, bisexual, queer, or otherwise non-heterosexual; and 4) have come out to at least one parent or primary caregiver at the time of the study. The exclusion criteria were: 1) not identifying as Black or as LGBQ, 2) at the time of survey completion, being either under 14 years of age or over 21 years of age; 3) identifying as trans*, gender non-conforming, or

otherwise not identifying with a male or female gender identity; 4) not having come out to at least one parent or primary caregiver, and 5) having a serious mental health or cognitive disability that prevents completion of the online or paper surveys.

A non-probability sampling approach was used, as it was not feasible to randomly select this sample of vulnerable youth. Participants were recruited using convenience and snow-ball sampling approaches, for example, word-of-mouth by participants, the researcher and her networks, colleagues, professors, active recruitment in LGBQ list-serves and organizations, and advertisements in popular LGBQ social and media outlets as described above. Consequently, the representativeness and generalizability of this sample is limited.

Further, because there is no data available regarding the demographic profile and number of Black LGBQ youth living in the U.S. , there was no way to evaluate whether the sample is representative of the Black LGBQ population. The sample could not be stratified because the stratification in the population is currently unknown. However, the researcher made every attempt to recruit Black LGBQ youth and young adults who are diverse regarding the study's key demographic variables (e.g., age, gender, outness, SES/class, education, and youth and parental religiosity), in order to evaluate the influence of these salient study variables on the primary outcome variables (depression and self-esteem). Prior studies using these variables suggest associations between variables range from .30 to .38, indicating a small (.02) to medium (.15) effect size. In order to ensure statistical power (Cohen, 1992) the anticipated sample was approximately 200 Black LGBQ youth and young adults. Power analyses indicate that we will have power ≥ .8 to detect *small-to-medium effect sizes* for multiple regression analyses. Yet after months of struggling to recruit 200 participants, after receiving permission from the dissertation

committee, data collection stopped when sample size reached 110 participants with complete data, enough to detect effects between key variables in this study.

Procedure

Setting

There was no particular geographic setting designated for this study; recruitment was open to all Black LGBQ youth or young adults (ages 14-21) currently living in the US. Participants had the option of completing an online survey or completing a hard copy of the survey with the researcher, either in a group setting or at another event when I recruited participants. Participants voluntarily completed the online survey or c a hard copy of the survey at a desired location of their choice. A letter of introduction (see Appendix B) was provided (either by email or in-person) to all interested participants. The link to the survey's website was included within the body of the introductory letter for easy access. The online survey link was active and data collection continued for eleven months.

Permissions

Once approval was obtained from the dissertation committee (May 5, 2013) and Drexel University's Institutional Review Board (October 8, 2013) (see Appendix A for consent forms for adolescents and young adults), the online survey was launched (October 30, 2013) and hard copies of the survey were distributed to eligible participants at the different venues identified above. Participation was anonymous and voluntary; participants were not required to provide any identifying information and could withdraw at any time without repercussions. After receiving permission from the dissertation chair (M. Davey) and committee, the online survey was closed on September 7, 2014, with a total sample of 110 completers. Note there were also195 non-

completers for a total sample of 305 participants who, at minimum, completed the consent form and demographic survey.

Data Collection

A letter of introduction (see Appendix B) was posted, inviting eligible respondents to participate. Completion of the demographic questionnaire and self-report surveys (see Appendix C for measures) took an average of 30-60 minutes (quickest time of completion was 8 minutes 6 seconds, and longest time of completion was 1 hour 3 minutes 1 second). Participants did not receive any monetary compensation for participating in the study. The risk to respondents was low, however, the researcher's and chair's contact information was provided, as well as a list of local and national depression resources, in case participants needed additional support, after completing the survey. The Drexel-sponsored survey software, Qualtrics, was used to post all study-related materials, to collect data online, and to export data into SPSS, version 22.0. Qualtrics offers the option of collecting anonymous responses and allows participants to access the survey website through an embedded link within an email, posting on a website or social media, and was even mobile/tablet-compatible.

Measures

Operational Definition of Study Constructs

Six major constructs were examined: 1) *Black racial identity, 2) LGBQ sexual identity, 3) Parental acceptance/rejection (both general and specific to sexual orientation)*, and the following two mental health outcomes: 1) *Depressive symptoms,* and 2) *Self-esteem*.

Black Racial Identity was defined as a feeling of belonging to a Black community, and understanding oneself as a Black person. As a socially constructed category, the term Black defines people by their racial identification, not their ethnic background. Individuals who

identified ethnically as African-American, Afro-Latino/a, Caribbean-American, African, or racially/ethnically mixed (Cross et al, 1991) were all eligible to participate in this study.

LGBQ Sexual Identity was defined as the process of coming to terms with one's sexual identity, and conceptualized as a dual process of *identity formation* (e.g., process of self-discovery, exploration, and awareness of one's emerging sexual orientation), and *identity integration* (e.g., acceptance and commitment to one's sexual identity and connecting to community) (Mohr & Fassinger, 2000; Rosario et al., 2008, 2011). In order to be eligible to participate in this study, individuals had to have a LGBQ sexual identity.

Parental Acceptance was defined as parents' global acceptance and their specific reactions to coming out where expressions of love, support, nurturance, and overall feelings of positivity continue to be shown. Parental acceptance has been linked to young people having better mental and physical health, higher self-esteem, and less propensity to be highly depressed or anxious, consider suicide, use illegal drugs, or engage in risky sexual behaviors (Ryan et al., 2010).

Parental Rejection was defined as parents' global reactions and specific reactions to coming out that are negative, distancing, conflictual, or otherwise suggest that the individual is bad, sinful, or depraved. Parental rejection has been linked to youth being at increased risk of suicide attempts, depression and anxiety, using illegal drugs, engaging in risky sexual behaviors (Ryan et al., 2009).

Psychological Well-being included the mental health outcomes of depressive symptoms and self-esteem. *Depressive symptoms* was defined as having a sad or despairing mood, decrease of mental productivity and reduction of drive, and retardation or agitation in motor behavior (Lorr, Sonn, & Katz, 1967). *Self-esteem* was defined as feelings or attitudes of satisfaction a

person has about him/herself (Silber & Tippet, 1965) and a global evaluation of one's worth, value, acceptance and comfortability with oneself (Rohner, 2005).

Quantitative Measurements

Predictor Variables

Two primary predictor variables were measured: 1) Black Racial Identity and, 2) LGBQ Sexual Identity.

Black Racial Identity

Black racial identity was measured using the Cross Racial Identity Scale (CRIS) (Vandiver et al., 2001). The CRIS is a 40-item self-report instrument designed to measure six attitudes as described in the expanded Nigrescence model (Cross & Vandiver, 2001). The six subscales are: 1) Pre-Encounter Assimilation (PA), 2) Pre-Encounter Miseducation (PM), 3) Pre-Encounter Self-Hatred (PSH), 4) Immersion-Emersion Anti-White (IEAW), 5) Internalization Afrocentricity (IA), and 6) Internalization Multiculturalist Inclusive (IMCI).

The CRIS includes 40 likert-scored items that measure attitudes associated with the four stages of African American development which was described in Cross' revised model of psychological Nigrescence (1991). Internal consistency for pre-encounter assimilation, miseducation, and self-hatred are .85, .79, and .89 respectively; .89 for immersion-emersion; .83 for internalization afrocentricity and .82 for multiculturalist inclusive. The scores on the subscales range from 5 to 35. Reliability estimates for the CRIS, based on Cronbach's (1951) alpha, range from .78 to .90. Exploratory factor analysis for the CRIS was investigated using a sample of 279 students (Cross & Vandiver, 2001).

Subscale inter-correlations ranged from an absolute value of .40 to absolute value of .42, with a median of .16. Confirmatory factor analysis inter-correlations ranged from .06 to.46, with

a median of .16. Convergent validity was tested by examining the association between subscales of the Multidimensional Inventory of Black Identity (MIBI) developed by Sellers, Smith, Shelton, Rowley, and Chavous, (1998) and the CRIS, using bivariate and canonical correlations (Worrell & Watson, 2008).

Like the CRIS, the MIBI is a measure of African American ethnic identity (not specifically racial identity). Several MIBI subscales measure constructs related to those measured by the CRIS. Subscales on the MIBI are: assimilation, centrality, humanist, nationalist, oppressed minority, private regard, and public regard (Sellers et al., 1998). Responses to CRIS items were made on a 7-point Likert-type scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Sample items are "I am not so much a member of a racial group, as I am an American" (Pre-Encounter Assimilation item) and "I see and think about things from an Afrocentric perspective" (Internalization Afrocentricity item). Subscale scores are obtained by summing scores of the five items that make up each subscale and dividing by 5, resulting in average total scores ranging from 1 to 7, which parallel the rating anchors and are easy to interpret. Subscale reliability estimates for the CRIS scores have ranged from .70 (PSH) to .89 (IEAW) (Worrell & Watson, 2008).

The first item in the scale is a filler item and is not associated with any subscale. The Assimilation (PA) items describe a pro-American identity; the Miseducation (PM) items focus on negative stereotypical views about African American people; and the Self-Hatred (PSH) items describe an anti-Black, self-hating identity. Anti-White (IEAW) items describe a person's dislike and distrust of Whites, whereas Black empowerment and success based on the work of Blacks characterize the Black Nationalist (IBN) items. The Multiculturalist Inclusive (IMCI) subscale describes Black self-acceptance and the acceptance of other cultural groups. The subscales are

examples of three identity types: pre-encounter (assimilation, miseducation, self-hatred), immersion-emersion (anti-White), and internalization (Afrocentricity, multiculturalist inclusive) (see Appendix C for a copy of the measure).

LGBQ Sexual Identity

LGBQ sexual identity was measured with the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011, original measure developed by Mohr & Fassinger, 2000). The LGBIS (Mohr & Kendra, 2011) is a 27-item self-report instrument that measures the process of sexual identity development using eight subscales. This instrument is a revision of the original measure, the Lesbian and Gay Identity Scale (LGIS; Mohr & Fassinger, 2000), however, the authors of the LGBIS reported that the original measure had several significant limitations. Among these limitations, and what were addressed and updated in the newer revised measure, were that some of the LGIS items and subscale labels could be perceived as insensitive, outdated, and pathologizing. For example, some items referred only to lesbians and gay men and marginalized bisexuals. Additionally, internal consistency estimates for one of the subscales in the original measure was below .70 and the original measure did not assess for two constructs that have emerged as central to sexual identity development, *Identity Centrality* and *Identity Affirmation* (Mohr & Kendra, 2011). The newer revised measure, therefore, was used in this study and was developed to meet the following goals:

> 1) feature language inclusive of bisexuals, 2) phrase items with respect to a broader LGB identity rather than a more specific sexual orientation identity, 3) eliminate phrases that could be perceived as stigmatizing, 4) improve internal consistency on the Identity Superiority subscale, and 5) include items assessing Identity Centrality and Identity Affirmation (Mohr & Kendra, 2011, p. 235).

Additionally, with explicit permission from the measure developers, the measure was changed to add the descriptor label of *Q* for *queer*, which is a relevant identity used by many sexual minority young people.

The LGBIS still has the six subscales in the original LGIS self-report measure, however, many of the items have changed for the reasons described above, and it also has two new subscales. The six subscales retained from the original measure are: 1) Acceptance Concerns, 2) Concealment Motivation, 3) Internalized Homonegativity, 4) Identity Uncertainty, 5) Difficult Process, 6) Identity Superiority. The two new subscales are: 7) Identity Centrality, and 8) Identity Affirmation. Responses to the LGBIS items are made on a 6-point Likert-type scale, ranging from 1 (disagree strongly) to 6 (agree strongly). Subscale scores are calculated by reverse-scoring items as indicated in the coding manual and averaging subscale item ratings (Mohr & Kendra, 2011) (see Appendix C for a copy of the measure).

Mohr and Kendra (2011) conducted an exploratory factor analysis (EFA) and a confirmatory factor analysis (CFA) using a sample of 654 participants with the revised LGBIS measure. These analyses resulted in retention of the 27 items in the revised scale. Six-weekly test-retest correlation coefficients yielded Cronbach's (1951) alphas ranging from .70 to .92, including moderate to high levels of internal consistency reliability.

Chronbach's (1951) alphas for the eight subscales are as follows: Acceptance Concerns (.83), Concealment Motivation (.70), Identity Uncertainty (.87), Internalized Homonegativity (.92), Difficult Process (.92), Identity Superiority (.81), Identity Affirmation (.91), and Identity Centrality (.80). Validity analyses also had positive results, as the LGBIS subscales were associated with the validity measures used in the original scale development study. Convergent validity was tested by examining associations between the LGBIS subscales and several scales

that measure similar constructs, including the Internalized Homonegativity Inventory (Mayfield, 2001), the Ego-Dystonic Homosexuality Scale (Martin & Dean, 1987), an adapted version of the Multigroup Ethnic Identity Measure (Phinney, 1992), the Collective Self-Esteem Scale (Luhtanen & Crocker, 1992), the Outness Inventory (Mohr & Fassinger, 2000), the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), the Center for Epidemiologic Studies Depression Scale (Radloff, 1977), the Positive and Negative Affect Scale – Expanded Form (Watson & Clark, 1994), the Self-Concealment Scale (Larson & Chastain, 1990), and the Marlowe-Crowne Social Desiralibity Scale – Form C (Reynolds, 1982). All hypothesized correlations conformed to the authors expectations (see Mohr & Kendra, 2011 for detailed results), and "the clearest convergent validity evidence emerged for Concealment Motivation, Internalized Homonegativity, Identity Affirmation, and Identity Centrality" (Mohr & Kendra, 2001, p. 242). Finally the developers noted that although preliminary evidence supports the reliability and validity of the LGBIS, further research and investigation into the scale's psychometric properties is still needed.

Mediator Variables

Parental Acceptance/Rejection

The mediator variable of parental acceptance/rejection was evaluated by assessing youth and young adults' perceptions of the following two constructs: 1) parental acceptance/rejection globally, and 2) parental acceptance/rejection specific to the youth's or young adult's sexual identity.

Global perceived parental acceptance/rejection was measured using the Child Parental Acceptance-Rejection Questionnaire – Short Form (PARQ-C; Rohner, 1984). The PARQ-C – Short Form is a 30-item self-report survey designed to measure the cross-cultural assessment of

children's/youths' perceptions of parental accepting-rejecting behaviors and to determine the impact of these perceptions on their social and personality development (Rohner, 1984) (see Appendix C for a copy of the measure).

There is a form that children/youth filled out to examine perceptions of their mothers and perceptions of their fathers (see Appendix C for two self-report measures). It is a shorter version of the longer 60-item measure. The PARQ-C includes the following four subscales: 1) Aggression/Hostility, 2) Warmth/Affection 3) Neglect/Indifference, and 4) Undifferentiated Rejection. Responses to the PARQ-C items are made on a 4-point scale, with *almost always true* = 4*, sometimes* = 3*, rarely* = 2*, and almost never* =1. Instructions for scoring the items on the scales are provided in the manual (Rohner, 1984) and must be done manually by the researcher. Scale scores are obtained by summing item scores for each scale, or a total PARQ-C score may be obtained by summing across the four scales (with reverse scoring of the Warmth/Affection scale total score).

The PARQ-C has consistently shown good reliability. The initial reliability data were gathered from a sample of 220 male and female youth, and internal consistency is good with Chronbach's (1951) alpha ranging from .72 to .90. Also, the composite (mean) reliability coefficient of all versions of the PARQ-C across time spans ranging from three weeks to 10 years is .62. Validity of the PARQ-C has also been established consistently and across several research studies, including concurrent/convergent validity between the PARQ-C's last three subscales and the Acceptance, Hostile Detachment, and Rejection Scales of the Child Report of Parent Behavior Inventory (Schaefer, 1964) (r = .83, .64, .74, respectively) and between first PARQ-C's first subscale and the Physical Punishment scale of Bronfenbrenner's Parent

Behavior Questionnaire (BPB; Siegelman, 1965) (r = .55). Construct validity and discriminant validity have also been demonstrated (see Appendix C for a copy of the measure).

Sexual identity-specific perceived parental acceptance/rejection was measured using the Perceived Parental Rejection Scale (PPRS; Willoughby et al., 2006). The PPRS is a 32-item measure that assesses youth's perceptions of parental reactions to their sexual orientation/identity disclosure (Willoughby et al., 2006). It was developed on the basis of Weinberg's (1972) love versus conventionality theory and Savin-Williams' (2001) initial reactions model. The scale examines nine theoretical dimensions, including: 1) parents' perceived level of general homophobia, 2) parent (or self) focus, 3) child focus, 4) shock, 5) denial, 6) anger, 7) bargaining, 8) depression, and 9) acceptance (Willoughby et al., 2006). The scale was initially developed to assess 9, and in its current form assesses 8, theoretical dimensions of parents' initial reactions to coming out, including negative shock, denial, anger, bargaining, depression, acceptance, general homophobia, and parent-focused concerns (the 9th used to be child-focused concerns) – 4 items assess each dimension. Items assessing the child-focused dimension were later removed based on the results of the initial scale development study, because these items did not correlate with the PPRS total as expected and lowered overall reliability estimates (i.e., alpha) in both the mother and father versions of the scale. The result, therefore, was a 32-item scale assessing for eight theoretical dimensions of perceived parental reactions.

Participants were asked to think back to a time when the disclosure of their sexual orientation occurred and, using a 5-point Likert scale, they indicated agreement or disagreement with several statements, such as "My parent supports me" and "My parent says I am no longer his/her child." Higher scores indicate more negative perceptions of their parent's reactions, and positive staged items are reverse scored. Scores on the PPRS ranged from 32 to 160 (M = 83.68,

SD = 34.11). Adequate reliability has been demonstrated, with Chronbach's (1951) alpha at .97 (Willoughby et al., 2006), and was re-established at .97 in a subsequent study (Bregman et al., 2013). Specifically, the PPRS showed item-total correlations of .40 or above and demonstrated good internal consistencies (mother version [n=70], alpha .97; father version [n=45], alpha =.97) (Willoughby et al., 2006). Also, good test-retest reliability was shown at a 2-week interval (mother version [n=19], *r* =.97; father version [n=12], *r* = .95) (Willoughby et al., 2006). Exploratory factor analyses were not conducted in the measure development study due to the small sample size (n=72). Also, validity is not reported (see Appendix C for the measure).

Outcome Variables

Depressive Symptoms

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to evaluate symptoms of depression. The CES-D is a freely available and widely used 20 item self-report scale that measures current level of depressive symptoms in the general population, with an emphasis on depressed mood during the past week (Radloff, 1977). The CES-D incorporates the main symptoms of depression, as derived from five validated depression scales including the Beck Depression Inventory (BDI). It is freely available in the public domain, has been validated in diverse samples of community and primary care populations (ages 13 and up), in cardiac patients and older populations and has good test-retest reliability.

It is a valid and reliable a 20-iem self-report measure that evaluates the presence and frequency of clinical symptoms associated with depression (Finch, Kolody, & Vega, 2000; Huynh, Devos, & Dunbar, 2012). Participants rate the extent to which they experienced depressive symptoms on a 4-point Likert-type scale. Participants are asked to mark an X against each statement which best describes how often they fit or behaved in a particular way. In order to

score this self-report measure, a number is coded in the box that participants mark an X for each statement: Rarely or none of the time (less than 1 day) = 0, Some or a little of the time (1-2 days) = 1, Occasionally or a moderate amount of the time (3-4 days) = 2, and most or all of the time (5-7 days) = 3. In order to score this self-report measure, a number is coded in the box that participants mark an X for each statement: Rarely or none of the time (less than 1 day) = 0, Some or a little of the time (1-2 days) = 1, Occasionally or a moderate amount of the time (3-4 days) = 2, and Most or all of the time (5-7 days) = 3. Items 4, 8, 12, and 16 are reverse coded, where Rarely = 3, Some = 2, Occasionally = 1, and Most = 0. Scores range from 0 to 60 with higher scores indicating more symptoms of depression. Scores of 16 to 26 are considered indicative of mild depression and scores of 27 or more indicative of major depression. Cronbach'a (1951) alpha for the CES-D is .75 (Huynh, Devos, & Dunbar, 2012) (see Appendix C for the measure).

Self-Esteem

Self-Esteem was measured using the Rosenberg Self- Esteem Scale (RSES; Rosenberg, 1965), which includes 10 items that measure global self-esteem. The RSES consists of 10 statements where the participant chooses among four possible responses, which include: "strongly agree" (SA), "agree" (A), "disagree" (D) or "strongly disagree" (SD). (Rosenberg 1965). Each of these aspects determines an individual's attitudes toward him/herself and how he/she views themselves in relation to their peers. Participants indicated how much they agree with the 10 statements by considering how they generally feel about themselves. For example, "On the whole, I am satisfied with myself" and "I wish I could have more respect for myself."

This measure has good internal consistency (alpha= .87). The original sample for which the scale was developed included a diverse sample of 5,024 high school juniors and seniors from

10 randomly selected schools in New York State (Rosenberg, 1965). Scoring consists of numbers coded for each answer. Scores are calculated as follows:

- *For Items 1, 2, 4, 6, and 7*:

  Strongly agree = 3

  Agree = 2

  Disagree = 1

  Strongly disagree = 0

- *For items 3, 5, 8, 9, and 10* (which are reversed in valence)

  Strongly agree = 0

  Agree = 1

  Disagree = 3

  Strongly disagree = 3

After items are reverse coded, then the scores for the 10 items are summed. The scale ranges from 0-30, with higher scores suggesting higher self-esteem (Rosenberg, 1965). Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem (see Appendix C for measure).

Exogenous (Socio-demographic) Variables

Additionally, participants completed a demographic questionnaire to examine salient socio-demographic variables such as age, gender, race, ethnicity, level of outness, sexual orientation, highest level of education, family income, youths' religious affiliation, and youths' reports of parental religious affiliation and level of religiosity. This information was gathered to assess for exogenous effects on the primary study variables. It was important to explore salient contextual characteristics of Black LGBQ participants because so little is known about the demographic profile of this understudied group. Additionally, assessing their demographic characteristics helped to explore key associations between these contextual variables and the primary study (predictor and outcome) variables.

Data Processing and Analysis

Data collected from the hard paper copy of surveys were first manually entered by the researcher into Qualtrics, then data collected online through Qualtrics (along with the manually entered data) was exported into IBM SPSS Statistics Version 22 and cleaned. Frequencies, range checks, and

descriptive statistics (e.g., mean, standard deviation, skewness) were analyzed as appropriate to level of measurement, and bivariate statistics (correlations, cross tabulations) were evaluated for all measures and subscales to ensure accuracy and logical consistency. All subscales for each measure were created and reliability was checked and compared to the original measures.

Frequencies were then calculated for demographic variables for the entire sample. Next, descriptive statistics (means, standard deviation, minimum and maximum) were run for the two predictor variables (Black racial identity and LGBQ sexual identity), mediators (global and sexual identity-specific family acceptance/ rejection) and the two outcome variables (depressive symptoms and self-esteem). Then, correlations were run for predictor, mediator, and outcome variables, for total scales and subscales for each of the measures.

Next, a series of Stepwise Regression Analyses were conducted to examine how the two predictors (Black racial identity and LGBQ sexual identity) and demographic variables were associated with the two outcome variables (depressive symptoms and self-esteem), with the probability of variable entry set at .10, to identify significant subsets of variables. After preliminary sets of predictors within each subset of variables were identified, final multivariate models were estimated for the two primary outcome variables (depressive symptoms and self-esteem).

Finally, to evaluate the possible mediating effect of global and LGBQ specific parental acceptance and parental rejection on the association between Black racial identity, LGBQ sexual identity, depressive symptoms and self-esteem, a s mediation analysis was conducted to evaluate direct and indirect effects. Preacher and Hayes' (2008) method was used, which involved conducting a series of regressions to test the size of the coefficient for the direct path (between the predictor and outcome variables) with and without the hypothesized mediator (parental acceptance/rejection). Finally, a series of t-tests and ANOVAs were conducted to assess for possible associations between the outcome variables (depressive symptoms and self-esteem) and salient demographic variables (age, gender,

ethnicity, level of outness across three domains (family, religion, world), family SES/class, and parental religiosity (as reported by youth).

Validation Procedures and Potential Threats

Reliability and validity of the quantitative data was addressed by using reliable and valid measures and using appropriate statistical analyses for the sample size (n= 110). Due to the non-probability sampling approach, the generalizability of these results is limited. Other threats to reliability and validity include having no way to ensure respondents who completed the survey fit all eligibility criteria, and respondents likely experiencing fatigue while completing the survey, which may have resulted in some random and inconsistent responses. Reliability and validity may have also been threatened by the use of questionnaires that were not previously widely used, and measures that were not specifically normed with Black, LGBQ, or youth populations.

Schedule, Obstacles, and Feasibility Issues

After first receiving approval from the doctoral dissertation committee, the proposal was submitted to Drexel's Institutional Review Board for review (see Appendix A for participant consent forms). Despite having a study that focused on youth, there were no major delays with the IRB process since the population of interest was anonymously completing self-report surveys online. One concern expressed by the IRB committee was ensuring the confidentiality of participants' data gathered on-line. This was addressed by keeping the study anonymous, with no identifying information collected from participants. Another concern among IRB committee members, which caused a minor delay, was the initial plan to include parents or caregivers and conducting focus groups to understand their experiences having an LGBTQ family member. IRB members were very worried about potential negative reactions from parents who had not fully accepted their children's sexual orientation, so after consulting with the chair and committee members, parents were not interviewed in this study.

IRB approval was received on October 8, 2013 (and again renewed in October, 2014). The online survey was launched in Qualtrics on October 10, 2013. The survey link remained active for 11

months starting on August 7, 2014; 305 surveys were started (at minimum demographic survey) and 110 participants had complete data. The sample (Black, LGBQ youth between ages 14-21) was recruited using a variety of methods. The link to the survey was posted on several social media sites, including on many group pages and Black youth and LGBTQ-specific pages on Facebook. It was tweeted to links at many different agencies, organizations, and Black youth and LGBTQ-specific resource groups on Twitter, and shared it with many Black and LGBTQ-specific blogs on Tumblr (which led to it being "liked," "shared," "re-tweeted, and "re-blogged" hundreds of times by participants and supporters). Participants were also recruited in-person (individually, and by having groups where youth could gather collectively) at several agencies in Philadelphia, including the Attic Youth Center, the Mazzoni Center, William Way Community Center, YHEP, and GALAEI. After 11 months of data collection, and several attempts to recruit the planned number participants, the dissertation chair and committee agreed to close out the survey and end recruitment with 110 participants who had complete data.

Unfortunately, the sample of 200 participants was much more difficult to obtain than expected. The following factors made reaching the targeted sample size of N=200 difficult: 1) multiple marginalized statuses and multi-stressed individuals, 2) participant fatigue –due to the number of questions, and the reverse wording of several of the questions, many youth were "annoyed," "frustrated," and "tired" of answering the questions, 3) taking the survey online may have resulted in more missing data compared to studies where in-person data collection took place, and 4) no incentive to participate. Although I tried, for months, to schedule a time to attend agencies/organizations in different cities in person, it never came to fruition for a variety of different scheduling-related reasons. Also, it seemed that some agencies were concerned about their youth being inundated with requests to participate in research studies, and at the time were not open to another researcher coming in.

It would have been more feasible to collect data in-person, either by hand or by supplying laptops, and being available to answer questions and provide encouragement if youth were becoming

fatigued while completing the self-report surveys. Even after using the "shortened" version of several measures (when one existed), youth participants were still asked to answer between 170 (if only answering the parental acceptance/rejection measures about one parent) and 236 (if answering the parental acceptance/rejection measures about two parents) questions. Other suggestions for how these feasibility issues and obstacles can be avoided in future research studies are addressed in the Future Research Implications section.

CHAPTER FOUR

RESULTS

The results are presented in the following two sections. In the first section, the demographic profile of the final sample of N=110 participants who have complete data is summarized and descriptive statistics for the key predictors (Black racial identity and LGBQ sexual identity), mediators (global and specific parental acceptance/parental rejection) and two outcome variables (depressive symptoms and self-esteem) are described. The second section summarizes the correlation analyses for the two predictors, mediators, and two outcome variables and a series of four Stepwise Regression analyses. The four Stepwise Regression analyses were conducted to examine if the predictors (Black racial identity [CRIS] and LGBQ sexual identity [LGBIS]), hypothesized mediators (general parental acceptance/rejection [PARQ-C] and parental acceptance/rejection specific to sexual orientation of offspring [PPRS]), and salient demographic variables (age, gender, sexual identity, ethnicity, education, SES, degree of outness, and youth and family religious affiliation and level of religiosity) are associated with the two outcome variables (depressive symptoms [CES-D] and self-esteem [RSES]), with the probability of variable entry set at .10 to identify significant subsets of variables.

After the preliminary sets of predictors within each subset of variables were identified, final multivariate models were estimated for the two outcome variables (depressive symptoms and self-esteem). Then, to evaluate for the possible mediating effect of global and specific parental acceptance/ rejection, a mediation analysis was conducted to evaluate the direct and indirect effects of racial and sexual identity on depressive symptoms and self-esteem. Preacher and Hayes' (2008) method was used, which involved conducting a series of regression analyses for testing the size of the coefficient for the direct path (between the independent and dependent variables) with and without the intervening mediator variables. Finally, the last section describes a series of Correlations, T-tests Chi-square tests, and ANOVAs that were conducted to assess for the possible influence of salient demographic variables

(age, gender, sexual identity, ethnicity, education, SES, degree of outness, and youth-reported parent level of religiosity) on the association between the independent variables (racial and sexual identity) and the dependent variables (depressive symptoms and self-esteem).

Analysis of Missing Data (Completers vs. Non-completers)

Of the 305 participants who clicked on the web link to the survey (or who began to fill out a paper copy), a total of 110 completed the survey; 105 did not complete the survey but at minimum filled out the demographic part of the survey, and the remaining 90 consented to participate in the study but did not provide their demographic information. Completer and non-completer data analyses were first conducted to examine if participants who completed the survey (n=110) were significantly different from those who did not complete the survey completed the demographic questions (n=105). The analyses included one t-test to examine self-reported age (see table 4.1) and a series of Chi-square (χ^2) tests comparing the group of completers (n=110) and non-completers (n=105) on 10 of the 15 demographic variables examined in this study (see table 4.2). Bonferroni adjustment was used to correct for the multiple independent t-tests and χ^2 tests. A total of 10 comparisons were conducted, setting the significant p level at .005 (.05 divided by the 10 tests).

The independent t-test suggests there is no significant difference in age between the completers and the non-completers (p=.619), with the mean age=19.10 for the completers and the mean age=18.96 for the non-completers (see table 4.1).

Table 4.1: Independent T-test for Completers vs. Non-completers

	Completers				**Non-completers**			
Variable	*t*	*df*	*M*	*sig*	*t*	*df*	*M*	*sig*
	N=110				N=105			
Age	.497	213	19.10	.619	.497	213	18.96	.619

^ Equal variances assumed according to Levene's Test for Equality of Variances
* Note: Bonferroni Adustment was used to correct for the T-test and multiple Chi-square tests. A total of 10 comparisons were conducted, setting the significant p level at .005 (.05 divided by 10 tests).

Yet, the Chi-square tests (see table 4.2) indicates the completers and non-completers were significantly different on 3 out of the 10 examined demographic variables: 1) sexual identity (χ^2(5,

N=214)=15.482, p=.008); 2) gender (χ^2(4), N=210)=34.422, p=.000); and 3) ethnicity (χ^2(4, N=182)=20.379, p=.000). These results suggest that more completers identified as gay, male, African-American, and more participants who did not complete the survey identified as multi-ethnic.

The Chi-square tests suggest that the completers and non-completers were not significantly different on the following six demographic variables: 1) how out to your family (χ^2(3,N=181)=5.364, p=.147); how out to your religious group (χ^2(3, N=181)=8.515, p=.036); how out to the world (χ^2(3, N=181)= 4.646, p=.200); level of education (χ^2(5, N=181)=3.445, p=.632); family level of religiosity (χ^2(2, N=179)=.852, p=.653; and SES/class (χ^2(4, N=181)=1.164, p=.884).

Table 4.2: Chi-square tests for Completers vs. Non-completers

	Entire Sample		
Variable	χ^2	*Df*	*p*
	N=214		
Sexual Identity	15.482	5	**.008**
	N=210		
Gender	34.422	4	**.000**
	N=182		
Ethnicity	20.379	4	**.000**
	N=181		
How Out – Family	5.364	3	.147
	N=181		
How Out – Religion	8.515	3	**.036**
	N=181		
How Out – World	4.646	3	.200
	N=181		
Education Level	3.445	5	.632
Parent Level of Religiosity	N=179		
	.854	2	.653
	N=181		
SES/Class	1.164	4	.884

* Note: Bonferroni Adustment was used to correct for the T-test and multiple Chi-square tests. A total of 10 comparisons were conducted, setting the significant p level at .005 (.05 divided by 10 tests).

Demographic Characteristics of Completers

The final sample includes 110 participants (see table 4.3 for demographic profile). Three-hundred and five participants logged onto the survey website or filled out a hard paper copy of the survey, and 110 completed responses between the launch date of October 30, 2013 and the date the

survey was closed on September 7, 2014 (11 months and 1 week of data collection). Out of the 249 participants who responded "YES, I would like to participate in this study" after reading the consent form (and 3 participants responded "NO"), 181 answered the 15 demographic questions, and after that there was a considerable drop in the number of completers. The CRIS (first measure that evaluated Cross Racial Identity) had 140 responses; the LGBIS (second measure that evaluated Lesbian, Gay, and Bisexual Identity) had 135 responses; the PARQ-C for Mother or primary/1st Parent (third measure that evaluated general parental/acceptance from a parent) had 123 responses and then about half of the participants noted they had a second parent (49% said YES, 50% said NO), thus 60 participants answered the PARQ-C for a Father or a second Parent; the PPRS (fourth measure that specifically evaluated perceived parental reactions to offspring's sexual orientation) had 110 responses and then about a third of participants responded they had a second parent (30% said YES, 68% said NO); the CES-D (fifth measure that evaluated depressive symptoms) and the RSES (sixth measure that evaluated self-esteem) also had 110 responses. Thus, 110 is the total number of participants who had complete data and were evaluated in this results chapter. Participants also had the opportunity to provide open-ended narrative feedback, by answering four open-ended questions; N=88, N=100, N=94, and N=89 participants responded to each of these questions, respectively and will later be summarized at the conclusion of this chapter.

Participants' ages ranged from 14 to 21 years old; most were between 19 and 21 (n=75; 68.18%) (see table 4.3 for demographic profile of n=110 completers). Participants self-identified racially as either Black-only (79%), Biracial (14%) or Multiracial (5%) and most self-identified ethnically as African-American (76%). A few participants ethnically identified as Latino@/ Hispanic/Afro-Latino@ (4%) and Multi-ethnic (10%). Most identified as female (64%); male participants made up 34% of the sample. There was a relatively even percentage of sexual identities represented which included: 24.5% lesbian (n=27), 24.5% gay (n=27), 20% bisexual (n=22), 20% queer (n=22), and 12% other non-heterosexual (n=12). More than half (60%) reported being

"completely out" to their families (or to at least to 1 parent/caregiver); approximately half (49%) reported they were not "out in their religion, at church or place worship"; and most (92%) were either "completely or somewhat out" in the world. Forty-percent identified as not religious/atheist/agnostic and 31% identified as Christian. Regarding participants' education, approximately half (55%) were either in college, had received "some college," or graduated college with either an Associate's or Bachelor's degree and 43.6% had some high school, or a high school diploma or GED.

Participants also answered some demographic questions about their parents/caregivers or family. Most reported their family's socioeconomic status as low-middle to middle (77%). Most religiously identified their family as Christian (79%), approximately half reported their family had a moderate (n=41; 47%) level of religiosity (e.g., were somewhat or occasionally influenced by their religious beliefs), and approximately one-third (n=30; 27.3%) reported their family is frequently influenced by their religious beliefs.

Participants were able to select multiple responses to the following question: "Who do you currently live with"; more than half (n=72; 65.6%) reported they lived with their birth and/or step-parent(s), with siblings (n=31; 28.2%), by themselves (n=25; 22.7%), or with friends, partners or chosen family (n=22). Only 16.4% (n=18) reported they had ever been kicked out of their homes, forced to leave, or abandoned by a parent/caregiver because of their sexual orientation. The demographic characteristics for participants who completed the surveys (n=110) are summarized below in table 4.3.

Table 4.3: Demographic Characteristics of the Participants who Completed Survey (N=110)

Variable	Sampling N	Valid %	Cumulative %
Age			
14	3	2.7%	2.7%
15	6	5.5%	8.2%
16	10	9.1%	17.3%
17	8	7.3%	24.5%
18	8	7.3%	31.8%
19	16	14.5%	46.4%
20	29	26.4%	72.7%

21	30	27.3%	100%
Sexual Identity			
Lesbian	27	24.5%	24.5%
Gay	27	24.5%	49.1%
Bisexual	22	20%	69.1%
Queer	22	20%	89.1%
Other non-heterosexual	12	10.9%	100%
Gender Identity			
Female	71	64.5%	64.5%
Male	37	33.6%	98.2%
Other	2	1.8%	100%
Race			
Black	87	79.1%	79.1%
Biracial	15	13.6%	92.7%
Multiracial	6	5.5%	98.2%
Other	2	1.8%	100%
Ethnicity			
African-American	84	76.4%	76.4%
Latino/a/Hispanic/Afro-Latino/a	4	3.6%	80%
Multi-ethnic	11	10%	90%
Other	11	10%	100%
How out are you in Family?			
Completely	66	60%	60%
Somewhat	36	32.7%	92.7%
Not at all	7	6.4%	99.1%
Does not apply	1	0.9%	100%
How out are you in Religion?			
Completely	11	10%	10%
Somewhat	17	15.5%	25.5%
Not at all	28	25.5%	50.9%
Does not apply	54	49.1%	100%
How out are you in the World?			
Completely	49	44.5%	44.5%
Somewhat	53	48.2%	92.7%
Not at all	6	5.5%	98.2%
Does not apply	2	1.8%	100%
Highest Education Level			
Some high school	31	28.2%	28.2%
HS diploma or GED	17	15.5%	43.6%
Some college	53	48.2%	91.8%
Trade/vocational training	2	1.8%	93.6%
Received Associate's degree	3	2.7%	96.4%
Received Bachelor's degree	4	3.6%	100%
***Youth* Religious Affiliation**			
Christian	34	30.9%	30.9%
Muslim	4	3.6%	34.5%
Buddhist	2	1.8%	35.4%

Spiritual	19	17.3%	53.6%
Not religious/Atheist/Agnostic	44	40%	93.6%
Other	7	6.4%	100%
***Family's* Religious Affiliation**			
Christian	87	79.1%	79.1%
Muslim	5	4.5%	83.6%
Buddhist	1	0.9%	84.5%
Spiritual	5	4.5%	89.1%
Not religious/Atheist/Agnostic	6	5.5%	94.5%
Other	6	5.5%	100%
***Family's* Level of Religiosity**			
Low/minimally	28	25.5%	25.5%
Medium/occasionally	52	47.3%	72.7%
High/frequently	30	27.3%	100%
Socioeconomic status/Class			
Low SES/class	14	12.7%	12.7%
Low-middle SES/class	39	35.5%	48.2%
Middle SES/class	46	41.8%	90%
Upper-middle SES/class	10	9.1%	99.1%
Upper-high SES/class	1	0.9%	100%
Who do you live with?			
By myself	25	22.7%	
Birth and/or step-parent(s)	72	65.5%	
Grandparent(s)	5	4.5%	
Sibling(s)	31	28.2	
Extended family	4	3.6%	
Foster family	1	0.9%	
Adopted family	1	0.9%	
Friend(s) and/or chosen family	11	10%	
Other	11	10%	
Have you ever been kicked out?			
Yes	18	16.4%	16.4%
No	92	83.6%	100%

Descriptive Statistics for Predictor, Mediator, and Outcome Variables

Scales and subscales were created for the six self-report surveys (Cross Racial Identity Scale [CRIS], Lesbian, Gay, Bisexual Identity Scale [LGBIS], General Child Parental Acceptance-Rejection Scale – Short Form [PARQ-C], Perceived Parental Reactions Scale [PPRS], Center for Epidemiologic Studies Depression Scale [CES-D], and the Rosenberg Self-Esteem Scale [RSES]). Scales and subscales were only created for participants who responded to at least 50% of the questions on each

questionnaire. Means were used to replace missing values for participants who were missing less than 50% of the responses on any of the questions.

Means, standard deviations, minimums, and maximums were then calculated for the two predictor variables (Black racial identity and Lesbian Gay and Bisexual Identity), the 2 hypothesized mediators (global parental acceptance/rejection and perceived parental reactions to sexual orientation), and two outcome variables (depressive symptoms and self-esteem). Finally, internal reliability (Chronbach alpha) was then evaluated for all key variables and compared to the reliability of the original measures (see table 4.4 for descriptive statistics for all scales).

The two predictor variables were Black racial identity development (6 subscales), measured by the Cross Racial Identity Scale (CRIS) and sexual identity development (8 subscales) measured by the Lesbian, Gay, and Bisexual Identity Scale (LGBIS). The mean and standard deviation for the Pre-Encounter Assimilation subscale of the CRIS was M=15.25 and SD=8.46, for the Pre-Encounter Miseducation subscale was M=14.12 and SD=7.66, for the Pre-Encounter Self-Hatred subscale was M= 14.51 and SD=8.42, Immersion-Emersion Anti-White was M=10.21 and SD=7.34, Internalization Afrocentricity was M=14.88 and SD=6.91, Internalization Multiculturalist Inclusive was M=28.55 and SD=5.54. The Chronbach alphas for this sample are summarized in table 4.4 and were all comparable and within range (within .2 of one another) to the chronbach alpha scores reported by the developers of this measure (e.g., Vandiver, Cross et al., 2002). Some exceptions were the Pre-Encounter Miseducation (α =.87) and the Immersion-Emersion Anti-White (α=.93) subscales, which had alpha scores slightly higher than the developers reported in their original study (.α =.79 and α=.89, respectively); and the Internalization Multiculturalist Inclusive (α=.78) subscale which had an alpha slightly lower than the original study (α=.82), but again all within an acceptable range.

It is important to note that because of a procedural error while developing the online survey, only four out of the eight subscales in the Lesbian, Gay, and Bisexual Identity Scale (LGBIS) were included in the online survey. Eight of the questions that should have been posted in the online survey

(from the correct version of the final measure) were accidentally replaced with 8 different questions from an earlier version when the measure was developed. The four subscales that were not included in the online survey are: 1) Internalized Homonegativity; 2) Identity Superiority; 3) Identity Affirmation; and 4) Identity Centrality. Thus, only the following 4 out of the original 8 LGBIS subscales will be evaluated in this study because of a procedural error: 1) Acceptance Concerns: 2) Concealment Motivation; 3) Identity Uncertainty; and 4) Difficult Process.

The mean and standard deviation for the Acceptance Concerns subscale of the LGBIS was M=3.54 and SD=1.53, for the Concealment Motivation subscale M=3.83 and SD=1.33, for the Identity Uncertainty subscale M=2.28 and SD=1.40, and for the Difficult Process subscale M=3.22 and SD=1.04. The Chronbach alpha scores for this sample are summarized in table 4.4 below. For this sample, the Chronbach alpha score for each of the four included LGBIS subscales were somewhat lower compared to the original study (Mohr & Kendra, 2011), and for this sample are as follows: Acceptance Concerns α=.73, Concealment Motivation α=.61, Identity Uncertainty α=.82, and Difficult Process α=.77. In the original study (Mohr & Kendra, 2011), the alpha scores were α=.83, α=.70, α=.87, and α=.92, respectively, but are acceptable.

The first mediator variable, global parental acceptance-rejection, was measured by the Child Parental Acceptance-Rejection Questionnaire – Short Form (PARQ-C) assessing general parental acceptance-rejection. The second mediator variable, the Perceived Parental Reactions Scale (PPRS) assessed parental acceptance-rejection specific to sexual orientation. Additionally, participants were asked to fill out the questionnaires for both parents and/or caregivers, if applicable, so there are two sets of descriptive statistics for each of these measures (mothers and fathers/second caregiver).

For the PARQ-C Mother/Parent 1, means and standard deviations were as follows for each of the four subscales and total scale: Warmth/Affection M=14.77, SD=5.65, Aggression/Hostility M=20.72, SD=3.77, Indifference/Neglect M=18.76, SD=4.39, Undifferentiated Rejection M=13.58, SD=2.68, and Total Scale M=78.30, SD=14.36. The Chronbach alpha scores for the total scale for this

sample was α=.86, much higher than the alpha reported in the original study (Rohner, 1984) α=.62. The Chronbach alphas for the PARQ-C subscales in this study were comparable to the original study.

The PARQ-C Father/Parent 2, means and standard deviations were as follows for each of the four subscales and total score: Warmth/Affection M=23.11, SD=6.49, Aggression/Hostility M=20.98, SD=4.26, Indifference/Neglect M=17.21, SD=4.62, Undifferentiated Rejection M=13.92, SD=2.89, and the total scale M=75.47, SD=13.77. The Chronbach alpha scores for the total scale for this sample was α=.72, much higher than the alpha reported in the original study (Rohner, 1984) α=.62. The Chronbach alpha for the PARQ-C subscales in this study was comparable to the original study.

Means and standard deviations for the eight PPRS Mother/Parent 1 subscales and total score are as follows: Negative Shock M=6.71, SD=3.82, Denial M=10.35, SD=4.48, Anger M=9.45, SD=5.14, Bargaining M=9.90, SD=4.81, Depression M=10.45, SD=5.12, Acceptance M=12.18, SD=4.92, General Homophobia M=10.94, SD=5.17, Parent-Focused Concerns M=12.30, SD=4.54, and the total scale M=82.23, SD=32.07. The Chronbach alpha scores for the total scale for this sample was α=.97, exactly the same as the original study (Willoughby et al., 2006).

In the original study, alpha scores were not reported for the eight sub-scales, however, they are reported in table 4.4 for the sample in this dissertation study. Means and standard deviations for the PPRS Father/Parent 2 were as follows: Negative Shock M=6.97, SD=4.16, Denial M=9.72, SD=5.12, Anger M=8.69, SD=4.62, Bargaining M=9.36, SD=4.19, Depression M=9.06, SD=4.31, Acceptance M=12.62, SD=4.62, General Homophobia M=11.27, SD=4.80, Parent-Focused Concerns M=12.65, SD=4.62, and the total scale M=78.65, SD=27.95. The Chronbach alpha scores for the total scale for this sample was α=.96, slightly lower than original study (α=.97; Willoughby et al., 2006). In the original study, alpha scores were not reported for the eight sub-scales, however, they are reported in table 4.4 for the sample in this dissertation study.

The two outcome variables, depressive symptoms and self-esteem, were measured by the Center for Epidemiologic Studies Depression Scale (CES-D) and the Rosenberg Self-Esteem Scale

(RSES). The mean and standard deviation for the CES-D in this sample was M=12.51, SD=10.07, and for the RSES was M=28.81, SD=6.80. For both measures, the Chronbach alpha scores were higher in this sample compared to the original studies. In the original CES-D study (Radloff, 1977), the alpha score was α=.75, which was significantly lower than the alpha score for the sample in this dissertation study, α=.92. In the original RSES study, the alpha score was α=.87, also lower than the alpha score for the sample in this dissertation study, α=.91. It is important to note that neither of these measures were normed with samples that included a significant number (if any) participants of color or who identified as non-heterosexual, although there have been more recent studies that have used these measures to study both of these populations.

Table 4.4: Descriptive Statistics for Predictors, Mediators, and Outcome Variables

Predictor Variables	**M**	**SD**	**Min**	**Max**	**Alpha** (α)	**Original Alpha** (α)
CRIS						
Pre-Encounter Assimilation	15.25	8.46	5.00	35.00	.87	.85
Pre-Encounter Miseducation	14.12	7.66	5.00	35.00	.87	.79
Pre-Encounter Self-Hatred	14.51	8.42	5.00	34.00	.89	.89
Immersion-Emersion Anti-White	10.21	7.34	5.00	32.00	.93	.89
Internalization Afrocentricity	14.88	6.91	5.00	31.00	.84	.83
Internalization Multiculturalist Inclusive	28.55	5.54	13.00	35.00	.78	.82
LGBIS						
Acceptance Concerns	3.54	1.53	1.00	6.00	.73	.83
Concealment Motivation	3.83	1.33	1.00	6.00	.61	.70
Identity Uncertainty	2.28	1.40	1.00	6.00	.82	.87
Difficult Process	3.22	1.04	1.00	6.00	.77	.92

Mediator Variables	**M**	**SD**	**Min**	**Max**	**Alpha** (α)	**Original Alpha** (α)
PARQ-C – Mother/Parent 1						
Total Scale	78.30	14.36	36.00	96.00	.86	.62
Warmth/Affection	14.77	5.65	8.00	30.00	.91	.90
Aggression/Hostility	20.72	3.77	8.00	24.00	.85	.87
Neglect/Indifference	18.76	4.39	7.00	24.00	.86	.77
Undifferentiated Rejection	13.58	2.68	4.00	16.00	.80	.72
PARQ-C – Father/Parent 2						
Total Scale	75.47	13.77	32.00	96.00	.72	.62
Warmth/Affection	23.11	6.49	8.00	32.00	.93	.90
Aggression/Hostility	20.98	4.26	10.00	24.00	.89	.87
Neglect/Indifference	17.21	4.62	7.00	24.00	.82	.77
Undifferentiated Rejection	13.92	2.89	5.00	16.00	.84	.72
PPRS – Mother/Parent 1						
Total Scale	82.23	32.07	32.00	156.00	.97	.97
Negative Shock	6.71	3.82	4.00	20.00	.86	not reported
Denial	10.35	4.48	4.00	20.00	.75	not reported
Anger	9.45	5.14	4.00	20.00	.88	not reported
Bargaining	9.90	4.81	4.00	20.00	.82	not reported
Depression	10.45	5.12	4.00	20.00	.87	not reported
Acceptance	12.18	4.92	4.00	20.00	.89	not reported
General Homophobia	10.94	5.17	4.00	20.00	.90	not reported
Parent-Focused Concerns	12.30	4.54	4.00	20.00	.82	not reported
PPRS – Father/Parent 2						
Total Scale	78.65	27.95	37.00	130.00	.96	.97
Negative Shock	6.97	4.16	4.00	16.00	.91	not reported

Denial	9.72	5.12	4.00	20.00	.89	not reported
Anger	8.69	4.62	4.00	20.00	.88	not reported
Bargaining	9.36	4.19	4.00	18.00	.75	not reported
Depression	9.06	4.31	4.00	19.00	.81	not reported
Acceptance	12.62	4.62	4.00	20.00	.88	not reported
General Homophobia	11.27	4.80	4.00	20.00	.85	not reported
Parent-Focused Concerns	12.65	4.62	4.00	20.00	.80	not reported
Outcome Variables	**M**	**SD**	**Min**	**Max**	**Alpha** (α)	**Original Alpha** (α)
CESD	12.51	10.07	.00	46.00	.92	.75
RSES	28.81	6.80	10.00	40.00	.91	.87

Correlations for Predictor, Mediator, and Outcome Variables

In order to address the first six research questions, bivariate correlations were conducted.

Question 1 ***"Is there an association between stage of racial identity development and sexual identity development of Black LGBQ youth?"*** was assessed by conducting bivariate correlations between the 6 CRIS subscales: 1) *pre-encounter assimilation* (PA), 2) *pre-encounter miseducation* (PM), 3) *pre-encounter self-hatred* (PSH), 4) *immersion-emersion anti-White* (IEAW), 5) *internalization afrocentricity* (IA), 6) *internalization multiculturalist inclusive* (IMCI); and the 4 (out of the 8, due to the procedural error described above) LGBIS subscales: 1) *acceptance concerns* (AC), 2) *concealment motivation* (CM), 3) *identity uncertainty* (IU), and 4) *difficult process* (DP) (see table 4.5).

CRIS-PSH was positively and significantly correlated with the LGBIS-AC ($r=.443$, $p<.01$), with LGBIS-IU ($r=.276$, $p<.01$), and with LGBIS-DP ($r=.277$, $p<.01$), suggesting youth who reported having more negative feelings about being Black and who were earlier in their racial identity development tended to have more concerns about being stigmatized as a LGBQ person, were more

uncertain (or more insecure) regarding their sexual identity, and experienced more difficulty in sexual identity development process.

CRIS-IEAW was positively, significantly and moderately correlated with LGBIS-IU (r=.313, p<.01) and LGBIS-DP (r=.355, p<.01), suggesting youth who reported having more disdain for White people and/or culture tended to be more uncertain (or insecure) about their sexual identity, and experienced more difficulty in sexual identity development process. CRIS-IA was positively and moderately correlated with LGBIS-AC (r=.275, p<.01), LGBIS-IU, (r=.295, p<.01), and LGBIS-DP (r=.260, p<.01), suggesting youth who reported having an internalized pro-Black identity and who privileged African-centered principles and traditions tended to have more concerns about being stigmatized as a LGBQ person, and were more uncertain (or more insecure) regarding their sexual identity, and tended to experience more difficulty during their sexual identity development process.

Finally, CRIS-IMCI was negatively and modestly correlated with LGBIS-IU (r=-.222, p<.05), suggesting youth who had reached a multicultural and inclusive ideology regarding racial identity where they could connect to, respect, and engage with other cultural groups tended to experience less uncertainty (or insecurity) about their sexual identity. These findings were consistent with the predictions that the processes of racial and sexual identity development, both central tasks of adolescence, would be strongly associated with each another.

Table 4.5: Correlations between Racial Identity Development (CRIS) and Sexual Identity Development (LGBIS) Subscale Scores. (N=110)

Variable	LGBIS Acceptance Concerns	LGBIS Concealment Motivation	LGBIS Identity Uncertainty	LGBIS Difficult Process
CRIS Pre-Encounter Assimilation	-.031 (N=110)	.072 (N=110)	-.090 (N=110)	.032 (N=110)
CRIS Pre-Encounter Miseducation	.033 (N=110)	-.016 (N=110)	-.167 (N=110)	-.154 (N=110)
CRIS Pre-Encounter Self-Hatred	**.443**** (N=110)	.050 (N=110)	**.276**** (N=110)	**.277**** (N=110)

CRIS Immersion-Emersion Anti-White	.165 (N=110)	.141 (N=110)	**.313**** (N=110)	**.355**** (N=110)
CRIS Internalization Afrocentricity	**.275**** (N=110)	.191* (N=110)	**.295**** (N=110)	**.260**** (N=110)
CRIS Internalization Multiculturalist Inclusive	.003 (N=110)	-.102 (N=110)	**-.222*** (N=110)	.051 (N=110)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Question 2 ***"Is there an association between youths' stage of racial identity development and their perceived level of parental acceptance/rejection (global and sexual identity specific)?"***

Bivariate correlations were conducted with the 6 CRIS subscales: 1) *pre-encounter assimilation* (PA), 2) *pre-encounter miseducation* (PM), 3) *pre-encounter self-hatred* (PSH), 4) *immersion-emersion anti-White* (IEAW), 5) *internalization afrocentricity* (IA), and 6) *internalization multiculturalist inclusive* (IMCI) and the following 4 PARQ global acceptance subscales: 1) *warmth affection* (WA), 2) *hostility aggression* (HA), 3) *indifference neglect* (IN), and 4) *undifferentiated rejection* (UR) and the *PARQ total scale* for Mom/Parent 1 and Dad/Parent 2 (see table 4.6) to assess for overall perceived parental acceptance/rejection. Bivariate correlations were also conducted for the 6 CRIS subscales and the following 8 PPRS sexual identity specific subscales: 1) *negative shock* (NS), 2) *denial* (Den), 3) *anger* (Ang), 4) *depression* (Dep), 5) *acceptance* (Acc), 6) *general homophobia* (GH), 7) *parent-focused concerns* (PFC), and 8) *bargaining* (Barg) and *PPRS total scale* (see table 4.7) to assess perceived parental acceptance-rejection specific to youths' sexual identity.

CRIS-PSH was negatively, moderately, and significantly associated with Mom/Parent 1 PARQ-WA ($r=-.189$, $p<.05$), Mom/Parent 1 PARQ-HA ($r=-.246$, $p<.01$), Mom/Parent 1 PARQ-IN ($r=-.296$, $p<.01$), Mom/Parent 1 PARQ-UR ($r=-.379$, $p<.01$), and with the Mom/Parent 1 PARQ total scale ($r=-.300$, $p<.01$), suggesting youth who reported having more negative feelings about being Black and who were in earlier stages of racial identity development tended to report lower levels of perceived

global parental acceptance (or higher levels of overall parental rejection) by their Mom/Parent 1 as measured by the PARQ total and all four subscales.

IEAW had a small, negative significant correlation with Mom/Parent 1 PARQ-UR ($r=-.237$, $p<.05$) and with the Mom/Parent 1 PARQ total scale ($r=-.198$, $p<.05$), suggesting youth who reported having more hatred or disdain for White people and/or culture tended to report believing their Mom/Parent 1 did not really care about or love them, or accept them overall. CRIS-IA also had a small, significant negative correlation with Mom/Parent 1 PARQ-HA ($r=-.233$, $p<.05$), Mom/Parent 1 PARQ-IN ($r=-.246$, $p<.01$), Mom/Parent 1 PARQ-UR ($r=-.211$, $p<.05$), and with the Mom/Parent 1 PARQ total scale ($r=-.237$, $p<.05$), suggesting youth who reported having an internalized pro-Black identity and privileged African-centered principles tended to report lower levels of perceived global parental acceptance (or higher levels of overall parental rejection) by their Mom/Parent 1 as measured by the PARQ total and 3 of the subscales.

Finally, CRIS-IMCI had a very small significant positive correlation with Mom/Parent 1 PARQ-UR ($r=.188$, $p<.05$), suggesting youth who reached a multicultural and inclusive ideology regarding racial identity where they could connect to, respect, and engage with other cultural groups tended to believe their Mom/Parent 1 did care about and love them. There were no significant correlations between CRIS-PA or CRIS-PM and youths' perceptions of global parental acceptance-rejection by Mom/Parent 1.

CRIS-PA was also moderately and negatively correlated with Dad/Parent 2 PARQ-WA ($r=-.301$, $p<.05$), Dad/Parent 2 PARQ-UR ($r=-.307$, $p<.05$), and with the Dad/Parent 2 PARQ total scale ($r=-.294$, $p<.05$), suggesting the more youth reported a desire to assimilate and viewed being American as their primary identity (with race as secondary, an earlier stage of racial identity development), the lower their levels of global parental acceptance (or higher levels of overall parental rejection) they perceived from their Dad/Parent 2 as measured by the PARQ total and two of the subscales. CRIS-PM was also moderately and negatively correlated with Dad/Parent 2 PARQ-WA ($r=-.288$, $p<.05$),

suggesting youth who were more likely to accept and internalize stereotypes about Black people and Black culture and who were earlier in their racial identity development tended to report experiencing more warmth and affection from their Dad/Parent 2.

Finally, CRIS-PSH was moderately and negatively correlated with Dad/Parent 2 PARQ-HA ($r=-.305$, $p<.05$), PARQ-IN ($r=.390$, $p<.01$), and the total scale ($r= -.305$, $p<.05$), suggesting youth who reported having more negative feelings about being Black and who were earlier in their racial identity development tended to report lower levels of perceived overall parental acceptance (or higher levels of overall parental rejection) by their Dad/Parent 2 as measured by the PARQ total and 2 of the subscales. There were no significant correlations between the CRIS-IEAW, CRIS-IA, or CRIS-IMCI and youth's perceptions of overall acceptance-rejection by Dad/Parent 2.

CRIS-PA and CRIS-PM both had small significant positive correlations with Mom/Parent 1 PPRS-NS ($r=.231$, $p<.05$) and ($r=.235$, $p<.05$), respectively, suggesting youth who had a stronger desire to assimilate and viewed being American as their primary identity (with race as secondary) and who were more likely to accept and internalize stereotypes about Black people and Black culture and (e.g., were earlier in their racial identity development) tended to report their Mom/Parent 1 reacted more negatively (shocked) to their coming out as LGBQ. CRIS-PSH had a small, positive correlation with Mom/Parent 1 PPRS-Barg ($r=.250$, $p<.05$), Mom/Parent 1 PPRS-Dep ($r=.208$, $p<.05$), and Mom/Parent 1 PPRS-GH (r-.192, $p<.05$), suggesting youth who reported having more negative feelings about being Black and who were earlier in their racial identity development tended to experience their Mom/Parent 1 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions (specifically bargaining, depression, and general homophobia) to their coming out.

CRIS-IEAW had a small, positive correlation with Mom/Parent 1 PPRS-Acc ($r=.192$, $p<.05$), suggesting that youth who reported having disdain for White people and culture tended to experience less acceptance from their Mom/Parent 1 regarding their coming out as LGBQ. CRIS-IA also had a small, positive correlation with Mom/Parent 1 PPRS-Den ($r=.248$, $p<.01$) and PPRS-Barg ($r=.188$,

p<.05), suggesting youth who reported having an internalized pro-Black identity and privileged African-centered principles and traditions tended to experience their Mom/Parent 1 as rejecting them based on their sexual identity, as evidenced by negative reactions (specifically denial and bargaining). Finally, CRIS-IMCI had a small, negative correlation with Mom/Parent 1 PPRS-NS (r=-.208, p<.05), suggesting that youth who reached a multicultural and inclusive ideology regarding racial identity where they could connect to, respect, and engage with other cultural groups (including LGBTQ culture) tended to experience less negative shock by their Mom/Parent 1 and thus experienced a more positive reaction to their coming out. There were no significant correlations found between the following PPRS subscales for Mom/Parent 1 Ang, PFC or total scale, and any of the 6 CRIS subscales.

CRIS-PA was highly to moderately and positively associated with Dad/Parent 2 PPRS-NS (r=.702, p<.01), Dad/Parent 2 PPRS-Dep (r=.350, p<.05), and with the Dad/Parent 2 PPRS total scale (r=.350, p<.05), suggesting youth who had a stronger desire to assimilate and who viewed being American as their primary identity (with race as secondary) were more likely to experience their Dad/Parent 2 as rejecting them based on their LGBQ identity, as evidenced by negative reactions (specifically negative shock and denial) to their coming out. CRIS-PM was moderately and positively associated with Dad/Parent 2 PPRS-NS (r=.421, p<.01), suggesting youth who were more likely to accept and internalize stereotypes about Black people and Black culture and (i.e., were earlier in their racial identity development) tended to report experiencing their Dad/Parent 2 as being more negatively shocked as a reaction to the youth's coming out. CRIS-PSH was moderately and positively associated with Dad/Parent 2 PPRS-Den (r=.401, p<.05), suggesting youth who reported being unhappy or having negative feelings about being Black and were earlier in their racial identity development tended to experience their Dad/Parent 2 as rejecting them based on their sexual identity, as evidenced by negative reactions (specifically denial) to their coming out.

Finally, CRIS-IEAW was moderately associated with Dad/Parent 2 PPRS-Den (r=.489, p<.01), suggesting youth who reported having more disdain for White people and/or culture tended to

experience their Dad/Parent 2 as rejecting them based on their sexual identity, as evidenced by negative reactions (specifically denial) to their coming out. There were no significant associations between CRIS-IA or CRIS-IMCI and any of the Dad/Parent 2 PPRS subscales or the total scale. There were also no significant associations between the following PPRS subscales for Dad/Parent 2: Ang, Barg, Acc, GH or PFC any any of the 6 CRIS subscales.

Table 4.6: Correlations between Racial Identity Development (CRIS) and Global Parental Acceptance-Rejection (PARQ-C) (N=110)

Variables	CRIS Pre-Encounter Assimilation	CRIS Pre-Encounter Miseducation	CRIS Pre-Encounter Self-Hatred	CRIS Immersion - Emersion Anti-White	CRIS Internal-ization Afrocen-tricity	Internal-ization Multicul-turalist Inclusive
PARQ Mom/Parent 1 Warmth Affection	.016 (N=110)	-.038 (N=110)	**-.189*** (N=110)	-.184 (N=110)	-.157 (N=110)	.142 (N=110)
PARQ Mom/Parent 1 Hostility Aggression	-.003 (N=110)	-.135 (N=110)	**-.246**** (N=110)	-.093 (N=110)	**-.233*** (N=110)	.089 (N=110)
PARQ Mom/Parent 1 Indifference Neglect	-.015 (N=110)	-.078 (N=110)	**-.296**** (N=110)	-.186 (N=110)	**-.246**** (N=110)	.023 (N=110)
PARQ Mom/Parent 1 Undifferentiated Rejection	-.068 (N=110)	-.107 (N=110)	**-.379**** (N=110)	**-.237*** (N=110)	**-.211*** (N=110)	**.188*** (N=110)
PARQ Mom/Parent 1 Total Scale	-.012 (N=110)	-.094 (N=110)	**-.300**** (N=110)	**-.198**** (N=110)	**-.237*** (N=110)	-.121 (N=110)
PARQ Dad/Parent 2 Warmth Affection	**-.301*** (N=54)	**-.288*** (N=54)	-.012 (N=54)	-.175 (N=54)	-.110 (N=54)	.193 (N=54)
PARQ Dad/Parent 2 Hostility Aggression	-.210 (N=53)	-.003 (N=53)	**-.305*** (N=53)	-.206 (N=53)	-.170 (N=53)	.108 (N=53)
PARQ Dad/Parent 2 Indifference Neglect	-.162 (N=53)	-.109 (N=53)	**-.390**** (N=53)	-.056 (N=53)	-.130 (N=53)	-.099 (N=53)
PARQ Dad/Parent 2 Undifferentiated Rejection	**-.307*** (N=52)	-.105 (N=52)	-.268 (N=52)	-.093 (N=52)	-.125 (N=52)	.003 (N=52)
PARQ Dad/Parent 2 Total Scale	**-.294*** (N=53)	-.182 (N=53)	**-.305*** (N=53)	-.195 (N=53)	-.183 (N=53)	.095 (N=53)

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Table 4.7: Correlations between Racial Identity Development (CRIS) and Parental Acceptance-Rejection Specific to Sexual Identity (PPRS) (N=110)

Variables	CRIS Pre-Encounter Assimilation	CRIS Pre-Encounter Miseducation	CRIS Pre-Encounter Self-Hatred	CRIS Immersion-Emersion Anti-White	CRIS Internal-ization Afrocen-tricity	Internal-ization Multicul-turalist Inclusive
PPRS Mom/Parent 1 Negative Shock	**.231*** (N=109)	**.235*** (N=109)	.070 (N=109)	.056 (N=109)	.062 (N=109)	**-.208*** (N=109)
PPRS Mom/Parent 1 Denial	-.088 (N=110)	.058 (N=110)	.186 (N=110)	.171 (N=110)	**.248**** (N=110)	-.107 (N=110)
PPRS Mom/Parent 1 Anger	.016 (N=110)	.051 (N=110)	.147 (N=110)	.128 (N=110)	.176 (N=110)	-.061 (N=110)
PPRS Mom/Parent 1 Bargaining	.037 (N=110)	.062 (N=110)	**.250**** (N=110)	.131 (N=110)	**.188*** (N=110)	-.014 (N=110)
PPRS Mom/Parent 1 Depression	.020 (N=110)	.020 (N=110)	**.208*** (N=110)	.064 (N=110)	.175 (N=110)	-.044 (N=110)
PPRS Mom/Parent 1 Acceptance	-.120 (N=110)	-.176 (N=110)	.148 (N=110)	**.192*** (N=110)	.039 (N=110)	-.056 (N=110)
PPRS Mom/Parent 1 General Homophobia	.046 (N=110)	.047 (N=110)	**.192*** (N=110)	.136 (N=110)	.083 (N=110)	-.155 (N=110)
PPRS Mom/Parent 1 Parent-focused concerns	-.070 (N=110)	-.047 (N=110)	.073 (N=110)	.002 (N=110)	.029 (N=110)	-.033 (N=110)
PPRS Mom/Parent 1 Total Scale	.008 (N=109)	.045 (N=109)	.176 (N=109)	.130 (N=109)	.152 (N=109)	-.078 (N=109)
PPRS Dad/Parent 2 Negative Shock	**.702**** (N=36)	**.421*** (N=36)	.105 (N=36)	.137 (N=36)	.138 (N=36)	-.073 (N=36)

PPRS Dad/Parent 2 Denial	.192 (N=36)	.161 (N=36)	**.401*** (N=36)	**.489**** (N=36)	.299 (N=36)	.097 (N=36)
PPRS Dad/Parent 2 Anger	.303 (N=35)	.063 (N=35)	-.041 (N=35)	.102 (N=35)	-.015 (N=35)	.038 (N=35)
PPRS Dad/Parent 2 Bargaining	.278 (N=36)	.166 (N=36)	.233 (N=36)	.211 (N=36)	.242 (N=36)	.149 (N=36)
PPRS Dad/Parent 2 Depression	**.350*** (N=35)	.165 (N=35)	.174 (N=35)	.220 (N=35)	.302 (N=35)	.127 (N=35)
PPRS Dad/Parent 2 Acceptance	.174 (N=37)	.261 (N=37)	.085 (N=37)	.053 (N=37)	.019 (N=37)	-.160 (N=37)
PPRS Dad/Parent 2 General Homophobia	.239 (N=37)	-.037 (N=37)	.058 (N=37)	.292 (N=37)	.036 (N=37)	-.023 (N=37)
PPRS Dad/Parent 2 Parent-focused concerns	.324 (N=37)	-.011 (N=37)	.069 (N=37)	.135 (N=37)	.207 (N=37)	.013 (N=37)
PPRS Dad/Parent 2 Total Scale	**.350*** (N=34)	.120 (N=34)	.159 (N=34)	.256 (N=34)	.106 (N=34)	.071 (N=34)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Question 3 asked. ***"Is there an association between youths' stage of sexual identity development and their perceived level of parental acceptance/rejection (global [PARQ] and sexual identity specific parental acceptance [PPRS])?"*** Bivariate correlations were next conducted for the 4 LGBIS subscales included in the online survey: 1) *acceptance concerns* (AC), 2) *concealment motivation* (CM), 3) *identity uncertainty* (IU), and 4) *difficult process* (DP), and the 4 PARQ subscales: 1) *warmth affection* (WA), 2) hostility *aggression* (HA), 3) *indifference neglect* (IN), 4) *undifferentiated rejection* (UR) and *the total PARQ score for Mom/Parent 1 and Dad/Parent 2* (see table 4.8) to assess overall perceived parental acceptance/rejection. Bivariate correlations were also conducted for the 4 LGBIS subscales, and the 8 PPRS subscales: 1) *negative shock* (NS), 2) *denial* (Den), 3) *anger* (Ang), 4) *depression* (Dep), 5) *acceptance* (Acc), 6) *general homophobia* (GH), 7)

parent-focused concerns (PFC), and 8) *bargaining* (Barg) and *PPRS total scale* (see table 4.9) to assess perceived parental acceptance/rejection specific to youth's sexual identity.

LGBIS-AC had a small, negative correlation with Mom/Parent 1 PARQ-HA ($r=-.190$, $p<.05$), and Mom/Parent 1 PARQ-IN ($r=-.189$, $p<.05$), suggesting the more youth reported concerns about being a LGBQ person, the more hostility and aggression (verbal and/or physical) and the more indifference and neglect (less available) they tended to report experiencing from their Mom/Parent 1. A moderate, negative correlation was found between LGBIS-CM and Mom/Parent 1 PARQ-UR ($r=-.254$, $p<.01$), suggesting the more youth felt a desire or motivation to hide or conceal their sexual identity, the less they tended to believe their Mom/Parent 1 really cared about or loved them. LGBIS-IU was moderately and negatively correlated with Mom/Parent 1 PARQ-HA ($r=-.300$, $p<.01$), Mom/Parent 1 PARQ-UR ($r=-.313$, $p<.01$), and the Mom/Parent 1 PARQ total scale ($r=-.263$, $p<.01$), suggesting the more youth expressed uncertainty (or insecurity) regarding their sexual identity, the more they tended to experience their Mom/Parent 1 as being hostile and aggressive (verbally and/or physically), not really caring about or loving them, and not accepting them overall. Finally, LGBIS-DP was moderately and negatively correlated with Mom/Parent 1 PARQ-UR ($r=-.228$, $p<.05$), suggesting the more youth experienced their sexual identity development process as difficult, the more they tended to not believe their Mom/Parent 1 really cared about or loved them. There were no significant correlations found between any of the LGBIS subscales and the Mom/Parent 1 PARQ-WA subscale.

Moderate, negative correlations were also found between LGBIS-AC and Dad/Parent 2 PARQ-IN ($r=-.352$, $p<.01$) and the Dad/Parent 2 PARQ total scale ($r=-.341$, $p<.05$), suggesting the more youth reported concerns about being as a LGBQ person, the more indifference and neglect (less available) and the more overall rejection they tended to report feeling from their Dad/Parent 2. A moderate, negative correlation was also found between LGBIS-CM and Dad/Parent 2 PARQ-HA ($r=-.279$, $p<.05$), suggesting the more youth felt they needed to hide or conceal their sexual identity, the more hostility and aggression (verbal and/or physical) youth tended to report experiencing from their

Dad/Parent 2. Finally, two moderate, negative correlations were found between Dad/Parent 2 PARQ-HA and LGBIS-IU (r=-.392, p<.01) and LGBIS-DP (r=-.396, p<.01), suggesting the more uncertain (or insecure) youth felt regarding their own sexual identity and the more they experienced their sexual identity development process as difficulty, the more they tended to report experiencing hostility and aggression (verbal and/or physical) from their Dad/Parent 2. There were no significant correlations found between any of the LGBIS subscales and the Dad/Parent 2 PARQ-WA or PARQ-UR subscales.

LGBIS-AC was modestly and positively correlated with Mom/Parent 1 PPRS-Den (r=.332, p<.01), Mom/Parent 1 PPRS-Barg (r=.202, p<.05), and the Mom/Parent 1 PPRS total scale (r=.191, p<.05), suggesting the more youth reported concerns about being a LGBQ person, the more they tended to experience their Mom/Parent 1 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions (specifically denial and bargaining) to their coming out. LGBIS-CM has a small to moderate, positive correlation with Mom/Parent 1 PPRS-Den (r=.209, p<.05), Mom/Parent 1 PPRS-Barg (r=.219, p<.05), Mom/Parent 1-Dep (r=.254, p<.01), Mom/Parent 1 PPRS-GH (r=.265, p<.01), and the Mom/Parent 1 PPRS total scale (r=.236, p<.05), suggesting the more participants felt a desire or motivation to hide or conceal their sexual identity, the more they tended to experience their Mom/Parent 1 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions to their coming out.

Finally, several moderate, positive correlations were found for LGBIS-DP with Mom/Parent 1 PPRS-Den (r=.275, p<.01), Mom/Parent 1 PPRS-Ang (r=.249, p<.01), Mom/Parent 1 PPRS-Barg (r=.304, p<.01), Mom/Parent 1 PPRS-Dep (r=.283, p<.01), Mom/Parent 1 PPRS-GH (r=.249, p<.01), and with the Mom/Parent 1 PPRS total scale (r=.288, p<.01), similarly suggesting the more youth experienced their sexual identity development process as difficult, the more they tended to experience their Mom/Parent 1 as rejecting them based on their sexual identity as evidenced by negative reactions to their coming out. An unexpected finding was that LGBIS-DP was modestly and positively associated with Mom/Parent 1 PPRS-Acc (r=.225, p<.05), suggesting youth who experienced their

sexual identity development process as more difficult also experienced more acceptance from their Mom/Parent 1, whereas it was anticipated that they would feel *less* accepted. There were no significant correlations between LGBIS-IU and any of the Mom/Parent 1 PPRS subscales, nor were any found for the PPRS subscales PFC or NS and any of the LGBIS subscales.

LGBIS-AC was moderately and positively correlated PPRS-Den ($r=.393$, $p<.05$), Dad/Parent 2 PPRS-Dep ($r=.369$, $p<.05$), suggesting the more youth reported concerns about being a LGBQ person, the more they tended to experience their Dad/Parent 2 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions (specifically denial and depression) to their coming out. LGBIS-CM was moderately and positively correlated with Dad/Parent 2 PPRS-NS ($r=.480$, $p<.01$), PPRS-Ang ($r=.434$, $p<.01$), Dad/Parent 2 PPRS-Barg ($r=.592$, $p<.01$), Dad/Parent 2 PPRS-Dep ($r=.567$, $p<.01$), Dad/Parent 2 PPRS-GH ($r=.366$, $p<.05$), and the Dad/Parent 2 PPRS total scale ($r=.474$, $p<.01$), suggesting the more youth felt a desire or motivation to hide or conceal their sexual identity, the more they tended to experience their Dad/Parent 2 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions to their coming out Finally, LGBIS-DP was moderately correlated with Dad/Parent 2 PPRS-NS ($r=.409$, $p<.05$), Dad/Parent 2 PPRS-Barg ($r=.476$, $p<.01$)., and Dad/Parent 2 PPRS-Dep ($r=.528$, $p<.01$), suggesting that the more youth experienced their sexual identity development process as difficult, the more they tended to experience their Dad/Parent 2 as having negative reactions (specifically negative shock, bargaining, and depression) to their coming out. An unexpected finding was that LGBIS-AC was moderately and positively associated with PPRS-Acc ($r=.354$, $p<.05$), suggesting that youth who were concerned about being an LGBQ person tended to experience more acceptance from their Dad/Parent 2, whereas it was anticipated that they would feel *less* accepted.

Table 4.8: Correlations between Sexual Identity Development (LGBIS) and Global Parental Acceptance-Rejection (PARQ-C) (N=110)

Variables	LGBIS Acceptance Concerns	LGBIS Concealment Motivation	LGBIS Identity Uncertainty	LGBIS Difficult Process
PARQ Mom/Parent 1 Warmth Affection	-.037 (N=110)	-.117 (N=110)	-.181 (N=110)	-.131 (N=110)
PARQ Mom/Parent 1 Hostility Aggression	**-.190*** (N=110)	-.181 (N=110)	**-.300**** (N=110)	-.107 (N=110)
PARQ Mom/Parent 1 Indifference Neglect	**-.189*** (N=110)	-.141 (N=110)	-.180 (N=110)	-.149 (N=110)
PARQ Mom/Parent 1 Undifferentiated Rejection	-.122 (N=110)	**-.254**** (N=110)	**-.313**** (N=110)	**-.228*** (N=110)
PARQ Mom/Parent 1 Total Scale	-.145 (N=110)	-.184 (N=110)	**-.263**** (N=110)	-.167 (N=110)
PARQ Dad/Parent 2 Warmth Affection	-.211 (N=54)	-.185 (N=54)	.065 (N=54)	-.145 (N=54)
PARQ Dad/Parent 2 Hostility Aggression	-.261 (N=53)	**-.279*** (N=53)	**-.392**** (N=53)	**-.396**** (N=53)
PARQ Dad/Parent 2 Indifference Neglect	**-.352**** (N=53)	-.003 (N=53)	-.114 (N=53)	-.067 (N=53)
PARQ Dad/Parent 2 Undifferentiated Rejection	-.172 (N=52)	-.178 (N=52)	-.237 (N=52)	-.201 (N=52)
PARQ Dad/Parent 2 Total Scale	**-.341*** (N=53)	-.211 (N=53)	-.194 (N=53)	-.263 (N=53)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 4.9: Correlations between Sexual Identity Development (LGBIS) and Parental Acceptance-Rejection Specific to Sexual Identity (PPRS) (N=110)

Variables	LGBIS Acceptance Concerns	LGBIS Concealment Motivation	LGBIS Identity Uncertainty	LGBIS Difficult Process
PPRS Mom/Parent 1 Negative Shock	.026 (N=109)	.080 (N=109)	-.031 (N=109)	.171 (N=109)
PPRS Mom/Parent 1 Denial	**.332**** (N=110)	**.209*** (N=110)	.088 (N=110)	**.275**** (N=110)
PPRS Mom/Parent 1 Anger	.174 (N=110)	.186 (N=110)	-.063 (N=110)	**.249**** (N=110)
PPRS Mom/Parent 1 Bargaining	**.202*** (N=110)	**.219*** (N=110)	.019 (N=110)	**.304**** (N=110)
PPRS Mom/Parent 1 Depression	.156 (N=110)	**.254**** (N=110)	.030 (N=110)	**.283**** (N=110)
PPRS Mom/Parent 1 Acceptance	.157 (N=110)	.109 (N=110)	.032 (N=110)	**.225*** (N=110)
PPRS Mom/Parent 1 General Homophobia	.103 (N=110)	**.265**** (N=110)	.027 (N=110)	**.249**** (N=110)
PPRS Mom/Parent 1 Parent-focused concerns	.074 (N=110)	.131 (N=110)	.077 (N=110)	.084 (N=110)
PPRS Mom/Parent 1 Total Scale	**.191*** (N=109)	**.236*** (N=109)	.001 (N=109)	**.288**** (N=109)
PPRS Dad/Parent 2 Negative Shock	.069 (N=36)	**.480**** (N=36)	.086 (N=36)	**.409*** (N=36)
PPRS Dad/Parent 2 Denial	**.393*** (N=36)	.324 (N=36)	.178 (N=36)	.321 (N=36)
PPRS Dad/Parent 2 Anger	.179 (N=35)	**.434**** (N=35)	.126 (N=35)	.228 (N=35)
PPRS Dad/Parent 2 Bargaining	.297 (N=36)	**.592**** (N=36)	.255 (N=36)	**.476**** (N=36)

PPRS Dad/Parent 2 Depression	**.369*** (N=35)	**.567**** (N=35)	.292 (N=35)	**.528**** (N=35)
PPRS Dad/Parent 2 Acceptance	**.364*** (N=37)	.268 (N=37)	-.015 (N=37)	-.015 (N=37)
PPRS Dad/Parent 2 General Homophobia	.209 (N=37)	**.366*** (N=37)	.103 (N=37)	.285 (N=37)
PPRS Dad/Parent 2 Parent-focused concerns	.163 (N=37)	.216 (N=37)	**.354*** (N=37)	.216 (N=37)
PPRS Dad/Parent 2 Total Scale	.314 (N=34)	**.474**** (N=34)	.262 (N=34)	.307 (N=34)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Question 4 asked, *"Is there an association between the perceived level of parental acceptance/rejection (global and specific to sexual identity) and youths' symptoms of depression and levels of self-esteem?"* To answer this question, bivariate correlations were conducted with the CESD depression scale and the RSES self-esteem scale and the 4 PARQ subscales: 1) *warmth affection* (WA), 2) *hostility aggression* (HA), 3) *indifference neglect* (IN), 4) *undifferentiated rejection* (UR) and *the PARQ total scale for Mom/Parent 1 and Dad/Parent 2* (see table 4.10) to assess overall perceived acceptance/rejection. Bivariate correlations were also conducted with the CESD depression scale and the RSES self-esteem scale and the following 8 PPRS subscales: 1) *negative shock* (NS), 2) *denial* (Den), 3) *anger* (Ang), 4) *depression* (Dep), 5) *acceptance* (Acc), 6) *general homophobia* (GH), 7) *parent-focused concerns* (PFC), and 8) *bargaining* (Barg) (see table 4.11) to assess perceived parental acceptance/rejection specific to sexual identity.

The first outcome variable, depressive symptoms (CESD), has a small and negative correlation with Mom/Parent 1 PARQ-IN ($r=-.216$, $p<.05$), Mom/Parent 1 PARQ-UR ($r=-.283$, $p<.01$), and the Mom/Parent 1 PARQ total scale ($r=-.199$, $p<.05$), suggesting that youth who experienced their Mom/Parent 1 as being less indifferent and neglecting (more available) and who believed their

Mom/Parent 1 really did care about and love them and accepted them overall tended to be less depressed. The second outcome variable, self-esteem (RSES), was modestly and negatively correlated with only one PARQ subscale, Mom/Parent 1 PARQ-WA ($r=-.246$, $p<.01$), suggesting that the less a youth experienced their Mom/Parent 1 as being warm, caring, nurturing and supportive, the lower their self-esteem tended to be. RSES was also moderately and positively correlated with the following PARQ subscales: Mom/Parent 1 PARQ-HA ($r=.231$, $p<.05$), Mom/Parent 1 PARQ-IN ($r=.251$, $p<.01$), Mom/Parent 1 PARQ-UR ($r=.288$, $p<.01$), and the Mom/Parent 1 PARQ total scale ($r=.288$, $p<.01$), suggesting youth who experienced their Mom/Parent 1 as being less hostile and aggressive (verbally and/or physically), less indifferent and neglecting (more available), and believed that their Mom/Parent 1 really did care about and loved them and accepted them tended to have higher self-esteem. These findings are consistent with the study hypotheses.

The first outcome variable, depressive symptoms (CESD), was moderately and negatively correlated with Dad/Parent 2 PARQ-HA ($r=-.380$, $p<.01$), Dad/Parent 2 PARQ-IN ($r=-.367$, $p<.01$), and the Dad/Parent 2 PARQ total scale ($r=-.366$, $p<.01$), suggesting that youth who experienced their Dad/Parent 2 as being less hostile and aggressive (verbally and/or physically), less indifferent and neglecting (more available) and accepting them overall tended to be less depressed. The second outcome variable, self-esteem (RSES), was moderately and positively correlated with three out of the four PARQ subscales: Dad/Parent 2 PARQ-HA ($r=.318$, $p<.05$), Dad/Parent 2 PARQ-IN ($r=.300$, $p<.05$), Dad/Parent 2 PARQ-UR ($r=.311$, $p<.05$), and the Dad/Parent 2 PARQ total scale ($r=.372$, $p<.05$), suggesting that youth who experienced their Dad/Parent 2 as being less hostile and aggressive (verbally and/or physically), less indifferent and neglecting (more available), and believed that their Mom/Parent 1 really did care about and loved them and accepted them overall tended to have higher self-esteem. There were no significant correlations found with the Dad/Parent 2 PARQ-WA subscale and either of the outcome variables. These findings are also consistent with the stated hypotheses.

The first outcome variable, depressive symptoms (CESD), was moderately and positively correlated with all but one of the Mom/Parent 1 PPRS subscales: PPRS-NS (r=.271, p<.01), PPRS-Den (r=.368, p<.01), PPRS-Ang (r=.310, p<.01), PPRS-Barg (r=.320, p<.01), PPRS-Dep (r=.298, p<.01), PPRS-GH (r=.327, p<.01), PPRS-PFC (r=.251, p<.01), and the Mom/Parent 1 PPRS total scale (r=.336, p<.01), suggesting the more youth experienced their Mom/Parent 1 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions to their coming out, the more youth tended to have depressive symptoms. The second outcome variable, self-esteem (RSES), was moderately and negatively correlated with Mom/Parent 1 PPRS-Den (r=-.194, p<.05), Mom/Parent 1 PPRS-Barg (r=-.220, p<.05), Mom/Parent 1 PPRS-Acc (r=-.202, p<.05), Mom/Parent 1 PPRS-GH (R=-.294, p<.01), and the Mom/Parent 1 PPRS total scale (r=-.196, p<.05), suggesting that the more youth experienced their Mom/Parent 1 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions to their coming out, the lower their self-esteem tended to be. These findings support the study hypotheses.

The first outcome variable, depressive symptoms (CESD), was moderately to highly correlated with two of the Dad/Parent 2 PPRS subscales: PPRS-Den (r=.445, p<.01), PPRS-Barg (r=.343, p<.05), and the Dad/Parent 2 PPRS total scale (r=.384, p<.05), suggesting that the more youth experienced their Dad/Parent 2 as rejecting them based on their LGBQ sexual identity, as evidenced by negative reactions of denial and bargaining when they came out, the more depressed they tended to be. The second outcome variable, self-esteem (RSES), was highly and negatively correlated with Dad/Parent 2 PPRS-Den (r=-.453, p<.01), and moderately and negatively correlated with Dad/Parent 2 PPRS-Acc (r=-.361, p<.05), suggesting the more a youth experienced their Dad/Parent being in denial about the youth's sexual identity and also showing less acceptance, the lower their self-esteem tended to be. There were no significant correlations between the Dad/Parent 2 PPRS-NS, PPRS-Ang, PPRS-Dep, PPRS-GH, PPRS-PFC, or the PPRS total scale and either of the outcome variables. These findings were also supported the study hypotheses.

Table 4.10: Correlations between Global Parental Acceptance-Rejection (PARQ-C) and Depressive Symptoms (CES-D) and Self-Esteem (RSES) (N=110)

Variables	CESD Total Scale	RSES Total Scale
PARQ Mom/Parent 1 Warmth Affection	.111 (N=110)	**-.246**** (N=110)
PARQ Mom/Parent 1 Hostility Aggression	-.141 (N=110)	**.231*** (N=110)
PARQ Mom/Parent 1 Indifference Neglect	**-.216*** (N=110)	**.251**** (N=110)
PARQ Mom/Parent 1 Undifferentiated Rejection	**-.283**** (N=110)	**.288**** (N=110)
PARQ Mom/Parent 1 Total Scale	**-.199*** (N=110)	**.288**** (N=110)
PARQ Dad/Parent 2 Warmth Affection	.169 (N=54)	-.193 (N=54)
PARQ Dad/Parent 2 Hostility Aggression	**-.380**** (N=53)	**.318*** (N=53)
PARQ Dad/Parent 2 Indifference Neglect	**-.367**** (N=52)	**.300*** (N=52)
PARQ Dad/Parent 2 Undifferentiated Rejection	-.249 (N=53)	**.311*** (N=53)
PARQ Dad/Parent 2 Total Scale	**-.366**** (N=53)	**.372**** (N=53)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 4.11: Correlations between Parental Acceptance-Rejection Specific to Sexual Identity (PPRS) and Depressive Symptoms (CESD) and Self-Esteem (RSES) (N=110)

Variables	CESD Total Scale	RSES Total Scale
PPRS Mom/Parent 1 Negative Shock	**.271**** (N=109)	-.066 (N=109)

PPRS Mom/Parent 1 Denial	**.368**** (N=110)	**-.194*** (N=110)
PPRS Mom/Parent 1 Anger	**.310**** (N=110)	-.165 (N=110)
PPRS Mom/Parent 1 Bargaining	**.320**** (N=110)	**-.220*** (N=110)
PPRS Mom/Parent 1 Depression	**.298**** (N=110)	-.157 (N=110)
PPRS Mom/Parent 1 Acceptance	.184 (N=110)	**-.202*** (N=110)
PPRS Mom/Parent 1 General Homophobia	**.327**** (N=110)	**-.294**** (N=110)
PPRS Mom/Parent 1 Parent-focused concerns	**.251**** (N=110)	-.135 (N=110)
PPRS Mom/Parent 1 Total Scale	**.336**** (N=109)	**-.196*** (N=109)
PPRS Dad/Parent 2 Negative Shock	.237 (N=36)	-.059 (N=36)
PPRS Dad/Parent 2 Denial	**.445**** (N=36)	**-.453**** (N=36)
PPRS Dad/Parent 2 Anger	.287 (N=35) 35	-.154 (N=35) 35
PPRS Dad/Parent 2 Bargaining	**.343*** (N=36)	-.315 (N=36)
PPRS Dad/Parent 2 Depression	.248 (N=35)	-.237 (N=35)
PPRS Dad/Parent 2 Acceptance	.303 (N=37)	**-.361*** (N=37)
PPRS Dad/Parent 2 General Homophobia	.306 (N=37)	-.250 (N=37)

PPRS Dad/Parent 2 Parent-focused concerns	.062 (N=37)	-.060 (N=37)
PPRS Dad/Parent 2 Total Scale	**.384* (N=34)	-.313 (N=34)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Question 5a-d asked, *"Is there an association between youths' age, gender, family SES/class or parents' level of religiosity (reported by youth) and their depressive symptoms and self-esteem?"*

In order to answer this question, bivariate correlations were conducted for the 4 corresponding demographic variables (age, gender, family SES/class, and youth's report of parents' religiosity) and the two outcome variables, depressive symptoms (CESD) and self-esteem (RSES) (see table 4.12). According to the correlations, there were no significant correlations between the four demographic variables and the outcome variables. Therefore, we cannot support or reject the hypotheses about youth's susceptibility to depressive symptoms or lower self-esteem based on demographics. This is a surprising finding, possibly due to the lower than anticipated number of participants. I anticipated finding that how depressed youth were and how they felt about themselves would be based, in part, on their age, gender, family's SES/class, and parent's level of religiosity (as reported by youth).

Table 4.12: Correlations between Demographic Variables (age, gender, family SES, parent's level of religiosity) and Depressive Symptoms (CES-D) and Self-Esteem (RSES) (N=110)

Question/Variables	CESD Total Scale	RSES Total Scale
How old are you?	.059 (N=110)	.039 (N=110)
What is your gender identity?	.093 (N=110)	.055 (N=110)
How would you describe your family's SES or class?	-.100 (N=110)	.060 (N=110)

What is your parents' level of religiosity?	**.168** (N=110)	-.049 (N=110)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Question 6a&b asked, "*Are racial identity and sexual identity development processes associated with symptoms of depression and self-esteem in Black LGBQ youth?"* In order to answer this question, bivariate correlations were conducted for the six subscales in the first predictor variable, racial identity development: CRIS pre-encounter assimilation (PA), pre-encounter miseducation (PM), pre-encounter self-hatred (PSH), immersion-emersion anti-White (IEAW), internalization afrocentricity (IA), and internalization multiculturalist inclusive (IMCI) and the two outcome variables, depressive symptoms (CESD) and self-esteem (RSES) (see table 4.13). Bivariate correlations were also conducted for the four included subscales of the second predictor variable, sexual identity development: LGBIS acceptance concerns (AC), concealment motivation (CM), identity uncertainty (IU), and difficult process (DP) and the two outcome variables, depressive symptoms (CESD) and self-esteem (RSES) (see table 4.14).

According to the correlations, only three of the predictor subscales were significantly associated with the two outcome variables. CRIS-PSH was moderately and positively associated with CESD ($r=.425$, $p<.01$), suggesting youth who reported being unhappy or having more negative feelings about being Black and who were earlier in their racial identity development tended to experience more depressive symptoms. CRIS-PSH was also highly and negatively associated with RSES ($r=-.495$, $p<.01$), suggesting youth who reported being unhappy or having negative feelings about being Black and who were earlier in their racial identity development tended to report lower self-esteem.

LGBIS-AC was modestly and positively associated with CESD ($r=.216$, $p<.05$), suggesting youth who reported having more concerns about being stigmatized as a LGBQ person, the more depressive symptoms they tended to report. LGBIS-AC was also moderately and negatively associated

with RSES (r=-.340, p<.01), suggesting youth who reported having more concerns about being stigmatized as a LGBQ person tended to report lower self-esteem. LGBIS-IU was moderately and positively associated with CESD (r=.223, p<.05), suggesting youth who were more uncertain (or more insecure) about their sexual identity tended to report more depressive symptoms. LGBIS-IU was moderately and negatively associated with RSES (r=-.262, p<.01), suggesting youth who were more uncertain (or more insecure) about their sexual identity tended to report lower self-esteem. These associations are all consistent with what was hypothesized.

Table 4.13: Correlations between Racial Identity Development (CRIS) and Depressive Symptoms (CES-D) and Self-Esteem (RSES) (N=110)

Variables	CESD Total Scale	RSES Total Scale
CRIS Pre-Encounter Assimilation	.097 (N=110)	-.104 (N=110)
CRIS Pre-Encounter Miseducation	.122 (N=110)	-.073 (N=110)
CRIS Pre-Encounter Self-Hatred	**.425**** (N=110)	**-.495**** (N=110)
CRIS Immersion-Emersion Anti-White	.102 (N=110)	-.168 (N=110)
CRIS Internalization Afrocentricity	.048 (N=110)	-.135 (N=110)
CRIS Internalization Multiculturalist Inclusive	-.087 (N=110)	.072 (N=110)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 4.14: Correlations between Sexual Identity Development (LGBIS) and Depressive Symptoms (CES-D) and Self-Esteem (RSES)

Variables	CESD Total Scale	RSES Total Scale
LGBIS	**.216***	**-.340****

Acceptance Concerns	(N=110)	(N=110)
LGBIS Concealment Motivation	.015 (N=110)	-.012 (N=110)
LGBIS Identity Uncertainty	**.223*** (N=110)	**-.262**** (N=110)
LGBIS Difficult Process	.094 (N=110)	-.080 (N=110)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Stepwise Regression Analyses

A series of four stepwise regression models were conducted to examine which of the predictor variables and subscales (CRIS and LGBIS) were significantly correlated with the outcome and mediator variables. Only variables and subscales were included in the regression models that were significantly associated with the outcome variables, as described above in the correlational analyses. A stepwise regression was chosen so that only those predictor variables that contributed incrementally above and beyond variables already in the model would be retained.

In the **first stepwise regression model**, the following predictors were entered: age, gender, CRIS-PSH, LGBIS-AC, LGBIS-IU, PARQ Mom total scale, and PPRS Mom total scale (without the subscales because of collinearity issues) to examine their associations with the first outcome variable, depressive symptoms (CESD).

First all regression test assumptions were checked (e.g., normality and outliers). The CRIS-PSH (pre-encounter self-hatred) subscale was the strongest predictor of depressive symptoms. Participants who reported being more unhappy or having negative feelings about being Black (self-hatred) tended to report the highest levels of depressive symptoms (Self-hatred $\beta = .378$, $p=.000$) (see table 4.15). Thus, as predicted Black LGBQ youth who were in the pre-encounter self-hatred stage of racial identity development tended to exhibit more depressive symptoms compared to youth who were

further along in their racial identity development. This partially answers **Question 6a:** ***Is racial identity associated with symptoms of depression and self-esteem in Black LGBQ youth?*** The other predictors, LGBIS-AC (acceptance concerns) and LGBIS-IU (identity uncertainly) did not significantly predict either depressive symptoms or self-esteem.

Additionally, the Mom PPRS total scale is a modest predictor of youths' depressive symptoms (PPRS total β= .269, p=.002). Participants who reported feeling that their Mom/Parent 1 was not accepting of their LGBQ identity tended to exhibit more depressive symptoms which was also predicted. This partially answers **Question 4**: ***Is there an association between the perceived level of parental acceptance/rejection and youths' symptoms of depression and levels of self-esteem?*** According to the stepwise regression results, the parental acceptance/rejection total score specific to sexual identity is a significant predictor of depressive symptoms for Black LGBQ youth/young adults in this study; the adjusted R square = .237 F(2, 106)= 17.76, p=.000. The β and p values for the significant predictor variables are as follows: CRIS pre-encounter self-hatred β= .378, p=.000, and PPRS Mom total scale β= -.269, p=.002.

Table 4.15: Stepwise Regression Analysis for Variables Predicting Depressive Symptoms (CESD) with the Parental Acceptance/Rejection (Global and Specific) Total Scales (N=107)

	B	SE B	β
Step 1			
CRIS Pre-Encounter Self-Hatred	.509	.105	-.425***
Step 2			
CRIS Pre-Encounter Self-Hatred	.452	.102	.378***
PPRS Mom Total Scale	.085	.027	.269**

* p<.05, ** p<.01, *** p<.001

In the **second stepwise regression model**, the following key predictors were entered: age, gender, CRIS-PSH, LGBIS-AC, LGBIS-IU, the following PARQ Mom subscales: warmth/affection

(WA), hostility/aggression (HA), indifference/neglect (IN), and undifferentiated rejection (UR), and the following PPRS Mom subscales: denial (Den), bargaining (Barg), acceptance (Acc), and general homophobia (GH) (without the total scales because of collinearity issues) to examine their associations with the first outcome variable, depressive symptoms (CESD).

After first checking for all regression test assumptions, the CRIS-PSH (pre-encounter self-hatred) subscale was the strongest predictor of depressive symptoms. Participants who reported being more unhappy or having more negative feelings about being Black (self-hatred) tended to report more depressive symptoms (Self-hatred β = .369, p=.000) (see table 4.16). Black LGBQ youth who were in the pre-encounter self-hatred stage of racial identity development tended to exhibit more depressive symptoms compared to youth who were further along in their racial identity development which was predicted. Again, this partially answers **Question 6a:** ***Is racial identity associated with symptoms of depression and self-esteem in Black LGBQ youth?*** Again, the other predictor subscales, LGBIS-AC (acceptance concerns) and LGBIS-IU (identity uncertainly), were did not significantly predict either depressive symptoms or self-esteem.

Additionally, the Mom PPRS-Den (denial) subscale is a moderate predictor of youths' depressive symptoms (Denial β= .300, p=.001). Participants who reported feeling their Mom/Parent 1 was less accepting of their LGBQ identity, as evidenced by attempting to deny or convince the youth otherwise also tended to exhibit more depressive symptoms. This partially answers **Question 4**: ***Is there an association between the perceived level of parental acceptance/rejection and youths' symptoms of depression and levels of self-esteem?*** (along with the findings from the second regression model, this question has been answered by the results).

According to these results, parental denial or a lack of acceptance specific to sexual identity [PPRS] is a significant predictor of more depressive symptoms for participants in this study; the adjusted R square = .254 F(2, 106)= 19.36, p=.000. The β and p values for the significant predictor

variables are as follows: CRIS pre-encounter self-hatred β= .369, p=.000, and PPRS Mom denial β= .300, p=.001.

Table 4.16: Stepwise Regression Analysis for Variables Predicting Depressive Symptoms (CESD) with the Parental Acceptance/Rejection (Global and Specific) Subscales (N=107)

	B	SE B	β
Step 1			
CRIS Pre-Encounter Self-Hatred	.509	.105	-.425***
Step 2			
CRIS Pre-Encounter Self-Hatred	.442	.101	.369***
PPRS Mom Denial	.673	.190	.300***

* p<.05, ** p<.01, *** p<.001

In the **third stepwise regression model**, after first checking for all regression test assumptions (e.g, normality and outliers) the following predictors were entered: age, gender, CRIS-PSH, LGBIS-AC, LGBIS-IU, PARQ Mom total scale, and PPRS Mom total scale (without the total scales due to collinearity issues) to examine associations with the second outcome variable, self-esteem (RSES).

The CRIS-PSH (pre-encounter self-hatred) subscale was the strongest and only predictor of self-esteem (1-step). Thus, participants who reported being more unhappy or having more negative feelings about being Black (self-hatred) tended to report having the lowest self-esteem (Self-hatred β = -.495, p=.000) (see table 4.17). Black LGBQ youth who were in the pre-encounter self-hatred stage of racial identity development tended to have lower self-esteem compared to youth who were further along in their racial identity development which was predicted. This partially answers **Question 6a: *Is racial identity associated with symptoms of depression and self-esteem in Black LGBQ youth?*** (along with the findings from the first regression model). According to the stepwise regression analysis, the adjusted R square = .238 F(1, 107)= 34.78, p=.000. The β and p values for the significant predictor variables are as follows: CRIS pre-encounter self-hatred β = -.495, p=.000. The other

predictor subscales, LGBIS-AC (acceptance concerns) and LGBIS-IU (identity uncertainly), were both found to not significantly predict either depressive symptoms or self-esteem.

Table 4.17: Stepwise Regression Analysis for Variables Predicting Self-Esteem (RSES) with the Parental Acceptance/Rejection (Global and Specific) Total Scales (N=108)

	B	SE B	β
Step 1			
Pre-Encounter Self-Hatred	-.400	.068	-.495***

* p<.05, ** p<.01, *** p<.001

In the **fourth and final stepwise regression model**, the following key predictors were entered: age, gender, CRIS-PSH, LGBIS-AC, LGBIS-IU, the following PARQ Mom subscales: warmth/affection (WA), hostility/aggression (HA), indifference/neglect (IN), and undifferentiated rejection (UR), and the following PPRS Mom subscales: denial (Den), bargaining (Barg), acceptance (Acc), and general homophobia (GH) (without the total scales due to collinearity issues) to examine their associations with the second outcome variable, self-esteem (RSES).

After first checking for all regression test assumptions (normality and outliers), the CRIS-PSH (pre-encounter self-hatred) subscale was the strongest predictor of self-esteem (second step). Participants who reported being unhappy or having negative feelings about being Black (self-hatred) tended to report having the lowest self-esteem (Self-hatred β = -.456, p=.000) (see table 4.18). Black LGBQ youth/young adults who were in the pre-encounter self-hatred stage of racial identity development tended to have lower self-esteem compared youth who were further along in their racial identity development which was predicted. Again, this partially answers **Question 6a:** ***Is racial identity associated with symptoms of depression and self-esteem in Black LGBQ youth?*** Again, the other predictor subscales, LGBIS-AC (acceptance concerns) and LGBIS-IU (identity uncertainly), did not significantly predict either depressive symptoms or self-esteem.

Additionally, the Mom PPRS-GH (general homophobia) subscale is a modest predictor of self-esteem (General homophobia β=-.206, p=.015). Participants who reported feeling their Mom/Parent 1 was less accepting of their LGBQ identity, as evidenced by expressing generally homophobic remarks or actions tended to have lower self-esteem which was predicted. This partially answers **Question 4**: ***Is there an association between the perceived level of parental acceptance/rejection and youths' symptoms of depression and levels of self-esteem?*** (along with the findings from the second regression model, this question has been answered by the results). According to the stepwise regression analysis, the adjusted R square = .273 F(2, 107)= 21.46, p=.000. The β and p values for the two significant predictor variables are as follows: CRIS pre-encounter self-hatred β= -.456, p=.000, and PPRS Mom general homophobia β= -.206, p=.015.

Table 4.18: Stepwise Regression Analysis for Variables Predicting Self-Esteem (RSES) with the Parental Acceptance/Rejection (Global and Specific) Subscales (N=108)

	B	SE B	β
Step 1			
CRIS Pre-Encounter Self-Hatred	-.400	.068	-.495***
Step 2			
CRIS Pre-Encounter Self-Hatred	-.368	.067	-.456***
PPRS Mom General Homophobia	-.277	.112	-.206*

* p<.05, ** p<.01, *** p<.001

Mediation Analyses

In order to evaluate the possible mediating effect of youths'/young adults' perceptions of global and specific to sexual orientation parental acceptance and parental rejection on the association between the two predictor variables (Black racial identity, LGBQ sexual identity) and two outcome variables (depressive symptoms and self-esteem), a mediation analysis was conducted to evaluate the direct and indirect effects. A series of six mediation models were conducted to evaluate the size of the coefficient for the direct path between the two predictor variables (CRIS and LGBIS), and the two dependent

variables (CESD and RSES) with and without the hypothesized mediator (PPRS Mom: sexual identity-specific parental acceptance/rejection for Mom/Parent 1).

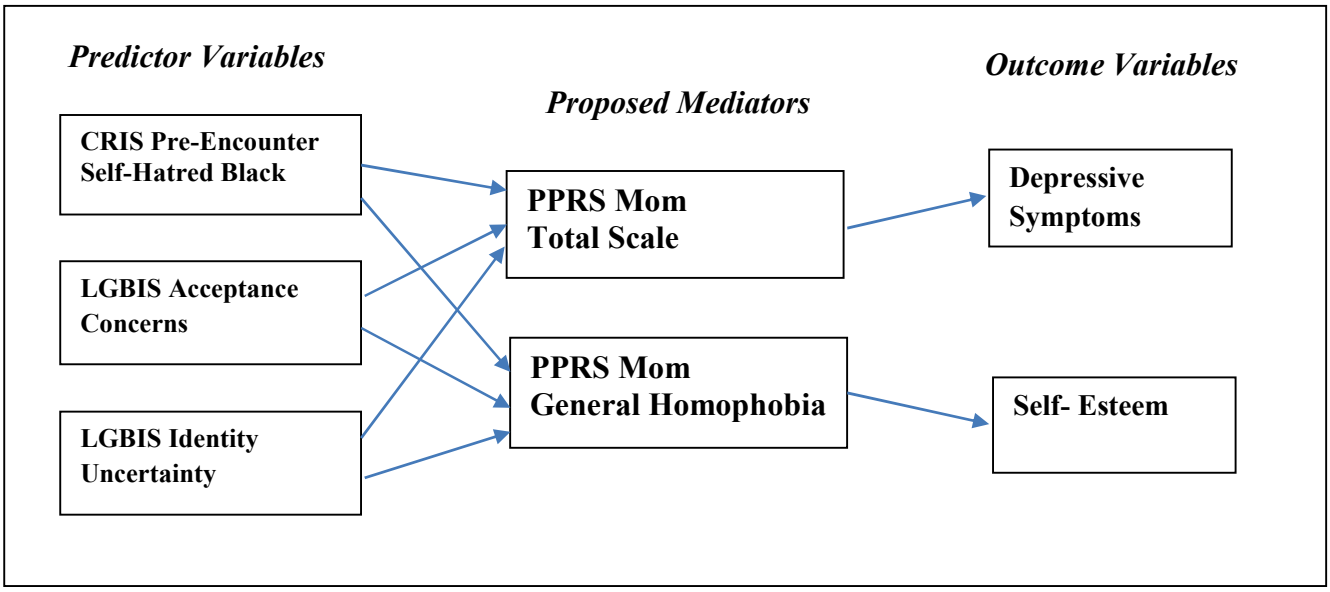
Since global parental acceptance/rejection (PARQ total or any of its subscales) was not significantly associated with either dependent variable (depressive symptoms and self-esteem), it was not included in the mediation analyses. The predictor subscales that were significantly associated with the outcome variables (depressive symptoms or self-esteem) in the earlier correlation and stepwise regression analyses, were included in the mediation analyses and included: 1) Cross Racial Identity subscale – Pre-Encounter Self-Hatred (CRIS-PSH); and, 2) Lesbian, Gay, Bisexual Identity subscales – Acceptance Concerns and Identity Uncertainty (LGBIS-AC and LGBIS-IU). For the depressive symptoms outcome, the total scale, Perceived Parental Reactions – Mom Total (PPRS MomTot), and one subscale from the same measure, Perceived Parental Reactions – Mom Denial (PPRS MomDen), were both significantly associated with depressive symptoms. For the self-esteem outcome, one subscale, Perceived Parental Reactions – Mom General Homophobia (PPRS MomGH), was significantly associated with the outcome, thus it was included in that mediation model.

Preacher and Hayes' (2008) method was used to evaluate the following **three predictors**: 1) Cross perceived self-hatred stage of racial identity development, 2) acceptance concerns stage of sexual identity development, and 3) identity uncertainty stage of sexual identity development; and the **two outcome variables**: 1) depressive symptoms and 2) self-esteem to answer the final 2 research questions: **Question 7a*: Is youths' perceived parental acceptance/rejection a significant mediator between racial identity and youths' symptoms of depression and levels of self-esteem?***
Question 7b*: Is youths' perceived parental acceptance/rejection a significant mediator between youths' sexual identity and their symptoms of depression and levels of self-esteem?*

As shown in Figure 5 below, the original diagram of hypotheses was revised to reflect the associations found between the predictor and outcome variables in the earlier correlation and regression analyses. Mediation analyses was conducted to address the following revised mediation

research questions: **Question 7c:** ***Is youths' overall perceived parental reaction to their LGBQ sexual identity (sexual identity-specific acceptance/ rejection) a significant mediator between youths' reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and feelings of uncertainty about their sexual identity (early stages of sexual identity development), and their depressive symptoms?*** **and Question 7d:** ***Is youths' perceived parental general homophobia or negative reactions to their LGBQ sexual identity (sexual identity-specific acceptance/ rejection) a significant mediator between youths' reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and feelings of uncertainty about their sexual identity (early stages of sexual identity development) and their self-esteem?***

Figure 5. Revised Diagram of Study Hypotheses



In order to address the first revised mediation research question, ***Is youths' overall perceived parental reaction to their LGBQ sexual identity (sexual identity-specific acceptance/ rejection) a significant mediator between youth's reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and feelings***

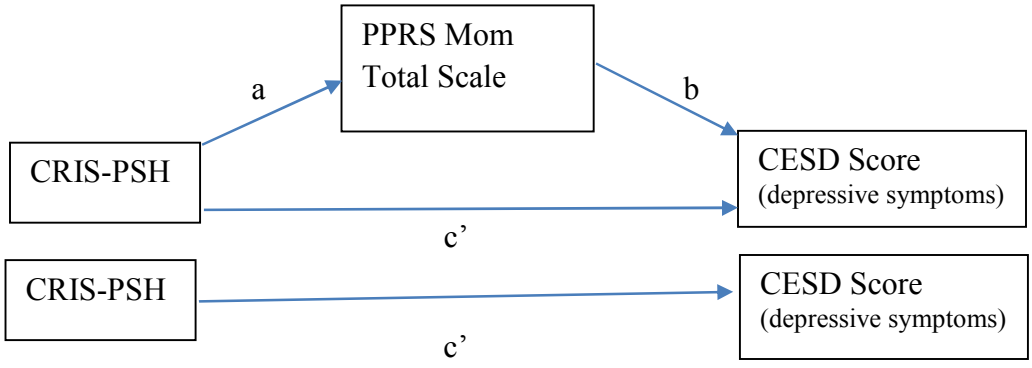
of uncertainty about their sexual identity (early stages of sexual identity development), and their depressive symptoms?, three mediation analyses were conducted.

In the first model with depressive symptoms as the outcome, the PPRS Mom Total scale was entered into the analysis as the mediator and CRIS-PSH as the predictor (see Figure 6). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=109).

Evaluation of PPRS Mom Total as a mediator of the association between CRIS-PSH and CESD suggests the association between CRIS-PSH and PPRS Mom Total approached significance (b=0.6636, p=0.07). The association between PPRS Mom Total and CESD was significant (b=0.0857, p=0.0021), and the direct effect between CRIS-PSH and CESD was significant (b=0.4545, p<.0001). Standard errors of the indirect effects were estimated using 1000 bootstrapped replications and indicated that the 95% confidence interval did not include 0 (b=0.0568 [0.0077-0.1499]). Overall, the model predicted 25% of the variance in CESD (F(2,106)=17.84, p<.0001).

Results suggest this is a partially mediated model in which youth who are earlier in their stage of racial identity development (report having more negative feelings about being Black) tended to report more depressive symptoms when youth perceived more negative parental reactions to their LGBQ sexual identity.

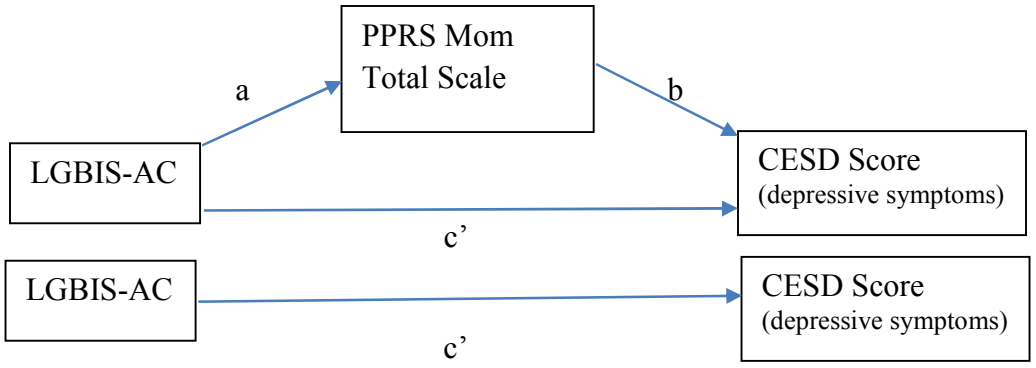
Figure 6: Mediation Model 1 for Depressive Symptoms Outcome



For the second model with depressive symptoms as the outcome, the PPRS Mom Total scale was entered into the analysis as the mediator, but this time the LGBIS-AC subscale was the predictor

(see Figure 7). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=109). Results suggest that the *PPRS Mom Total scale fully mediates* the association between youth in the acceptance concerns stage and their depressive symptoms and explains 14% of the variance in depressive symptoms, $F(2, 106)=8.41$, p=.0004. The coefficient for the direct effect of being in the acceptance concerns stage on depressive symptoms (path c') is not significant, 1.044, p=.0878. The coefficient for the indirect effect of youths' perceived parental reaction to their LGBQ sexual identity on depressive symptoms is significant .0973, p=.0012, thus it is a fully mediated model.

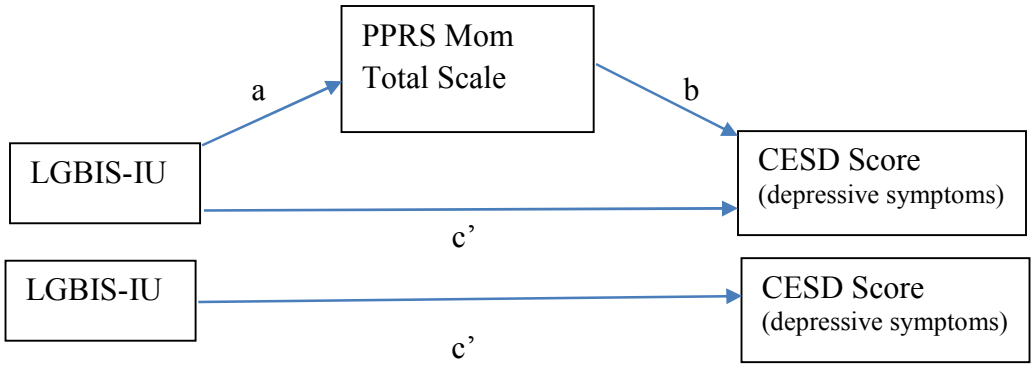
Figure 7: Mediation Model 2 for Depressive Symptoms Outcome



For the third model with depressive symptoms as the outcome, the PPRS Mom Total scale was entered into the analysis as the mediator, but this time the LGBIS-IU subscale was the predictor (see Figure 8). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=109). Results suggest that the PPRS Mom Total scale is a significant, positive, and partial mediator of the association between youth in the uncertainty stage of sexual identity development and their depressive symptoms, $F(2, 106)=10.335$, p=.0001. Youth who were in the earlier stages of sexual identity development and who reported being more unsure or insecure about their sexual identity tended to report more depressive symptoms. The coefficient for the direct effect of being in the identity uncertainty stage on depressive symptoms (path c') is significant, 1.627, p=.0130. The coefficient for the indirect effect of youth's perceived parental reaction to their LGBQ sexual identity on depressive

symptoms is also significant .1069, p=.0003, indicating a partially mediated model that explains 16% of the variance in depressive symptoms.

Figure 8: Mediation Model 3 for Depressive Symptoms Outcome

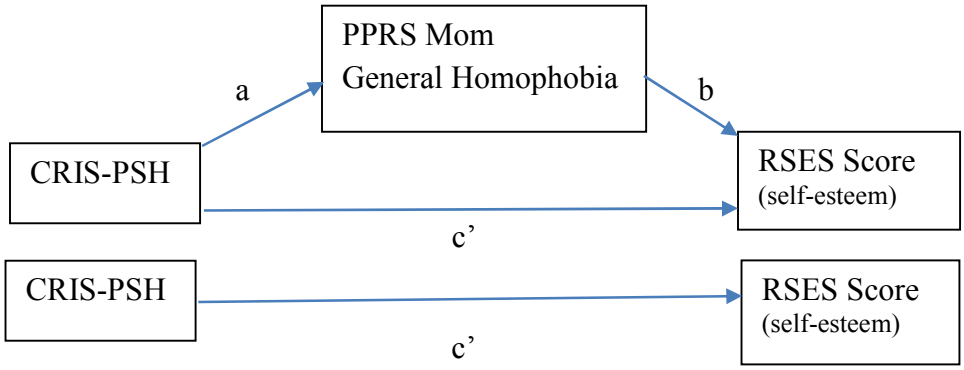


In order to address the second revised mediation research question, ***Is youths' perceived parental general homophobia or negative reactions to their LGBQ sexual identity (sexual identity-specific acceptance/ rejection) a significant mediator between youths' reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and feelings of uncertainty about their sexual identity (early stages of sexual identity development), and their level of self-esteem?,*** additional mediation analyses were conducted.

For the first model with self-esteem as the outcome, the PPRS Mom General Homophobia (Mom GH) subscale was entered into the analysis as the mediator and CRIS-PSH as the predictor (see Figure 9). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=110). Results suggest the PPRS Mom GH subscale is a significant, negative, and partial mediator of the association between youth in the pre-encounter self-hatred stage of racial identity development and their self-esteem, $F(2, 107)=21.46$, p=.000. Youth who were in the early racial identity stage of having negative feelings about being Black and who perceived more negative parental reactions to their LGBQ identity tended to report lower self-esteem; this model explained 29% of the variance in self-esteem. The coefficient for the direct effect of being in the pre-encounter self-hatred stage on self-esteem (path c') is significant, -.3679, p=.000. The coefficient for the indirect effect of

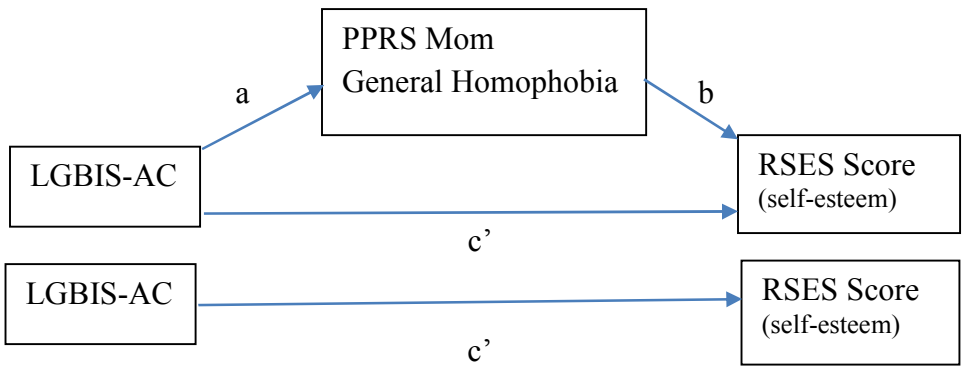
youth's perceived parental general homophobia or negative reaction to their LGBQ sexual identity on their self-esteem is also significant, -.2767, p=.0147, indicating it is a partially mediated model.

Figure 9: Mediation Model 1 for Self-Esteem Outcome



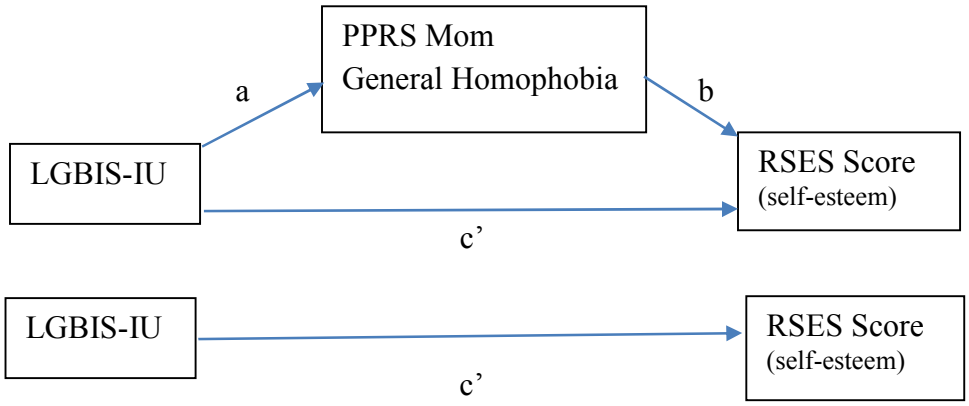
In the second model with self-esteem as the outcome, the PPRS Mom GH subscale was entered into the analysis as the mediator, but this time LGBIS-AC was the predictor (see Figure 10). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=110). Results suggest the PPRS Mom GH subscale partially mediates the association between youth in the acceptance concerns stage of sexual identity development and their self-esteem and explains 18% of the variance in self-esteem, $F(2, 107)=12.01$, p=.000. The coefficient for the direct effect of being in the acceptance concerns stage of sexual identity development on self-esteem (path c') is significant, -1.3883, p=.0005. The coefficient for the indirect effect of youth's perceived parental general homophobia or negative reaction to their LGBQ sexual identity on their self-esteem is also significant, -.3509, p=.0036, indicating that it is a partially mediated model.

Figure 10: Mediation Model 2 for Self-Esteem Outcome



In the third and final model with self-esteem as the outcome, the PPRS Mom GH subscale was entered into the analysis as a mediator, but this time the LGBIS-IU subscale was the predictor (see Figure 11). The confidence interval was set at .95 and the number of samples for bootstrapping was set to 1000 (n=110). Results suggest that the PPRS Mom GH subscale is a significant, negative, and partial mediator of the association between youth in the identity uncertainty stage of sexual identity development and their self-esteem, with the model explaining 15% of the variance in self-esteem, $F(2, 107)=9.518$, p=.0002. Youth who reported being more unsure (or insecure) about their sexual identity tended to report lower self-esteem when their parent had more negative reactions to their LGBQ sexual identity. The coefficient for the direct effect of being in the identity uncertainty stage of sexual identity development and self-esteem (path c') is significant, -1.233, p=.0052. The coefficient for the indirect effect of youth's perceived parental general homophobia or negative reaction to their LGBQ sexual identity on their self-esteem is also significant, -.3847, p=.0017, indicating that it is a partially mediated model.

Figure 11: Mediation Model 3 for Self-Esteem Outcome



Overall, the six mediation models suggest the PPRS Mom Total scale partially mediates the association between being in the pre-encounter self-hatred stage of racial identity development and youths' self-report of depressive symptoms, and the association between being in the uncertainty stage of sexual identity development and youth self-report of depressive symptoms.

These results suggest Black LGBQ youth who are in the earlier stages of racial and sexual identity development (have more negative feelings about being Black and tend to be unsure or more insecure about their sexual identity), tended to report more depressive symptoms when they perceived their parent(s) or caregiver(s) reacting negatively to their coming out as LGBQ. Additionally, the mediation models suggest the PPRS Mom GH subscale partially mediates the association between the pre-encounter self-hatred stage of racial identity development and youth's self-esteem, and the association between being in the identity uncertainty stage of sexual identity development and youth's self-esteem.

Thus, Black LGBQ youth who are earlier in their racial and sexual identity development (have more negative feelings about being Black and are unsure or insecure about their sexual identity) were more likely to report lower self-esteem when they perceived their parent(s) or caregiver(s) reacting negatively and/or with generally homophobic responses to their coming out as LGBQ.

Taken together, results support the original research hypotheses that the processes of racial and sexual identity development occur along a similar trajectory, affect youths' self-reports of depressive symptoms and self-esteem, and are partially and in one case fully mediated by parental acceptance/rejection. One finding that was not predicted was that global parental acceptance/rejection (PARQ, total or any of its subscales) was not significantly associated with either depressive symptoms or self-esteem and thus was not included in the six mediation models. Thus, a noteworthy finding is that only mom's parental acceptance specific to coming out as LGBQ was a significant mediator for youth in the earlier stages of identity development, leading to more depressive symptoms and lower self-esteem if their mothers' did were less accepting of their sexual identity when they came out.

Associations between Depressive Symptoms, Self-Esteem, and Demographic Variables

Finally, a series of correlations, t-tests, and ANOVAs were conducted to assess for possible associations between the two dependent variables (depressive symptoms and self-esteem) and salient demographic variables (gender, age, ethnicity, family level of religiosity as reported by youth,

class/SES, and level of outness across three domains – family, religion, world) to address the remaining research questions: **Questions 5a-d: Is age, gender, SES/class, and parent's level of religiosity (as reported by youth) associated with youth's depressive symptoms and self-esteem?** ANOVA's were also run to assess whether youth's ethnic identity and their level of outness across 3 domains (family, religion, and world) are associated with their depressive symptoms and self-esteem (although these associations were not previously hypothesized).

First, to evaluate associations between gender and the two outcome variables (depressive symptoms and self-esteem), independent samples t-tests were conducted to determine whether scores on the outcome measures were significantly different in male versus female participants. Independent t-test results suggest no significant differences based on gender for both depressive symptoms (t(106)= -.667, p=.448) and self-esteem (t(106)= -.665, p=.779).

Then ANOVAs were conducted to compare scores on the depressive symptoms and self-esteem measures and participants' age, SES/class, parent's level of religiosity (as reported by youth), ethnic identity, and level of outness across three domains (family, religion, world). ANOVAs for self-esteem revealed no significant differences by age of participants (F(7,102)=.674, p=.694), parent's level of religiosity (F(2,107)=.571, p=.567), SES/class (F(4,105)=.990, p=.417), ethnic identity (F(3,106)=.242, p=.867), or level of outness across the 3 domains: family (F(3,106)=.231, p=.875), religion (F(3,106)=.520, p=.669), and world (F(3,106)=2.042, p=.112).

ANOVAs for depressive symptoms also suggest no significant differences for four out of the five socio-demographic variables: age (F(7,102)=.655, p=.709), SES/class (F(4,105)=1.356, p=.254), ethnic identity (F(3,106)=.643, p=.589), and level of outness across the 3 domains: family (F(3,106)=.741, p=.530), religion (F(3,106)=.118, p=.949), and world (F(3,106)=1.246, p=.297). Noteworthy, there was one significant difference comparing parent's level of religiosity (as reported by youth) and youths' depressive symptoms (F(2,107)=3.258, p=.042). Post-hoc tukey tests suggest youth who reported their parents were highly religious tended to have more depressive symptoms compared

to youth who reported their parents are moderately or minimally religious. The results of this ANOVA are summarized in table 4.19.

Table 4.19: One Way ANOVA for Depressive Symptoms Outcome and Youth's Report of Parent's Level of Religiosity

Parent's Level/Frequency of Religiosity (youth report)					
	Low/Minimally N=28	Medium/Occasionally N=52	High/Frequently N=30		
CESD Total	M	M	**M**	F	Sig
	11.90	10.72	**16.42**	3.258	**.042**

Open-Ended Questions

Participants (n=52, 45, 42, and 41, respectively for the four open-ended questions) selectively responded to the four optional open-ended questions that were included at the end of the self-report survey. The four questions were: 1) **Are there any other factors that have influenced your feelings of safety or acceptance within your family?"; 2) Have your parent(s) or caregiver(s) ever said anything about feeling a sense of "grief" or "loss" after your came out OR talked about struggling with acceptance due to their religious/spiritual beliefs?"; 3) "Is there anything that I *did not* ask about that you think is important to share about your racial identity, sexual identity, or experiences with depression or low self-esteem?"; and finally, 4) "Do you have any additional feedback or suggestions about how to make this survey better? Was there anything that you did not like about it?"** The number of respondents for each commonly reported theme is next described along with a brief summary of their comments (see Appendix D for a full description of comments).

Between 37% and 47% (n=52, 45, 42, and 41, respectively for the 4 questions) responded to the optional four open-ended questions. For the first question that asked about other factors that influenced participants' feelings of safety or acceptance in their families, the following common themes emerged: 1) Parent made it clear they did not want to think, hear, or talk about their child's sexual identity or dating life – for example, "My family never asks about who I'm dating after I was outed" (15%, n=8);

2) Parent commented that their child's sexual identity was a "sin," "unnatural," or "against our religion" (13%, n=7); 3) Youth reported they already felt distant or disconnected from their families so they did not expect to feel accepted after coming out (10%, n=5); 4) A few youth reported a fear of being violently hurt and one reported being fearful of death by a parent or other family member (15%, n=8); 5) Several youth stated that a clash of cultures influenced how accepted they felt – for example, "My parents are both immigrants from Africa while I was born in America, so our cultures clash a lot" (6%, n=3); 6) Parent making homophobic or disparaging comments about LGBTQ people (13%, n=7); and 7) Two youth had a prior interest in dating people of a different gender, and their parent sometimes had an even more difficult time understanding and accepting their identities – for example, "I am pansexual but I have a boyfriend so I believe my parents think that there is no chance of me dating a girl or trans person in the future" (4%, n=2). One positive theme that emerged was some youth reported having other LGBTQ family members, making their coming out process a little bit easier; the family was sometimes more accepting because other family members came out before them.

For the second question that asked about parent's expressing "grief" or "loss" or religious/spiritual disagreement, the following common themes emerged: 1) It is "wrong," "unnatural," or "immoral" (16%, n=7); 2) It is not in line with our religion – for example, "God doesn't' love you that way" (26%, n=11); 3) Expressions of anger or rage – for example, "My mother now hates me and said to me, she's dead"(7%, n=3); 4) Comments about needing to be changed or converted, or youth being forced to go to a place of worship or study religion more often – for example, "They sat me down and made me read scriptures for hours daily" (12%, n=5); and 5) Youth being told that they are a disappointment or not meeting the family's expectations – for example, "She [Mom] said I was a disappointment. It's hard hearing that from the most important person in the world" (14%, n=6). Other comments that youth reported hearing from their parent(s) or caregiver(s) after coming out were: "It's just a phase" (2%, n=1), "You're too cute to be gay" (5%, n=2), and one mother stated that she would "go through a process of grieving the wedding and children that I won't have" (2%, n=1).

For the third question that asked participants if there was anything else they would like to share about their experiences, the following common themes emerged: 1) Ask questions about the origins of depression or current depressive episode, and low self-esteem because it may have nothing to do with sexuality – for example, "I only have low self-esteem because of my break-up" (36%, n=15); 2) Make a clearer distinction between African American and Black as racial or ethnic identity categories, some youth felt questions about these constructs were confusing (7%, n=3); 3) Add questions about gender and gender identity (2%, n=1); 4) Ask about experiences as a "double or triple minority" – for example, one youth wrote "You should realize that being Black in America is, in fact, a task… now imagine that two fold" (2%, n=1); 5) Some youth reported their queerness is a political identity, being invisible, and being something that they wanted to enhance or make more known, and suggested I ask about that – for example, "… I personally like to make my lesbianism more known because any can look at me and see a Black woman [but] people don't see me and think "she's gay" (5%, n=2) so I verbalize it more often; 6) A few youth commented that I should have investigated how race organizes or affects one's treatment in the LGBTQ community – for example: "My Blackness has made me feel insecure about prospective partners as I feel people do not notice Black women with the influence of the hegemonic White beauty standard" (10%, n=4); 7) Assessing for history of self-injury and/or suicidality, as well as experiences with suicidality among friends and/or family (10%, n=4); 8) Ask questions about whether participant's have accessed therapy or other mental health services (5%, n=12%); and 9) Ask questions about geographic location and its racial and political demographics (5%, n=4).

For the fourth and final open-ended question that asked participants if they had any additional feedback or if there were things they disliked, the following common themes emerged: 1) Several participants reported that they liked and appreciated the survey, using words like "useful," "insightful," "burden lifted," "intense," "thorough," and "comprehensive" – for example, "Thank you for having this survey specifically for Black LGBTQA youth. Our experience is a lot different than other races.

Spirituality is a huge part of being African American and for a lot of us or our family might feel betrayed or stripped by our queerness"(41%, n=17); 2) Some noted many of the questions felt repetitive – for example, "… very repetitive in an insulting way" (15%, n=6); 3) A few stated they did not like some of the questions on the racial identity measure – for example: "I did not like the questions like "Agree or Disagree: I hate White people," the context of the question and the phrasing is off-putting"(15%, n=6); 4) Racial and ethnic, and gender, categories should be further expanded, left open to self-identify in addition to choosing a more universally recognized category, and/or allow for selecting more than one category (20%, n=8); and 5) Edit the instructions and layout to make them more clear and consistent, and define or contextualize some of the more complex terms – for example: "Maybe define some of the terms used, [like] how is Afrocentricity being defined within the context of this survey?"(15%, n=6). Additionally, one participant suggested the survey should be shortened, ask about more than mother and father, add questions about siblings and other out LGBTQ family members(5%, n=2), ask about parents' or caregivers' sexual identity (2%, n=1), and include more questions about bi- and multi-racial people and their experiences and positioning in society (2%, n=1).

One theme that kept emerging in the last two questions was some frustration and annoyance about the repetitiveness (and reverse wording of questions) in some of the self-report measures. Additionally, some participants offered thoughtful critiques of the perpetuation of negative stereotypes attributed to African Americans in the Cross Racial Identity Scale, as well the binary racial categorization this measure used. For example, one participant noted, "It seems weird that White people make up the majority of the questions of inclusion in a survey about Black American youth". Another commented that, "The whole hating White people thing and how Black people turn to drugs to make money that was ridiculous to me but I guess some really might feel that way," and yet another stated their conflict as a mixed-race individual was, "I did not feel entirely included in the survey's questions about "hating White people" etc., as a person of mixed race… though I identify as Black, I

still love my White family and accept that they are part of me and my experience, and I felt that the survey asked many questions which excluded the experience of someone who is part White."

The questions about gender and gender identity also left some participants feeling frustrated because of our limited language and categories that do not fully capture their complex identities. Some participants reported struggling with the focus of their family's rejecting comments, for example, was it solely about their sexual identity, or perhaps also or solely about their gender nonconformity (even if they do not identify as transgender). There was one participant who noted that "transgender is not a gender identity… there are transmen and transwomen, and a spectrum of non-binary individuals… the wording of that threw me off a little," and another who stated that "the gender options should let you choose more than one box [as] transgender is not a gender it's a gender identity…."

CHAPTER FIVE

DISCUSSION

Each research question, hypotheses, and corresponding result is discussed below in the context of the three theories used to design this cross-sectional web-based dissertation study: Attachment Theory (Bowlby, 1969/1982), Intersectionality Theory (Crenshaw, 1989), and the [Multiple] Minority Stress Model (Meyer, 1995). Additionally, prior research on the Family Acceptance Project (FAP; Ryan et al., 2009, 2010), Attachment Based Family Therapy (ABFT; Diamond, et al., 2011), and Parental Acceptance-Rejection Theory (PARTheory; Rohner, et al., 2005, 2012), Black racial identity development, and LGBQ sexual identity development is reviewed to explain some of the expected and unexpected findings in this study.

Hypothesis One

Question #1: *Is there an association between stage of racial identity development and sexual identity development in Black LGBQ youth, do the processes occur along a similar trajectory?*

Hypothesis #1: *The processes of racial identity development and sexual identity development will occur along a similar trajectory, and the stage of racial identity development will be positively associated with stage of sexual identity development.*

It was hypothesized that racial and sexual identity development processes would occur along a similar trajectory and be positively associated with each other. Prior research suggests both racial and sexual identity development is central tasks in adolescence. Yet, identity development researchers have reported conflicting results among racial/ethnic and sexual minority youth; some scholars suggest processes are different and unrelated (Rosario et al., 2004), while others suggest the two processes occur simultaneously (Jamil et al., 2009). It was hypothesized there would be a significant, positive association between racial identity and sexual identity development in this study; youth who are earlier or further along in one stage of identity development, would be earlier or further along in the other.

The correlations support this hypothesis; CRIS-PSH was positively and significantly associated with LGBIS-AC, LGBIS-IU, and LGBIS-DP. Youth who were in the earlier pre-encounter self-hatred stage of racial identity development (having negative feelings about being Black) also tended to be in the earlier stages of sexual identity development (acceptance concerns – having more concerns about being accepted as an LGBQ person; identity uncertainty – being more uncertain or insecure about their sexual identity, or difficult process –difficulty coming to terms with their sexual identity). This finding confirms Cross (1991) and Worrell et al.'s (2001) first pre-encounter stage of racial identity development (experiencing self-hatred because of a Black individual's assimilation and internalization of negative societal messages about race and dominant culture politics). It is also noteworthy that in the expanded Cross model, Vandiver et al. (2002) separated two Pre-Encounter stages, miseducation and self-hatred, and reported there is a negative association between self-hatred and self-esteem. This association will be further examined in question #6a below.

Another significant finding was a negative and moderate association between CRIS-IMCI and LGBIS-IU, which further confirms what was hypothesized. This finding suggests youth who were in the multicultural inclusive ideology stages (the final stage of racial identity development), where they were able to connect to, respect, and engage with other cultural groups, tended to experience less uncertainty or insecurity about their sexual identity (reminder: identity uncertainty is an earlier stage of sexual identity development). This finding supports the hypothesis that processes of racial and sexual identity development are positively associated with each other.

The internalization multiculturalist inclusive stage describes an individual's development of security about his or her racial identity and ability to establish meaningful relationships with White people and culture, without conversely feeling negatively about his or her Black racial identity. Additionally, individuals in the multiculturalist stage of racial identity are able to focus on two or more other salient identities. LGBQ people of color often report feeling pressured to choose one community as their primary identity or group allegiance, as opposed to reaching a level of integration that

privileges all parts of themselves and embraces the complexity that exists when individuals have multiple identities. However, Morales (1989, 1990) proposed a model of sexual identity formation for ethnic minorities, in which progression through five stages is theorized. The fifth and final stage of Morales' model, *integrating various communities*, describes attempts by LGBQ people of color to live wholly as part of both their racial/ethnic and LGBQ communities by embracing a politic of intersectionality (Morales, 1989). This supports the study's results that individuals in the later multiculturalist inclusive stage of racial identity development, and thus able to honor multiculturalism as a concept overall, are able to hold more than one, and seemingly contradictory, identities without the threat of negative feelings developing about oneself and his or her multiple, intersecting identities.

There were also some unexpected findings. CRIS-IEAW and CRIS-IA were both positively and moderately correlated with LGBIS-AC, LGBIS-IU, and LGBIS-DP. This suggests some youth were further along in their racial identity development (immersion-emersion anti-White – having disdain for White people and/or culture or internalized afrocentricity – having an internalized pro-Black identity and privileging African-centered principles and traditions), but at the same time in earlier stages of their sexual identity development (acceptance concerns – having more concerns about being accepted as an LGBQ person, identity uncertainty – being more uncertain or insecure about their sexual identity, and difficult process – experiencing more difficulty in their process of coming to terms with their sexual identity). This result is supported by prior literature which suggests racial and sexual identity development process does not occur along a similar trajectory, but are separate and distinct processes (Rosario et al., 2004).

These results can be further understood by considering the parental racial socialization literature. Peters (1985) defines racial socialization as "the tasks Black [or other racial minority] parents share with all parents – providing for and raising children - … but include the responsibility of raising physically and emotionally healthy children who are Black in a society in which being Black has serious negative consequences" (p. 161). Phinney and Rotheram (1987) added that it is a

developmental process where children acquire behaviors, perceptions, values, and attitudes of an ethnic/racial group, develop resiliency and learn to manage racial discrimination, and how to see themselves and others as members of their respective racial groups/ethnic. These unexpected results could be explained by the positive and healthy outcome of Black youth being racially socialized by their Black parents, where the same outcome cannot be expected among youth who are socialized by their (presumably) Black straight parents. Given the literature on parental racial socialization and research suggesting that when children feel more connected to their Black identities and communities, they are more likely to develop positive racial identity development (Edwards and Polite, 1992; Stevenson, 1994, 1995), youth could have progressed further in their racial identity development and at the same time not progressed as much in their sexual identity development. This is especially true if sexual minority youth do not have opportunities to connect with sexual minority peers and experience group identity socialization, which is also important for racial identity development (Edwards and Polite, 1992, Phinney and Rotheram, 1987; Stevenson, 1994, 1995).

Hypothesis Two

Question #2: *Is there an association between youths' stages of racial identity development and their perceived levels of parental acceptance/rejection?*

Hypothesis #2: *Racial identity development, a byproduct of parents' and caregivers' racial socialization practices, will not be associated with youths' perceived level of parental acceptance/rejection.*

It was hypothesized there would be no associations between youths' stages of racial identity development and their perceived levels of parental acceptance or rejection because prior research reported that race, ethnicity, and parental racial socialization are not the most significant indicators of how accepting or rejecting a parent or caregiver will be. Prior research suggests culturally-based values, such as traditional roles, expectations, or religious/spiritual beliefs, have a greater impact on parental/caregiver accepting or rejecting behaviors (LaSala & Frierson, 2012; Ryan et al., 2009, 2010).

Despite what prior literature suggests, parental or caregiver acceptance or rejection is a complex process. It is affected by parents' judgments and biases (e.g., unexamined beliefs that they tend to automatically or systematically hold) based on their culturally-based values, like traditions, values, expectations, or religious beliefs.

Erikson (1968) described the fifth stage of adolescent development, *identity vs. identity confusion*, which for Black LGBQ youth is lkely much more complex because they need to negotiate several types of identity development and confusion at the same time: 1) racial, 2) gender, and 3) identities. Additionally, Closs (2010) suggested that because perceived threat (fueled by racism, and racial oppression and discrimination) tends to activate physical closeness and attachment to the primary attachment figure, the Eurocentric belief that autonomy is critical for healthy adolescent development does not necessarily apply to Black LGBQ adolescents and young adults. Instead, Black LGBQ youth and young adults may simultaneously reach out to their families during this tough time when they are examining their racial identity and having experiences with racial oppression, but at the same time may need to withdraw from their families if they are not fully accepted (including their sexual identities), which can disrupt the attachment process and development of a *secure home base*.

The correlations between the Cross Racial Identity Scale (CRIS) and the PARQ (Parental Acceptance-Rejection Questionnaire measure of global parental acceptance rejection) did not support the hypothesis for Mom/Parent 1. Four out of the CRIS subscales (CRIS-PSH, CRIS-IEAW, CRIS-IA, and CRIS-IMCI) were significantly associated with various subscales of the global parental-acceptance rejection scale for Mom/Parent 1, the PARQ Mom (specific subscales for Mom were, PARQ-WA, PARQ-HA, PARQ-IN, PARQ-UR, and PARQ total scale). The findings were: 1) youth who reported having more negative feelings about being Black and who were in the earlier stages of racial identity development (CRIS-PSH) tended to perceive less global parental acceptance (or more rejection); 2) youth who reported having more hatred or disdain for White people and or culture (CRIS-IEAW) tended to report believing Mom/Parent 1 did not really care about or love them or accept them overall;

3) youth who reported having an internalized pro-Black identity and privileged African-centered principles (CRIS-IA) tended to report lower levels of perceived global acceptance (or higher rejection) by their Mom/Parent 1; and 4) youth who reached a multicultural and inclusive ideology regarding their racial identity where they could connect to, respect, and engage with other cultural groups (CRIS-IMCI) tended to believe that their Mom/Parent 1 did care about and love them.

In these same correlations with Dad/Parent 2, only three of the CRIS subscales (CRIS-PA, CRIS-PM, and CRIS-PSH) were significantly associated with various subscales of global parental acceptance/rejection (PARQ-WA, PARQ-HA, PARQ-IN, PARQ-UR, and PARQ total scale). Overall, findings suggest: 1) youth who reported a desire to assimilate, who viewed being American as their primary identity and race as secondary, and who were at an earlier stage of racial identity development (CRIS-PA) tended to report lower levels of parental acceptance (or higher levels of rejection), specifically the warmth/affection (PARQ-WA) and undifferentiated rejection (PARQ-UR) dimension; 2) youth who were accepted and internalized stereotypes about Black people and culture, and at an early stage of racial identity development, tended to report experiencing more warmth and affection (PARQ-WA) from their Dad/Parent 2; and 3) youth who reported having negative feelings about being Black (CRIS-PSH), another early stage of racial identity development, tended to report lower levels of perceived overall acceptance (or higher levels of rejection) by their Dad/Parent 2 (PARQ total scale).

If we consider parental racial socialization and the "tasks Black parents [have of] raising physically and emotionally healthy children who are Black in a society in which being Black has serious negative consequences" (Peters, 1985, p. 161), some results are consistent with prior research and others are not. Extant research on parental racial socialization, which is in contrast to this study's hypothesis, suggests youth and younger adults in earlier stages of their racial identity development (pre-encounter assimilation, pre-encounter miseducation, pre-encounter self-hatred or immersion-emersion anti-White stages) may feel less accepted by their parents or caregivers because of how parents socialize Black children. Yet parenting practices are not always experienced by youth as

loving, caring, supportive, and accepting, particularly in comparison to how we have typically defined love, care, support, and acceptance from a privileged, White, middle-class, nuclear family structure.

Black parents must simultaneously develop a home environment that fosters trust, safety, and solace, and at the same time teach their children the outside world is not always going to be kind to them, because of their race. This is a difficult balance to strike as a Black parent, so sometimes a "tough love" parenting style may be perceived by youth as unsupportive, and at times, even rejecting. The finding that youth who were in the multicultural inclusive stage of racial identity (the final stage in the Cross model) tended to perceive more acceptance and less rejection by their parents supports this assertion. Black youth will more likely be able to hold two seemingly contradictory ideas, understanding their connection and influence on one another (e.g., feel solid in their own racial identity while also being able to connect with and embrace differences), and may be able to better tolerate and understand perceived unsupportive or rejecting behaviors from their parents as "tough love" and preparation for the outside world.

One unexpected finding was that youth in the internalization afrocentricity stage of the Cross model tended to perceive less global parental acceptance (or more rejection) by their Mom/Parent 1 (this was not true for Dad/Parent 2). Another was that youth in the pre-encounter assimilation stage (the first stage in the Cross model) tended to perceive more global warmth and affection from their Dad/Parent 2 (this was not true for Mom/Parent 1). It is important to note the correlations with Dad/Parent 2 are based on a significantly smaller number of participants (n=40, on average), as youth were given the option to answer or not answer questions about a Dad or a second parent (depending on whether they had one, were out to them, or maybe just did not felt like answering the two questionnaires again for another parent), limiting the generalizability of these findings.

The correlations between the CRIS and the Perceived Parental Reactions Scale (PPRS, measure of sexual identity-specific acceptance/rejection) did not support the hypothesis for Mom/Parent 1; all six of the CRIS subscales (CRIS-PA, CRIS-PM, CRIS-PSH, CRIS-IEAW, CRIS-IA, and CRIS-IMCI)

were associated with six of the subscales assessing perceived parental acceptance/rejection specific to youth's sexual identity for Mom/Parent 1 (PPRS-NS, PPRS-Den, PPRS-Barg, PPRS-Dep, PPRS-Acc, and PPRS-GH). The findings were: 1) youth who reported a stronger desire to assimilate and viewed being American as their primary identity and race as secondary (CRIS-PA), and who accepted and internalized stereotypes about Black people and Black culture (CRIS-PM), tended to report that their Mom/Parent 1 reacted more negatively and shocked to their coming out as LGBQ; 2) youth who reported having more negative feelings about being Black and in earlier in their sexual identity development (CRIS-PSH) tended to experience their Mom/Parent 1 as more rejecting based on their LGBQ identity, as evidenced by the negative reactions of bargaining (PPRS-Barg, depression (PPRS-Dep) or expressing general homophobia (PPRS-GH); 3) youth who reported having more disdain for White people and culture (CRIS-IEAW) tended to perceive less overall acceptance (PPRS-Acc) from their Mom/Parent 1, after coming out as LGBQ; 4) youth who reported having an internalized pro-Black identity with privileged African-centered principles and traditions (CRIS-IA) tended to perceive their Mom/Parent 1 as more rejecting of their LGBQ identity, as evidenced by negative reactions of denial (PPRS-Den) and bargaining (PPRS-Barg); and 5) youth in the multicultural and inclusive ideology where they could connect to, respect, and engage with other cultural groups (CRIS-IMCI) tended to perceive their Mom/Parent 1 as less negative or shocked, thus having a more positive or accepting reaction to their coming out as LGBQ.

In these same correlations with Dad/Parent 2, four of the CRIS subscales (CRIS-PA, CRIS-PM, CRIS-PSH, and CRIS-IEAW) were significantly associated with three of the PPRS subscales (PPRS-NS, PPRS-Den, PPRS-Dep) and the total scale score. The results were: 1) youth who had a stronger desire to assimilate and viewed being American as their primary identity and race as secondary (CRIS-PA), and who were earlier in their racial identity development, tended to perceive their Dad/Parent 2 as rejecting them after coming out, as evidenced by the negative reactions of negative shock (PPRS-NS) and denial (PPRS-Den); 2) youth who were more accepted and internalized stereotypes about Black

people and Black culture tended to perceive their Dad/Parent 2 as more negative or shocked by their coming out as LGBQ, and 3) youth who reported being more unhappy or having negative feelings about being Black (CRIS-IEAW), tended to perceive their Dad/Parent 2 as more rejecting, as evidenced by the negative reaction of denial (PPRS-Den).

Considering these results through the lens of parental racial socialization, it is understandable why Black youth and young adults who are in the earlier or middle stages of racial identity development (pre-encounter assimilation, pre-encounter miseducation, pre-encounter self-hatred, or even immersion-emersion anti-White) tended to perceive both Mom/Parent 1 and Dad/Parent 2 as exhibiting more negative reactions or rejection to their coming out as LGBQ (such as negative shock, denial, depression, bargaining, or less overall acceptance). Yet, it also makes sense that Black youth/young adults in the final stages of racial identity development, internalization multiculturalist inclusive, tended to perceive more acceptance and positive reactions from Mom/Parent 1 after coming out as LGBQ. An interesting finding was that Black youth who were in the internalized afrocentricity stage of racial identity (the second to last stage in the Cross' model) tended to report perceiving less acceptance from their Mom/Parent 1. This could be explained by being socialized so well and consistently about celebrating, taking pride in, and privileging their Black and/or African heritage, that youth felt this message was in contradiction to celebrating, taking pride in, or privileging a LGBQ identity. Unfortunately, there is still a widely held belief in some Black communities that being LGBQ is not "of us," that it is a White phenomenon or an imposition of Eurocentrism.

Parental Acceptance-Rejection Theory (PARTheory) is another model that can explain the findings. PARTheory suggests, "Children everywhere need a particular form of positive response – *acceptance* – from parents and other attachment figures" (Rohner et al., 2005, p. 300) to develop into healthy adults and relational beings. The warmth/affection dimension of parenting describes the quality of the affectional or attachment bond between parents or caregivers and their children, and the four dimensions that make up parental rejection, including: 1) hostility/aggression, 2) cold/unaffectionate

(opposite of warmth/affection), 3) indifference/neglect, and 4) undifferentiated rejection. This theory suggests all parenting behaviors, real or perceived, individually and collectively, will encourage children to feel unloved or rejected at some point. Additionally, the theory suggests that racial, ethnic, and cultural groups have diverse ways of and reasons for exhibiting parental warmth, affection, hostility, aggression, indifference, neglect, and otherwise perceivably rejecting behaviors.

Hypothesis Three

Question #3*: Is there an association between youths' stages of sexual identity development and their perceived levels of parental acceptance/rejection?*

Hypothesis #3*: There will be an association between youths' stages of sexual identity development and their perceived levels of parental acceptance/rejection. Specifically, youth who are "more out" or further along in their sexual identity development will view their parents as more accepting and less rejecting.*

It was hypothesized there would be a positive association between youths' stages of sexual identity development and their perceptions of parental acceptance, and a negative association between stages of sexual identity development and their perceptions of parental rejection. Prior research describes the "coming out" process (disclosing one's sexual identity to other individuals), particularly among adolescents, as a critical step in healthy sexual identity development. It has been linked to better overall mental health and well-being, and feeling more connected to parents, family members, friends, or others that an individual has come out to (Ayala & Coleman, 2000; Lewis et al., 2003).

The results of the correlations between sexual identity development (LGBIS), global parental acceptance/rejection (PARQ) and sexual identity-specific parental acceptance/rejection (PPRS) did support the hypothesis. For Mom/Parent 1, results suggest: 1) youth who reported having more concerns about being accepted as a LGBQ person (LGBIS-AC) tended to perceive more hostility and aggression (PARQ-HA) and more indifference and neglect (PARQ-IN) from their Mom/Parent 1; 2) the more youth reported needing to hide/conceal their sexual identity (LGBIS-CM), the less they

believed their Mom/Parent 1 really cared about or loved them (PARQ-UR); 3) the more youth were uncertain or insecure about their sexual identity (LGBIS-IU), the more they perceived their Mom/Parent 1 as being hostile or aggressive (PARQ-HA), not really caring about or loving them (PARQ-UR), and not accepting them overall (PARQ total scale); and 4) the more youth experienced their sexual identity development as difficult (LGBIS-DP), the less they believed their Mom/Parent 1 really cared about or loved them (PARQ-UR).

Most of these same results were found for Dad/Parent 2; however, it is important to again note that only a small number of participants (n=40, on average) answered the two surveys about a Dad or second parent, which limits generalizability of findings for fathers. Specifically, the results of the correlations for Dad/Parent 2 suggest that: 1) the more youth reported having concerns about being accepted as a LGBQ person (LGBIS-AC), the more they tended to feel rejected overall (PARQ total scale) by their Dad/Parent 2; 2) the more youth felt a need to hide or conceal their sexual identity (LGBIS-CM), the more hostility and aggression (PARQ-HA) they tended to report receiving from their Dad/Parent 2; and 3) the earlier the stage of sexual identity development in which youth experienced uncertainty or insecurity about their sexual identity (LGBIS-IU) and had a difficult identity development process (LGBIS-DP), the more youth tended to report experiencing hostility and aggression (PARQ-HA) from their Dad/Parent 2.

The correlations for youths' stage of sexual identity development (LGBIS) and sexual identity-specific parental acceptance/rejection (PPRS) supported the hypothesis. The findings were: 1) youth who reported having more concerns about being accepted as a LGBQ person (LGBIS-AC) tended to perceive their Mom/Parent 1 as more rejecting of their LGBQ identity, as evidenced by the negative reactions of denial (PPRS-Den) and bargaining (PPRS-Barg); 2) the more youth felt a need to hide/conceal their sexual identity (LGBIS-CM), the more they perceived their Mom/Parent 1 as more rejecting of their LGBQ identity, as evidenced by the negative reactions of denial (PPRS-Den), bargaining (PPRS-Barg), depression (PPRS-Dep), general homophobia (PPRS-GH), and overall

rejection (PPRS total scale); 3) the more youth experienced their sexual identity development process as difficult, the more they perceived their Mom/Parent 1 as rejecting their LGBQ identity, as evidenced by the negative reactions of anger (PPRS-Ang), bargaining (PPRS-Barg), depression (PPRS-Dep), general homophobia (PPRS-GH), and overall rejection (PPRS total scale).

For Dad/Parent 2, the correlation results suggest that: 1) the more youth reported having concerns about being accepted as a LGBQ person (LGBIS-AC), the more they tended to report experiencing rejection specific to their sexual identity, as evidenced by denial and depression (PPRS-Den and PPRS-Dep); 2) the more youth felt a need to hide or conceal their sexual identity (LGBIS-CM), the more they tended to report experiencing rejection specific to their sexual identity, as evidenced by negative reactions such as negative shock (PPRS-NS), anger (PPRS-Ang), bargaining (PPRS-Barg), depression (PPRS-Dep), general homophobia (PPRS-GH), and overall (PPRS total scale); and 3) youth who experienced a difficult identity development process (LGBIS-DP) tended to report experiencing rejection specific to their sexual identity, as evidenced by negative reactions such as negative shock (PPRS-NS), bargaining (PPRS-Barg), and depression (PPRS-Dep).

An unexpected result emerged for youth who were in the difficult process (LGBIS-DP) stage of sexual identity development; youth who reported experiencing their sexual identity development as more difficult tended to report *more acceptance from their Mom/Parent 1* (it was predicted they would report feeling *less* acceptance). Another unexpected finding specific to PPRS Dad/Parent, was youth who reported being more concerned about being accepted as a LGBQ person tended to perceive *more acceptance from their Dad/Parent 2* (it was predicted they would feel *less* accepted by their parent). Yet, the remaining findings for Dad/Parent 2 (again noting that a smaller number (approximate 40) of participants reported on their dads) were pretty consistent with the findings for Mom/Parent 1.

It is helpful to examine these findings within the larger framework of LGBQ sexual identity development. Sexual identity development describes the dual process of *identity formation* (a process of self-discovery, exploration, and awareness of one's emerging sexual orientation) and *identity*

integration (a process of acceptance and commitment of one's sexual identity, and connecting to community). Prior research suggests "not all LGB youth experience the same aspects of identity formation in the same way, or the same time, and some of the hypothesized stages (such as identity pride, which connotes a feeling of superiority over heterosexuals) may not be experienced at all" (Bregman et al., 2013, p. 418). Additionally, it is important to note that not all LGBQ youth and young adults describe their identity using the same language. Some theorists have categorized LGBQ youth and young adults as "post-gay," suggesting that they are redefining sexual orientation and identity in new and unique ways. This was partially true in this study, yet in other ways youth reported feeling affirmed by using the identity terms that were used in this study. This is relevant because most Black youth or young adult participants reported not feeling their sexual identity was accepted or affirmed by their parents or caregivers, regardless of their stage of sexual identity development.

There could be several explanations for this result. Perhaps, the stages of sexual identity development used in this study from the Lesbian, Gay, and Bisexual, Identity Scale (LGBIS; Mohr & Kendra, 2011) did not resonate with the some Black youth. Most sexual identity development researchers have studied primarily White participants, and only one model was developed for racial minorities. Morales' (1990) model highlights and appreciates the overlapping and intersecting processes of coming out for LGBQ people of color, and describes challenges many face choosing one community or group allegiance over another. Unfortunately, there is no scale to accompany Morales' model of sexual identity development for racial minorities, so in this study an existing measure was used, but was possibly not culturally relevant for this sample.

Another explanation concerns a term developed by Luna (1989) "*gay racism*" (as cited in Parks, 2001, p. 44), which describes a persistent experience throughout LGBQ communities where racial minority LGBQ individuals report not feeling accepted by others and experiencing overt and covert discrimination experiences from White LGBQ individuals." It could also be that participants' were experiencing a pull to choose a *more marginalized identity* to situate their experiences of

rejection from their parent's or caregivers, and because (usually) the youth or young adult shares the same race as their parent or caregiver, sexual identity is where they differ and is the identity in which they feel most misunderstood or rejected. Another issue to consider is how intersectionality informed participants' understanding of these questions.

The demographic questionnaire and some of the comments provided in the open-ended section suggest most participants were educated, and highly insightful. Thus, for some participants they could be less concerned with an experience of rejection or acceptance that is specific to one of their social locations or (marginalized) identities, because they embrace an intersectional framework in which any form of rejection means a full rejection. For example, if a youth's parent can understand that she identifies as a lesbian and only dates women, but the parent cannot fully understand and accept queer identity, where that youth rejects rigid notions of gender and dates people (which could include male-bodied or female-bodied individuals), then that youth could still view that parent as rejecting. Thus findings suggest that perhaps a new and more comprehensive theory and measure of sexual identity development is warranted – one that can measure the complexity of multiple marginalized and intersecting identities.

Hypothesis Four

Question #4*: Is there an association between the perceived level of parental acceptance/rejection and youths' symptoms of depression and levels of self-esteem?*

Hypothesis #4*: A negative association will be found between perceived level of parental acceptance/rejection and youths' symptoms of depression, and a positive association will be found for self-esteem. Higher levels of perceived parental acceptance/lower level of perceived parental rejection will be associated with lower levels of depression and higher levels of self-esteem.*

It was hypothesized that associations would be found between perceived parental acceptance/ rejection (both global, and sexual identity-specific). Specifically, it was predicted that it would be

negatively associated with depressive symptoms (as perceived acceptance goes up or rejection goes down, depressive symptoms will go down or will go up, respectively), and positively associated with self-esteem (as perceived acceptance goes up or rejection goes down, level of self-esteem will go up or will go down, respectively). Prior literature describes the important role of parental and family acceptance and support to facilitate children's healthy development so they are at a decreased risk of experiencing depressive symptoms and lower self-esteem (Bowlby, 1973; Diamond et al., 2011; Rohner et al., 2005, 2012; Ryan et al., 2009, 2010). Parental acceptance is an important protective factor, and parental rejection is a significant risk factor for predicting youth and young adults' current and future development, and emotional and mental health.

The results of the correlations and regression models support these predicted associations. For the measure of global parental acceptance/ rejection, the PARQ, several subscales and the total scale for Mom/Parent 1 were all significantly associated with depressive symptoms. Youth who reported experiencing their Mom/Parent 1 as being more available (less indifferent and rejecting) and who felt their Mom/Parent 1 cared about, loved, and accepted them overall tended to report less depressive symptoms. Similarly for the second outcome variable, self-esteem, all the PARQ subscales were associated with self-esteem, suggesting youth who perceived their Mom/Parent 1 as being more warm, caring, supportive, and who tended to believe their Mom/Parent 1 cared about and loved them, tended to report having higher self-esteem. An unexpected finding was that as the data analyses progressed from correlations to stepwise regressions to the mediation analysis, the PARQ (measuring global acceptance/rejection) fell out as a significant mediator variable.

The hypothesis that was most supported (from correlation to stepwise regression to mediation models) was that *sexual identity-specific parental acceptance/rejection is significantly associated with the two outcome variables, depressive symptoms and self-esteem*. All of the PPRS subscales and the total scale (parental acceptance specific to sexual identity) for Mom/Parent 1 were significantly correlated with the first outcome variable, depressive symptoms. Youth who reported experiencing

their Mom/Parent 1 as rejecting based on their LGBQ sexual identity, as evidenced by negative reactions (such as denial, anger, bargaining, depression, general homophobia, and parent-focused concerns) to their coming out tended to have more depressive symptoms. For the second outcome variable, self-esteem, the same results were found; youth who reported experiencing their Mom/Parent 1 as more rejecting based on their LGBQ sexual identity, as evidenced by negative reactions (such as denial, bargaining, acceptance concerns, and general homophobia) to their coming out tended to have lower self-esteem.

Despite the smaller number of participants who answered the survey questions about a Dad/Parent 2, the results of the correlations and regressions are relevant (although generalizability is limited). The examination of overall parental acceptance/rejection (PARQ) yielded the following results specific to Dad/Parent 2 and the outcome variables: 1) youth who experienced their Dad/Parent 2 as less hostile and aggressive (PARQ-HA), less indifferent and neglecting (PARQ-IN), and more overall accepting (PARQ total scale) tended to report less depressive symptoms; and 2) youth who experienced their Dad/Parent 2 as less hostile and aggressive (PARQ-HA), less indifferent and neglecting (PARQ-IN), and believed that their Dad/Parent 2 really did care about and loved them and accepted them overall (PARQ total scale) tended to report having higher self-esteem. The results for Dad/Parent 2 acceptance/rejection specific to sexual identity yielded the following results: 1) the more that youth experienced their Dad/Parent 2 as rejecting them based on their sexual identity, as evidenced by negative reactions such as denial (PPRS-Den) and bargaining (PPRS-Barg), the more depressive symptoms they tended to report; and 2) the more youth experienced their Dad/Parent 2 being in denial (PPRS-Den) and showing less overall acceptance (PPRS-Acc), the lower they tended to report their self-esteem to be.

These results are supported by prior literature, and the three theoretical frameworks used to design this dissertation study. From an attachment and parental acceptance-rejection theory (PARTheory) perspective, a safe, emotionally secure base where children know they can come back to

their parent(s) when needed is critical for healthy development. What a child learns and feels during their early attachment experiences with their parent(s) or primary caregiver(s) significantly shapes their internal working models as they move through adolescence and adulthood (Bowlby, 1980; Armsden & Greenberg, 1987; Kobak et al., 1993). Additionally, Rohner et al. (2005, 2012) reported that PARTheory research suggests: 1) positive or accepting responses from attachment figures is associated with emotionally and behaviorally healthy responses from children ; 2) the connection between an individual having a differentiated sense of self, a strong sense of self-determination, and an ability to depersonalize in healthy ways and their capacity to cope with rejection; and 3) the association between child or adolescent's personality development and behaviors and the level of parents' accepting/rejecting behaviors, which are rooted in institutionalized expressive systems such as religious traditions, artistic traditions, or other symbolic beliefs (Rohner et al., 2005, 2012).

When these findings are considered using these theories, it helps to explain the result that youth and young adults who perceived their parent(s) or caregiver(s) as being more accepting, loving, supportive, nurturing, caring and responsive upon "coming out," tended to experience significantly less depressive symptoms and higher self-esteem. This suggests *parents may accept their child overall and in theory (the global parental acceptance scale fell out of the models as a predictor and as a mediator), and at the same time reject their child's sexual identity, which is associated with worse mental health outcomes, specifically more depressive symptoms and lower self-esteem*.

From an intersectionality and (multiple) minority stress framework, we should consider how "particular forms of intersecting oppressions… work together to produce injustice" (Collins, 2000, p. 18) and how experiencing, what Meyer (1995) describes as, the "psychosocial stress derived from minority status" (p. 38) contributes to worse overall psychosocial, mental, and emotional health outcomes (e.g., depressive symptoms and lower self-esteem) in this sample of Black LGBQ youth. The intersections of multiple minority statuses that participants occupy place them at an increased risk for experiencing negative health outcomes. Prior research describes the chronic and long-term

psychological effect of sexual identity-based and race-based oppression, for example, social isolation/loneliness, low self-esteem, demoralization, guilt, suicidal ideation, and overall higher rates of psychiatric disorders (Diaz et al., 2001; Harper et al., 2004; Mays & Cochran, 2001; Meyer, 1995; Moore, 2011). Additionally, an individual's conception of self is associated with their psychological well-being, therefore "stressors that damage or threaten self-concepts are likely to predict emotional problems" (Thoits, 1999, p. 346). Consequently, when a young person is already fighting the oppression, discrimination, and victimization from the outside world because of being Black and LGBQ, having parents/caregivers/family in which that young person does not feel affirmed, safe, accepted, and nurtured can take an even greater toll on their identity development, and their ability to be protected from depressive symptoms and low self-esteem.

Hypothesis Five

Question #5a-d*: Is there an association between age of coming out, gender, family SES/class or parents' level of religiosity and youths' symptoms of depression and levels of self-esteem?*

Hypothesis #5a-d*: An association will exist between all of these salient demographic variables: youth's age, youth's gender, their family's SES/class, and their parents' level of religiosity, and youths' self-reported reports of symptoms of depression and levels of self-esteem. Specifically, it was hypothesized that youth who come to terms with their sexual identities and who come out younger ages will show more positive adjustment and have lower levels depression and higher self-esteem. It was also hypothesized that lesbian, bisexual, or queer female youth will report less symptoms of depression and higher self-esteem, as compared to gay, bisexual, or queer male youth; and that youth who self-report that they are out more to their families will report less symptoms of depression and higher self-esteem compared to youth who are not out to their families. Regarding SES/class, it was hypothesized that youth from families of lower SES/class would report more depressive symptoms and have lower self-esteem. Finally, parents rated, by*

the youth, as exhibiting higher religiosity was hypothesized to contribute to more symptoms of depression and lower self-esteem in youth.

The hypotheses for most of the salient demographic variables of age, gender, and family's SES/class being associated with depressive symptoms and self-esteem were not supported by the results (T-tests, ANOVAs, and chi-square). There was only one significant difference comparing parent's level of religiosity (as reported by youth) and youth's depressive symptoms in the ANOVA, suggesting that *youth who reported their parents as highly religious tended to have more depressive symptoms compared to youth who reported their parents as moderately or minimally religious*.

Prior literature identified age as a salient factor for identity development, specifically sexual identity. Youth who are able to move through identity formation and integration at younger ages tend to be at lower risks for mental and emotional disturbances (e.g., depressive symptoms and lower self-esteem) (Floyd & Stein, 2002; Floyd et al., 1999; Mustanski et al., 2011). Prior research also suggests gay, bisexual, and/or queer boys tend to experience more harassment, victimization, and less parental and family acceptance compared to lesbian, bisexual, and/or queer girls (Bostwick et al., 2010; LaSala & Frierson, 2012; Lemelle & Battle, 2004). This is possibly because of society's increased tolerance and fetishization of female bodies and sexuality (Williams et al., 2005).

In general, women tend to embrace and exhibit greater levels of sexual fluidity (Diamond, 2005), and may be protected because of more tolerance regarding female sexuality, and consequently less societal stigma exists about two women being romantically involved with each other (Savin-Williams & Diamond, 2000). In many Black communities, Black hyper-masculinity is often viewed as a virtue which can make (especially effeminate) Black gay, bisexual, and queer men targets of more victimization and shaming (LaSala & Frierson, 2012; Lemelle & Battle, 2004; Ward, 2005). There has also been more focus on gender differences in sexuality research, where previously it was assumed that the experiences for women and men were the same (Diamond, 2005, 2007; Mustanski et al., 2011; Savin-Williams, 2000).

Regarding family's SES/class and parent's level of religiosity (as reported by youth), previous research suggests SES is significantly associated with mental health outcomes (Adler et al., 1994; Anderson & Armstead, 1995; Goodman & Huang, 2002; Wilkinson, 1999). It is important to note that this association is not a direct one; there are many reasons individuals from lower SES/class tend to experience worse mental health outcomes, which can best be explained by the minority stress model. The compounding stressors associated with being in a lower SES/class often lead to difficulty meeting basic family needs, and may be internalized by a child as neglect. Additionally there are higher concentrations of lower SES families in unsafe, financially scarce, and resource-deficient neighborhoods, which add additional stress, and is a strong predictor of depressed mood, more than the actual income level (Grant et al., 2004; Wilson et al., 2009).

Ryan et al.'s (2009, 2010) research on the Family Acceptance Project (FAP) examined the association between parental religiosity and family acceptance or rejection among Latino and White youth and their families. The FAP reported parental religiosity was significantly associated with family acceptance or rejection, with highly accepting families reporting lower religiosity and highly religious families reporting lowers levels of acceptance (Ryan et al., 2010) which is also what was found in this study with Black LGBQ youth. This suggests cultural values and beliefs, such as religion or spirituality, are significant predictors of parental acceptance/rejection of youth's sexual identity.

In addition to the findings and prior studies, the researcher's own personal and professional experience of the Black Church suggest that growing up LGBQ in a Black, Christian (or other religious) family and church community can negatively affect one's ability to develop a healthy, positive sexual identity; thus leading to more depressive symptoms and lower self-esteem (Barnes & Meyer, 2012; Harris et al., 2008; Herek et al., 2010; Schuck & Liddle, 2001; Ward, 2005). It is also important to note that there are examples of positive experiences with Black Churches and its history.

Part of the reason no significant associations were found between most of the salient demographic variables and the outcome variables may be due to the convenience sample who

volunteered this study. This was a relatively small sample (n=110), with little variability in age of participants with almost 70% (n=75) between 19-21 years old; a higher percentage of female participants at 65% (n=71); limited variability in SES/class (as reported by youth) with 77% identifying their family as being low-middle and middle class (n=85); and possibly the ability of youth to reject religious beliefs that they do not hold or agree with. Only 31% (n=34) of the youth identified as Christian and 40% (n=40) identified as not religious/atheist/agnostic, and finally the fact that this was a non-clinically depressed sample of youth participants. Yet, there was one significant difference in the ANOVAs comparing youths' report of parent's level of religiosity and youths' depressive symptoms, suggesting youth who reported their parents are highly religious had more depressive symptoms compared to youth who reported their parents were moderately or minimally religious. This finding is supported by previous literature, specifically from the Family Acceptance Project study, suggesting level of parental religiosity is significantly associated with family acceptance or rejection, with highly accepting families reporting lower religiosity and highly religious families reporting lowers levels of acceptance (Ryan et al., 2010).

Hypothesis Six

Question #6a-6b: *Is racial and sexual identity associated with symptoms of depression and self-esteem in Black LGBQ youth?*

Hypothesis #6: *Racial and sexual identity development will both be significantly associated with the outcome variables, depressive symptoms and self-esteem. That is, youth who are in earlier stages of identity development will report more depressive symptoms and as they progress, depressive symptoms will decrease; and youth who are in earlier stages of identity development will report lower self-esteem and as they progress, self-esteem will increase.*

It was hypothesized that processes of racial and sexual identity development would be significantly associated with the two outcome variables, depressive symptoms and self-esteem. Specifically, it was predicted youth who were in the earlier stages of racial and sexual identity

development would report more depressive symptoms and lower self-esteem. Prior research suggests identity development has important implications for youths' mental health outcomes, and stagnated identity development is associated with more negative outcomes and poorer adjustment (Archer & Stein, 2002; Constantine & Blackmon, 2002; Cross, 1991; Meeus, 2011; Parman & Helms, 1985a, 1985b Stone-Fish & Harvey, 2005)

The results of the correlation and regression analyses partially supported the predicted associations. For racial identity, one of the subscales was significantly associated with depressive symptoms and self-esteem. The CRIS pre-encounter self-hatred (PSH) stage was significantly associated with depressive symptoms and self-esteem, suggesting youth who reported being more unhappy or having more negative feelings about being Black (earlier in their racial identity development process) tended to report more depressive symptoms and lower self-esteem. Additionally, results of the regression models suggest CRIS-PSH was the strongest predictor of depressive symptoms and self-esteem. Participants in the earlier pre-encounter self-hatred stage of racial identity development tended to report more depressive symptoms and lower self-esteem.

According to the expanded Nigrescence (racial identity) model, the pre-encounter self-hatred stage describes being vulnerable to internalizing negative messages and stereotypes about being Black, which is related to self-esteem (Vandiver et al., 2002). Furthermore, it outlines a series of events that describe how, why and when individuals move from one stage to the next, ultimately arriving at the final multiculturalist inclusive stage, where one is able to exhibit acceptance of self and others in their racial group, as well as respect and accept members of other groups (e.g., racial, gender, sexual orientation, nationality, etc.). Some youth in this study were in an earlier stage of racial identity development, thus their ability respect and accept multiple group identities (multiculturalist-inclusive stage) may have been limited because of their earlier stage of racial identity development. Prior research also describes the long-term psychological and emotional impact of race-based and sexuality-based oppression, which oftentimes is exhibited as internalizing behaviors such as depression and low

self-esteem (Constantine & Blackmon, 2002; Crenshaw, 1989; Cross, 1991; Harper et al., 2004; Meyer, 1995; Nadal et al., 2010; Parham & Helms, 1985a, 1985b).

Regarding sexual identity development, two of the subscales were significantly associated with depressive symptoms and self-esteem. LGBIS-AC (acceptance concerns) and LGBIS-IU (identity uncertainty) were associated with depressive symptoms and self-esteem; youth who reported having more concerns about being stigmatized as a LGBQ person and more uncertainty or insecurity about their sexual identity tended to report more depressive symptoms and lower self-esteem. Yet both the LGBIS-AC and LGBIS-IU were not significant predictors in the regression models predicting self-esteem and depressive symptoms.

In this study, sexual identity development is conceptualized as a dual process of *identity formation* (process of self-discovery, exploration, and awareness of one's emerging sexual orientation), and *identity integration* (acceptance and commitment to one's sexual identity and connecting to community) (Mohr & Fassinger, 2000; Rosario et al., 2011). Rosario et al. (2008) describes the progression through stages of sexual identity development as unique for each individual. Thus, identity integration can change over time for some individuals. This might explain why sexual identity development was not a significant predictor of depressive symptoms or self-esteem. Acceptance concerns (LGBIS-AC) and identity uncertainty (LGBIS-IU), are sexual identity stages where one has more concerns about being accepted as an LGBQ person and is more uncertain or insecure about his or her sexual identity. Youth in these earlier stages may vacillate more between stages because they are coming to terms with their sexual identity and integrating it into a larger understanding of themselves.

Although there is a dearth of research in this area, intersectionality researchers suggest racial/ethnic and sexual identity development occur in a parallel fashion during adolescence; however, the processes are different and unrelated (Rosario et al., 2004). This is likely because racial identity development is a very public and visible identity, while sexual identity development is a more private process and invisible identity, until it is disclosed (Jamil et al., 2009). For youth who have multiple

marginalized identities, their identity integration processes are likely more difficult and may require more time compared to their majority (White, heterosexual) peers. Again, it may have been more useful to use Morales' (1990) model of sexual identity development among racial and ethnic minorities, because this model includes stages that describe the tension about choosing one primary group affiliation, and theorizes a process of integration when you are a member of multiple groups.

Hypothesis Seven (revised)

Question #7c-d (revised)*: Is youths' overall perceived parental acceptance/rejection to their LGBQ sexual identity (sexual identity-specific acceptance/rejection) a significant mediator between youths' reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and feelings of uncertainty about their sexual identity (early stages of sexual identity development), and their depressive symptoms? Is youths' perceived parental general homophobia or negative reactions to their LGBQ sexual identity (sexual identity-specific acceptance/rejection) a significant mediator between youths' reported negative feelings about being Black (early stage of racial identity development), their concerns about being accepted as an LGBQ person and their feelings of uncertainty about their sexual identity (early stages of sexual identity development), and their level of self-esteem?*

Hypothesis #7*: Perceived parental acceptance/rejection will mediate the associations between youths' racial and sexual identity processes and depressive symptoms and level of self-esteem.*

It was hypothesized that both perceived global and sexual identity-specific parental acceptance/rejection would be significant mediators between youths' racial and sexual identity development and self-reports of depressive symptoms and self-esteem. Prior research suggests higher levels of parental acceptance are associated with less depressive symptoms and higher self-esteem in LGBQ youth. Conversely, higher levels of parental rejection are associated with more depressive symptoms and lower self-esteem. Results of the mediation analyses partially supported this hypothesis

for only perceived parental acceptance/rejection specific to sexual identity (PPRS), but not globally (PARQ). Again, the PARQ was not included in the mediation model because the PARQ was *not* significantly associated with depressive symptoms or self-esteem.

For the first mediation model, with depressive symptoms as the outcome variable, results suggest a partial mediation. Youth who reported being in the earlier stages of racial identity development (CRIS-PSH – having negative feelings about being Black), tended to report more depressive symptoms when they perceived their Mom/Parent 1 as more overall rejecting of their sexual identity. Noteworthy, *the second model was fully mediated*. Thus, youth who reported more concerns about being accepted as a LGBQ person (LGBIS-AC), tended to experience more depressive symptoms *only when they also* perceived their Mom/Parent 1 as more overall rejecting of their sexual identity. Finally, the results of the third mediation model, suggest a partial mediation. Youth who reported being in the earlier identity uncertainty stage of sexual identity development (LGBIS-IU) tended to report more depressive symptoms, when they perceived their Mom/Parent 1 as more overall rejecting of their sexual identity.

The results of the first mediation model with self-esteem suggest that the Perceived Parental Reactions General Homophobia Scale (Mom/Parent 1 PPRS-GH) is a *negative and partial mediator* of the association between youth who reported being in the earlier pre-encounter self-hatred stage of racial identity development (CRIS-PSH) and lower self-esteem. Thus, youth who reported being in the earlier stages of racial identity development *and* who perceived more negative reactions from their mothers' about being LGBQ, tended to report lower self-esteem. The second mediation model with self-esteem suggests that the Mom/Parent 1 PPRS-GH scale *partially mediates* the association between youth who reported being in the earlier acceptance concerns stage of sexual identity development (LGBIS-AC) and lower self-esteem. Youth who reported being in the earlier stages of sexual identity development, acceptance concerns stage, tended to report lower self-esteem when they perceived more negative reactions from their mothers' about being LGBQ. Finally, the third mediation model with

self-esteem suggests that the Mom/Parent 1 PPRS-GH scale is a *negative and partial mediator* between youth who reported being in the earlier identity uncertainty stage of sexual identity development (LGBIS-IU) and lower self-esteem. Youth who reported being more unsure or insecure about their sexual identity development tended to report lower self-esteem when their mothers had more negative reactions to their LGBQ identities.

Attachment theory (Bowlby, 1969/1982), the Family Acceptance Project (FAP; Ryan et al., 2009, 2010, Attachment-Based Family Therapy (ABFT; Diamond et al., 2012), Parental Acceptance-Rejection Theory (PARTheory, Rohner et al., 2005, 2012), and LaSala and Fierson's (2012) study provide the most comprehensive understanding of the associations between youths' and young adults' perceptions of parental acceptance/rejection and their depressive symptoms and self-esteem. Mallon (1999) suggests, "given the stigmatizing status that [an LGBQ identity] still holds for many in society, the family is one place where a gay or lesbian young person most needs to feel same… [as] most gay and lesbian young people hope that their family, those who know them best, will see that they are the same persons they've always been" (p. 70). "Coming out" to others, as one part of some youths' sexual identity development process, has been said to "activate the attachment system" (Mohr & Fassinger, 2003) and if they are met with discrimination, homophobia or heterosexism, and overall rejection from their parents or families, it can have a significant impact on adolescents' mental, emotional, and psychological wellbeing. Thus, secure attachment and acceptance from parents plays an important role in youths' behavioral and emotional responses to social, environmental, and intrapersonal challenges. We also know that positive social adjustment as it relates to secure attachment and parental acceptance during adolescence is associated with fewer mental health problems, such as depressive symptoms and low self-esteem.

More specifically, Ryan and colleagues (2009, 2010) reported in the Family Acceptance Project research, youth who reported higher levels of family rejection specific to their sexual identity during adolescence were almost six times more likely to report higher levels of depression. This study

suggests family acceptance specific to sexual identity helps to buffer against depression (and other internalizing or externalizing behaviors) and promotes self-esteem, social support, and overall health. Similarly, in ABFT studies with depressed youth and suicidal LGBTQ youth, families who received ABFT were able to strengthen and improve the parent-child relationship and repair attachment ruptures, and youth reported a greater reduction in depressive symptoms (Diamond et al., 2002, 2012). Considering prior research, the mediation results in this dissertation study partially supports previous literature.

Thus, unlike what was hypothesized, youths' perception of *global* (or overall) parental acceptance/rejection was not a mediator between racial or sexual identity, and depressive symptoms and self-esteem. Instead like the Family Acceptance project with Latino LGBQ youth in California, *sexual identity-specific* parental acceptance/rejection was an important partial, and in one model full, mediator for youth in the earlier pre-encounter self-hatred stage of racial identity (negative feelings about being Black), and the earlier acceptance concerns (worrying about being accepted as a LGBQ person) and identity uncertainty (being more unsure or insecure about one's sexual identity) of sexual identity development. All human beings want to feel accepted and supported for *all* of who they are, especially by parent(s) or primary caregiver(s). If parents (and in this study mothers especially) typically exhibit overall warmth, openness, and acceptance of their child, and then uncharacteristically a parent responds with rejection and negative reactions when their child is first coming out as LGBQ, this experience can lead to lower self-esteem and depressive symptoms (e.g, my parent loves me as a person but does not accept or support my sexual identity). Overall, these mediation results suggest when Black LGBQ youth are in the earlier sexual identity stages of acceptance concerns and identity uncertainty and they perceive more negative reactions from their mothers about being LGBQ or more overall rejection of their sexual identity, then they are more vulnerable to experiencing more depressive symptoms and lower self-esteem.

Limitations

There are several limitations in this dissertation study that are noteworthy. As previously noted, the researcher's personal connection to this study may have posed a limitation because of the possible researcher bias (see self of the researcher, pp. 28). I consulted regularly with my dissertation chair, M. Davey, throughout the data analysis and discussion phases and she reviewed the results to help keep personal biases in check and remain true to the data. Reliability and validity were also potential limitations because many of the measures used in this study were relatively new or had not been used with this population. The Parental Acceptance-Rejection Questionnaire (PARQ-C), for example, had never been used to measure warmth and attachment between Black parents and their LGBQ children. Furthermore, when the PARQ is has been used, data is typically gathered from multiple sources (e.g., parent, child, and teacher rating scales) and then results are compared; however, in this study data was only collected from the youth/young adult who self-reported their perceptions of warmth and attachment from their parent(s) or primary caregiver(s).

Similarly, the Lesbian, Gay, and Bisexual Identity Scale (LGBIS) has established validity, but has not been normed for Black LGBQ populations. Additionally as noted earlier, because of a procedural error while developing the online survey, only four out of the eight subscales in the Lesbian, Gay, and Bisexual Identity Scale (LGBIS) were included in the online survey. Eight of the questions that should have been posted in the online survey (from the correct version of the final measure) were accidentally replaced with eight different questions from an earlier version when the measure was developed. The four subscales that were not included in the online survey are: 1) Internalized Homonegativity; 2) Identity Superiority; 3) Identity Affirmation; and 4) Identity Centrality. Thus, only the following 4 out of the original 8 LGBIS subscales will be evaluated in this study because of a procedural error: 1) Acceptance Concerns: 2) Concealment Motivation; 3) Identity Uncertainty; and 4) Difficult Process.

Previously noted limitations of the LGBIS measure may have also been limitations in this study, including: 1) unaccounted for gender differences, 2) marginalizing bisexuality status, and 3) language that could be perceived as insensitive or pathologizing (for example, some participants reject identity "labels" altogether or find it difficult to choose one that reflects their sexual identity). I also received permission from the measure developers, to slightly change the measure by adding the descriptor *Q* for *queer*, which is a relevant identity used by many youth and young adults (although many still do not like that identity term).

For the Cross Racial Identity Scale (CRIS), a potential limitation that was hypothesized prior to data collection and confirmed by participants' open-ended comments at the conclusion of the study, was that it did not fully capture diverse Black racial experiences and was more specific to African Americans. The CRIS used the term Black and African American interchangeably, although they are different constructs – one is a racial term and the other is a term describing ethnicity. In this study, there were Black participants who did not identify as African American, ethnically, but were racially Black, thus the language used in some of the questions were not reflective of participants. This may limit the generalizability to other Black populations in the U.S. Additionally, many participants were frustrated about some of the questions because they felt there were unreasonable assertions being made (e.g., "I hate White people" or "Too many Blacks 'glamorize' the drug trade and fail to see opportunities that don't involve crime"). Many participants commented in the open-ended narrative section of the survey that they were turned off by these questions, which could have affected their responses, thus potentially affecting reliability.

Other study limitations included: 1) the non-probability sampling approach, including snowball and convenience sampling approaches which significantly limits generalizability of the results; 2) having no way to ensure respondents who completed the survey truly fit eligibility criteria; 3) some eligible participants may not have had access to resources (computers) required to complete the online surveys; 4) saturation (Morse, 1995) of the sample of youth most accessible to me was achieved

relatively quickly; 5) no monetary incentive for participation in this study; 6) respondents likely experienced fatigue while completing the six self-report surveys, which may have resulted in some random and inconsistent responses; and 7) lack of demographic variability for: age (most were young adults between 19-21), gender (most were girls), ethnicity (most were African-American), education (half were college educated), SES/class (almost half were middle class), religious affiliation (most were either Christian or not religious at all), and most were never kicked out or asked to leave their homes by a parent.

It was clear from the distribution of results (dropping sharply after the demographic questionnaire), all of the missing data, and the fact that over 300 participants started the study, but only n=110 fully completed all survey instruments, there was significant participant drop out, most likely because of fatigue. Additionally, most participants responded to the survey through a link posted online and could have been easily distracted, missed or skipped questions, or randomly answered questions when they were confused about what was being asked of them. Also, only 40 respondents answered questions about their fathers which prevented multivariate analyses of how youth felt about fathers or a second parent/primary caregiver. Finally, despite the different convenience sampling strategies used in this study, the sample of 200 participants, which was estimated based on the power analysis, was much more difficult to obtain. This led to less than optimal statistical power especially for some of the analyses (e.g. ANOVA), for which the sub-groups were much smaller.

Implications for Future Research

Future research should focus on transgender, gender non-conforming, genderqueer, gender variant, or otherwise non gender-binary (trans*) youth and their families. They were excluded from this study because sexual identity, and not gender identity, was examined. It is important to study gender identity development, parental rejection, and depressive symptoms and self-esteem among trans* youth in a separate study. In order to conduct this research, collaboration with other researchers who have trans* experience is needed. Also, because trans* communities experience different, and

oftentimes more severe forms of victimization, protective factors should be examined that buffer them from the effects of transphobia, discrimination, and gender-based violence. The parental and family acceptance process is very different when a child comes out as having a marginalized gender identity (or rejecting gender altogether) compared to when a child has a marginalized sexual identity. This future area of study is important because there is not enough information available for parents and families, clinicians and other healthcare providers about best practices.

Future studies should also include more outcome variables, in addition to self-esteem and depressive symptoms. For example, it is widely known that suicidal ideation, attempt, and completion is an unfortunate frequent consequence of growing up and living in a heterosexist, heteronormative, transphobic, and cisnormative society. In future research, suicidal ideation should also be examined as an outcome variable (as well as other outcomes such as substance abuse, self-injurious behaviors, anxiety, risky sexual behaviors, and homelessness) to inform the development of effective prevention and intervention programs for LGBTQ youth and their families at the individual, family, community, and school levels. Additionally, future research should examine the various racial and sexual identity development stages over time (longitudinally) to fully address the question of whether the processes indeed occur in a parallel fashion (concurrently). Longitudinal examination should also be conducted in order to note any changes in the outcome variables over time, and also in youths' experiences and reports of acceptance and rejection by their parents or caregivers.

An attempt was made to replicate the Family Acceptance Project (FAP) study, which was originally conducted with a sample of Latino and White youth and their families in California, and resulted in new measures of family accepting and rejecting behaviors. Unfortunately, because of IRB issues, parents were not included in this study as originally planned, nor could all of the various outcome variables (e.g., suicidality) be included. In future studies, both parents and LGBQ youth should be included to examine whether similar results are found when parents report their views versus youths' self-report of parental acceptance or rejection. Some possible questions are: 1) What helps

some Black parents exhibit more warmth and acceptance of their LGBQ child or family member, as opposed to shame, denial, or rejection?; 2) What do parents and families feel they do not know and what do they want and need to know about the constructs analyzed in this study?; 3) What difficulties are parents and families experiencing, questions they might have, and type of support do they need?; 4) What resources would be validating and helpful to help parents and families use skills they have already gained by raising a Black or other child of color; and 5) What keeps parents and families stuck, scared, unwilling, or unable to move towards acceptance and support of their LGBQ youth/young adult? This leads to the next future area of research.

Especially for Black and other families of color, future research should examine the role that religion and spirituality does or does not play in the acceptance/rejection process of LGBQ youth. For Black families, it is important to consider the historical role of the Black Church and consider how it has been both a source of strength, and pain and condemnation for many Black LGBQ individuals. It is important to note that not all Black people are Christian or part of Black Churches, thus, future research should also examine the role of religion (especially religious fundamentalism) and spirituality more broadly. There is a prevalent, and largely unexamined, belief system that Black communities are more homophobic, heterosexist, and transphobic compared to other racial groups. Future studies should examine the validity of such beliefs, and the purpose or function it may serve certain groups to keep this belief system in place. Future studies should also evaluate the recent advent of "welcoming and affirming" churches, and the expansion or opening up of certain denominations to be more inclusive of LGBTQ clergy and communities.

With the support of future external funding, research should be conducted with larger, random, and more diverse samples of Black LGBQ youth and young adults, and their families. Globally, future research should explore the experiences of Black youth and young adults, and their families, in the Caribbean and Latin America, in Canada, and in other countries that seem more socially progressive about sexuality and sexual identity, and gender and gender identity. A better understanding of how

parents and families in more socially progressive states or regions within the U.S., and in other countries could help us understand their experiences regarding what has worked and not worked to help young people experience less emotional and psychological distress upon coming out as LGBTQ.

Based on this study, future research with LGBTQ youth populations should include: 1) less questions or shorter measures to prevent fatigue; 2) monetary or other direct, immediate incentives; 3) different data collection methods to prevent so much missing data; 4) using a survey engine (i.e., Qualtrics, Survey Monkey, etc.) that has a mechanism to prevent moving forward in the survey until all questions are answered; 5) a wider range of identity options depending on what constructs are being measured; and 6) possibly a more lengthy and critical investigation of the measures to be used to ensure that they have strong reliability and validity with the specific population being studied. Finally, new theories and measures should be developed and/or existing measures should be updated to reflect changes in current societal beliefs about identity development so they reflect a politic of intersectionality and more complex identity formations for youth growing up in today's culture.

Clinical Implications

Many scholars in the fields of Counseling, Social Work, and Psychology have conducted clinical research to examine parent's and family member's reactions when a child comes out as lesbian, gay, bisexual, or queer (LGBQ) (Barnes & Meyer, 2012; Beckstead & Morrow, 2004; Beeler & DiProva, 2004; Beski & Diamond, in press; Ben-Ari, 1995; Bregman et al., 2013; Closs, 2010; Crosbie-Burnett et al., 1996; D'Augelli et al., 2010; DeVine, 1984; Diamon et al., 2012; Diamond & Shpigel, 2014; Gallor & Fassinger, 2010; Goldfried & Goldfried, 2001; Goodrich, 2009; Kircher & Alijah, 2011; LaSala, 2000, 2007, 2010; LaSala & Frierson, 2012; Lemelle & Battle, 2004; Mays et al., 1998; Mohr & Fassinger, 2003; Morales, 1990; Mustanski et al., 2011; Needham & Austin, 2010; Parks, 2011; Phillips & Ancis, 2008; Potoczniak et al., 2009; Rosario et al., 1996, 2004; Ryan et al., 2009, 2010; Saltzburg, 2009; Samarova, Shilo & Diamond, 2013; Savin-Williams, 1989, 2000; Shpigel et al., 2012; Shpigel, Belsky & Diamond, 2013; Shpigel & Diamond, 2014; Washington, 2001;

Willoughby et al., 2006, 2008). Yet, few Couple and Family Therapy (CFT) scholars have examined the parental and family acceptance process (Almeida, 2012; Green, 2000; Jamil et al., 2009; Long et al., 2006; Stone-Fish & Harvey, 2005; Tanner & Lyness, 2004). The field of family therapy has produced even less little literature specifically with Black LGBQ youth, and/or their parents or families, using systemic and relational theories. This dissertation study filled a gap in the field by examining factors associated with better mental health outcomes for Black LGBQ youth and young adults. This study has also more closely examined the processes of racial and sexual identity development for Black LGBQ youth, how it is impacted by parental acceptance and support.

Findings suggest it is important to have at least one parent (mothers in this study) who is accepting of his or her child coming out as LGBQ, especially during the earlier stages of sexual identity development. Thus, therapists who work with Black LGBQ youth who are struggling with depressive symptoms and low self-esteem, and who may be struggling with sexual identity, should assess that young person's racial and sexual identity stage. The therapist should also partner with parents, and see them both individually and in family sessions – to help them talk about their fears, worries, grief and loss and ask any question they may have – so they are less reactive and better able to respond to and validate and their children, which can improve their mental health outcomes. It is recommended that therapists regularly screen and utilize racial and sexual identity measures, as well as assess for parental acceptance and rejection specific to sexual identity. Furthermore, family therapists should discuss the different stages of sexual identity with LGBQ youth and their parents to connect them to presenting problems (e.g., mental health symptoms or behavioral issues), when appropriate.

Specifically, therapists should work with Black parents to help them uncover their strengths and resilience, activating their parenting skills that they already employ to help their child survive and thrive in a world that discriminates against them because of their race, they can also help them survive and thrive in a word that discriminates based on sexual identity. Therapists can encourage Black parents to talk more openly about their feelings regarding their child's sexual identity and help them

understand, in a culturally sensitive way, how their lack of acceptance can contribute to the their child's risk of distress. Parents should also understand that this risk is also increased when adolescents are in the early stages of their racial and sexual identity development. Thus, it is important that youth and young adults have a safe, supportive, and affirming home life. Findings suggest that parents may love and accept their child globally, but if that parent is rejecting or dismissive of their child's sexual identity (or exploration) when they are first "coming out" as LGBQ, then they are at risk of negative mental health outcomes.

Finally, therapists should also help Black parents explore and resolve any religious convictions that may be inhibiting them from fully accepting their LGBQ child, if this is relevant for a particular family. This study, as well as previous studies, found that highly religious parents tended to be more rejecting of their LGBQ child, and vice versa, parents who were not at all or not very religious tended to be more accepting. It is important to note that all religions are inherently rejecting of LGBQ individuals, but rather depending on how one interprets religious texts and applies their belief systems, it can influence the ability to remain open, non-judgmental, and affirming of certain identities and ways of being in the world. Family therapy can be a safe milieu to talk about some of these sensitive issues, and explore the importance of religion (and the Black Church, when relevant) in Black communities to help develop ways to stay connected to their faith, while not allowing it to interfere with a supportive and accepting parent-child relationship.

Additionally, therapists should help youth talk about their experiences with race-based, gender-based, and sexuality-based (or any other) oppression and discrimination, both at home and in their communities. Therapists need to stay attuned, and culturally sensitive by validating painful experiences, and helping youth repair attachments, especially to parents during their "coming out" process. This study also found that youth who are in the later stages of their racial and sexual identity development tended to have less depressive symptoms and higher self-esteem. Creating a safe space where youth can explore their identities over time will likely help to buffer them from internalizing

oppressive experiences that may lead to depressive symptoms and lower self-esteem. Overall, findings suggest that therapists who are treating Black LGBQ youth, and their families, should have more open conversations about the importance of acceptance, and the things that may interfere with that process.

Based on the results of this study, support groups and trainings are also indicated with youth, parents, social service providers, as well as schools, teachers and school counselors, and also clergy members and churches. Given successful and positive outcomes reported in prior research, for example, the Family Acceptance Project and literature on Attachment Based Family Therapy with depressed and suicidal adolescents, it is important to strengthen parent-child relationships, and to help marginalized youth heal from the effects of trauma and oppression, or other difficult life experiences. Peer support groups are important for young people in early stages of identity development, and support groups for parents of LGBQ youth can help participants process, ask questions, share stories, connect with other families, and work through some of their difficult emotions. These types of support groups do exist, one of the most widely recognized national groups is PFLAG (Parents, Friends and Families of Lesbians and Gays). Yet, what is often missing is a diversity of experience (in terms of race, age, religion, etc.), although there has been some success with specific groups in major cities, such as Black and/or Latino chapters of PFLAG.

Trainings should be conducted with various community stakeholders and support systems who work with Black LGBQ youth. Trainings on best practices while working with LGBQ youth, and specific to this study, racially marginalized youth and their families, should be conducted in schools, youth and community centers, social service agencies, and child welfare agencies. Finally, after partnerships with providers and systems (e.g., school) have been established and rapport has been built, these trainings and conversations should extend to church leaders who want to resolve the tension that often exists between the church and LGBTQ communities. For example, the mission of the organization Soulforce is to challenge and end religious and political oppression of LGBTQ people from a social justice perspective. It is important for therapists, particularly those who view their work

as activism or advocacy, to collaborate more with religious communities and its leaders, to help Black LGBQ youth and families more openly seek support. Social service providers and religious institutions can work together, with respect and with shared goals. Additionally, several welcoming and affirming churches, such as Metropolitan Community Church, have paved a way to foster this type of negotiation, understanding, and acceptance that both honors religious tradition and values the diversity of human experience.

Final Self of the Researcher Reflections

Completing this dissertation was a major, life-changing, insightful, and harrowing experience for me, both personally and because of the work involved. I have grown tremendously over the last two and a half years, as I moved through the various stages of the dissertation process, sometimes more smoothly and quickly than others. Doing this work has challenged and helped my personal development because my story was reflected so often in the responses of participants. Conducting this study also challenged me to confront some childhood memories, traumas, and difficult family experiences that, at the time, I did not want to revisit – or that I did not realize was still affecting me so strongly. I have learned so much more than I can ever articulate in words, but I will never forget the *feeling* of this experience and what it has taught me. Throughout this dissertation experience, I have become a yogi, a practicer of mindfulness meditation and Nicherin Buddhism, a renewed lover of journaling, an advocate of acupuncture, a blogger, a (mostly) vegetarian, and I have utilized individual and couples therapy and coaching for the longest stretch of time ever (albeit, later than I probably should have). These experiences will be carried with me throughout the rest of my life and career.

Early on in this process, there were many times when I questioned what I was doing? Why? What was the purpose? Is this important? Is this feasible? Will anyone else care? – all questions that I, inherently, knew the answers to. However, they were becoming increasingly unclear to me as I delved deeper into the literature and began considering how I would set up my own study. I had some early disappointments, such as needing to change my dissertation chair, which ultimately I believe was the

universe's way of giving me something and someone that I really needed, even if I did not understand that at the time. Another researcher, whose prior study I wanted to design my dissertation after and replicate, was not willing to collaborate or share measures and information from that project with me. I found out that I would not be receiving a dissertation grant that I was excited about, even after preparing a solid application. At the IRB stage, I realized that I designed a study that was probably too complex and time-consuming for a dissertation study. I had to re-design my study, and had to remove one of my initial outcome variables (suicidality) because of concerns about "liability" for the University. These setbacks, and other experiences, left me feeling momentarily defeated and frustrated, not knowing exactly if or how I wanted to move forward. Thankfully, I had several people along the way to remind me of my passion and my purpose, to remind me that these experiences are all part of the research process, and to remind me that there are larger forces at play – many of which the parties involved may be completely oblivious to or unaware that they are perpetuating.

I also had some intense and difficult self-work that I needed to do – or in some ways, I was forced to do. I had to get honest with myself about some of my bad habits, some of my insecurities, and some of my ways of being and relating that had the potential of making it difficult to maintain healthy relationships. I also had to look at some of the problematic work ethics and beliefs that I held, that used to be functional and maybe even helpful for me, but that were no longer serving me in a positive or constructive way. I also had to have some difficult conversations with people, faculty, mentors, colleagues, friends, and family members, with whom relationships have shifted, ended, and flourished during this process.

One of the relationships was strengthened the most, because of this process, is with myself. I went through a period of about a year and a half, where I experienced depression unlike anything I had ever experienced before. I was angry, sad, confused, I felt lost, I could not think clearly, I could not articulate myself, I cried uncontrollably and for what seemed like no reason at all sometimes, I was inconsolable, I was stand-offish, I was withdrawn, and overall did not feel like being bothered with

anything or anyone. I did not want anyone to have any expectations of me because I was not even living up to the expectations that I had of myself, and felt like I could not or did not know how. In retrospect, I understand this experience differently than when I was actually going through it – I was facing and fighting with my *Black* (and Queer) *Shadow*, to use the words of one of my beloved dissertation committee and faculty member, Dr. Marlene Watson. This was completely unexpected and unsettling for me, and it was not until after the fact that I realized that this was happening, so that meant I did not have the ability to openly talk about it or receive the support that was being offered.

I could go on with what I have experienced and learned from conducting this dissertation study, from the participants in this study and the data, and about myself, but I will not do that here. I ultimately want to share that this process has taught me to be in constant dialogue with myself, to remain introspective and curious, to remain open to being taught from the most unlikely sources, and to practice self-disclosure even when it feels risky and I am not sure what the outcome will be. I learned that I can rely on and trust my family in ways that I never expected. I learned that they can and will continue to surprise me especially regarding things that I have (unfairly) decided they are *ignorant* about, and may have even judged about them. I learned that people who should really be in your life will stick by you and remain there even when you are making it really difficult for them. I have learned what the meaning of the word compassion truly is – compassion for myself, compassion for and from others, and the importance of compassion, as a social justice agent, for those who are still developing their critical consciousness. I've learned that the research process can be daunting and draining, that it almost never goes exactly as planned (especially in terms of time frame) – I have to constantly adapt, be flexible, and "roll with the flow." I learned that oppression and attempts to silence, especially race-based, gender-based, and age-based oppression, will show up when and where I least expect it. I have learned to avoid placing people on pedestals, or holding in too high regard with expectations of flawlessness because they will fall, and I will take it personally and feel that it was unexpected. I am continuing to practice compassion and develop my critical consciousness, and I was reminded so many

times through this process that we are all continually *a work in progress* – and that absolutely goes for me as well!

Conclusions

As evidenced by the results of this dissertation study, as well as numerous other studies and theories that have come before, we have much more work to do as a field and as mental health professionals. The field of Couple and Family Therapy (CFT) has a long history of ignoring and overlooking issues related to diversity, multiculturalism, and oppression – specifically as oppression resulting racism and heterosexism. The detrimental effects of trauma and dealing with pervasive racism and heterosexism (among other –isms for some individuals) have been well documented, and corroborated in this dissertation study. Including, but not limited to, mental and physical health outcomes such as: considerably higher rates of depression, lower self-esteem and self-image, increased likelihood of becoming suicidal, higher rates of smoking, higher rates of alcohol and other drug abuse, and chronic stress that results in dramatic and disproportionate increases in health disparities (such as hypertension, cardiovascular disease, breast cancer, mortality and infant mortality) to name a few (Shavers, Klein & Fagan, 2012; Takeuchi & Williams, 2011). The CFT field has must do better. Research must not continue to be conducted primarily with White, heterosexual, middle class populations, and then attempts made to generalize findings to other populations. Research must incorporate and understanding of contextual variables especially as this push toward "evidence-based" practice and research continues, and must include and value qualitative methodologies and other ways of knowing that cannot simply quantified with measures and numbers. Theories must be developed for and about communities of color, diverse family structures, and include intersectional ways of understanding experiences. Clinical work and teaching with and about diverse populations must go beyond stereotypes and narrow-minded views of people, problems, and solutions, particularly when addressing the systemic effects of oppression. Therapists must be just as curious about and able to recognize their biases and privileges, as they are about the identities of the clients they serve. It is

imperative that therapists exercise and ethic of social justice, understanding their role as activists and advocates on behalf of those who are voiceless, ignored, and on the margins in our society. As clinicians, researchers, and educators, we must attend to issues of race-based, class-based, gender-based, sexuality-based, religious-based oppression, among other forms, because *lives* depends on it.

The CFT field should contribute to the growing body of research, clinical interventions, and theoretical literature about family, relational, and systemic influences on marginalized LGBQ youth and young adults. With the growing numbers of LGBQ individuals feeling more comfortable expressing themselves and fully embracing who they are, and sadly, the growing numbers of LGBQ youth continuing to be victimized for these same reasons, culturally responsive future research and clinical work is imperative. Parents and family are important buffers for Black LGBQ youth who are coping with prejudice and discrimination from the outside world, from their communities, or from peers at school. Black LGBQ youth and young adults should not have to also contend with negativity and rejection in their own homes, or be forced out of their homes and onto the streets because their family is not accepting of their sexual identity. It is important to eliminate health disparities in (multiple) "minority" populations, by decreasing the rate of depression, by reducing the number of suicides and suicide attempts among LGBQ youth, and by reducing the rate of homelessness, particularly for LGBQ youth who are disproportionately reflected in the homeless or street-living population. This type of societal change must start with each individual, each parent, each family, inside of each home, within each community, and each place of worship. Our society is changing, the field of CFT, and the mental health field in general, should continue to change along with it by focusing more on underserved and misrepresented populations in the United States.

APPENDICES

Appendix A: Consent Forms

Drexel University

Consent/Assent to Take Part in a Research Study

1. **Title of research study:** How Black LGBQ Youths' Perceptions of Parental Acceptance and Rejection are Associated with their Self-Esteem and Mental Health

2. Researcher: *Monique D. Walker, MS, Doctoral Candidate and Maureen Davey, PhD, LMFT*

3. Why you are being invited to take part in a research study

We are inviting you to volunteer for a research study because you are a Black youth or young adult between 14-21 years old, identify as Lesbian, Gay, Bisexual, or Queer (LGBQ), and have told your parents or primary caregivers that you are not heterosexual. The purpose of this research study is to learn more about how parents' views affects Black youth's feelings about their race and about their sexual identity and how they feel about themselves (self-esteem and symptoms of depression)

4. What you should know about a research study

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want before you decide.

5. Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team at ***(215) 762-1708 or email us at*** mdw49@drexel.edu ***or*** mpd29@drexel.edu***.*** This research has been reviewed and approved by an Institutional Review Board. You may talk to them at (215) 255-7857 or email HRPP@drexel.edu for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

6. Why are we doing this research?

The purpose of this research study is to understand the experiences of Black LGBQ youth and young adults. Specifically, we are interested in learning more about racial and sexual identity development among Black LGBQ youth (age 14-17) and young adults (age 18-21), as well how they feel about themselves.

7. How long will the research last?

We expect that you will be in this research study for a one-time survey administered either on-line or you can complete paper versions of the survey. If you agree to be in the study, you will be asked to complete the anonymous survey which will take about 60 minutes.

8. How many people will be studied?

About 200 Black LGBQ youth or young adults (ages 14-21) will be recruited to complete several anonymous self-report surveys.

9. What happens if I say yes, I want to be in this research?

If you agree to be in the study, you will first complete either an online survey or receive hard copies of the surveys and complete them which will take about 60 minutes to complete. You will be asked questions about what it means to be Black, what it means to be LGBQ, feelings about how accepting your parents/primary caregivers are overall and specific to you being LGBQ, and you will also be asked about how you feel about yourself.

10. What happens if I do not want to be in this research?

You may decide not to take part in the research and it will not be held against you.

11. What happens if I say yes, but I change my mind later?

If you agree to take part in the research now, you can stop at any time and it will not be held against you.

12. Is there any way being in this study could be bad for me?

This research is not expected to cause any harm or discomfort. However, if you feel discomfort (feeling sad or anxious) while you complete the surveys, you can stop participating at any time. We also have a list of resources in the survey link that you can contact and you can also contact us directly if you need additional resources or a referral to talk to someone (mpd29@drexel.edu or mdw49@drexel.edu).

13. Do I have to pay for anything while I am on this study?

There is no cost to you for participating in this study.

14. Will being in this study help me anyway?

Benefits for being in this study may be that you learn new things about yourself.
However, we cannot guarantee or promise that you will receive any direct benefit by participating in this study. One indirect benefit is that you are contributing to our knowledge about how best to help LGBQ youth and young adults and their parents and caregivers. This could benefit other families like yours.

15. What happens to the information we collect?

Efforts will be made to limit your personal information, including research study records, to people who have a need to review this information. Your responses to the survey are completely anonymous and we cannot link your responses to your name or other identifying information. We will store your anonymous survey responses in a password protected computer in a locked office which only we will have access to so that your responses are confidential. We cannot promise complete secrecy. Organizations that may inspect and copy your information include the IRB and other representatives of this organization. By signing this form, you authorize the following persons and organizations to receive your PHI for purposes related to this research: Dr. Maureen Davey and Ms. Monique Walker who are part of the Drexel research team. These individuals will need this information to conduct the research, to assure the quality of the data, and/or to analyze the data.

We may publish the results of this research. However, we will keep your name and all other identifying information confidential.

We will destroy the information that will be collected for this study 6 years after completion of the project. Your permission to use and share the information and data from this study will continue until the research study ends and will expire 6 years after completion of the project.

We will do our best to keep your personal information private and confidential. However, we cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. For instance, if we find out that you intend to hurt yourself or someone else or that you have been abused, we must report this.

17. Can I be removed from the research without my OK?

The person in charge of the research study can remove you from the research study without your approval. Possible reasons for removal include:

- You are very depressed and unable to participate in the study
- You are incarcerated during the study
- You exhibit violence directed at study personnel or behave in a manner that is considered threatening by study personnel.

We will tell you about any new information that may affect your health, welfare, or choice to stay in the research

18. What else do I need to know?

This research study is being done by Drexel University.

Federal Law Protections

Federal law provides additional protections of your personal information that are described here.

A. Individually Identifiable Health Information That Will Be Collected

The following personal health information about you will be collected and used during the research study and may be given out to others:

- Your name, address, telephone number, date of birth;
- Personal and family financial and social circumstances, and education levels;
- Information learned during telephone calls, surveys, and questionnaires done as part of this research study

B. Who Will See and Use Your Health Information within Drexel University

The researcher and other authorized individuals involved in the research study at Drexel University will see your health information during and may give out your health information during the research study. These include the researcher and the research staff, the institutional review board and their staff, legal counsel, research office and compliance staff, officers of the organization and other people who need to see the information in order to conduct the research study or make sure it is being done properly. Your health information may be disclosed or transmitted electronically.

C. Who Else May See and Use your Health Information

Other persons and organizations outside of Drexel University may see and use your health information during this research study. These include:

- Governmental entities that have the right to see or review your health information, such as The Office for Human Research Protections
- Doctors and staff at the hospital where this research study will take place.

If your health information is given to someone not required by law to keep it confidential, then that information may no longer be protected, and may be used or given out without your permission.

D. Why your health information will be used and given out

Your information may also be used to meet the reporting requirements of governmental agencies.

E. If you do not want to give authorization to use your health information

You do not have to give your authorization to use or give out your health information. However, if you do not give authorization, you cannot participate in this research study.

F. How to cancel your authorization

At any time you may cancel your authorization to allow your health information to be used or given out by sending a written notice to Human Research Protection at 1601 Cherry Street, 3 Parkway Bldg., Mail Stop 10-444, Philadelphia, Pennsylvania, 19102. If you leave this research study, no new health information about you will be gathered after you leave. However, information gathered before that date may be used or given out if it is needed for the research study or any follow-up.

G. When your authorization ends

After the research study is finished, your health information will be maintained in a research database. Drexel University shall not re-use or re-disclose the health information in this database for other purposes unless you give written authorization to do so. However, the Drexel University Institutional Review Board may permit other researchers to see and use your health information under adequate privacy safeguards.

H. Your right to inspect your research records

You will not be able to look at your research records while you are taking part in this research study. Your personal information will be made available in an emergency if doctors need this information to treat you. You can have access to your medical record and any research study information to you if it is not part of your medical record**.**

Appendix B: Letter of Introduction

Dear [Potential participant],

I would like to ask for your help with a dissertation study of considerable significance for Black Lesbian, Gay, Bisexual and Queer youth and young adults. I am inviting you to consider participating in a web-based version or filling out hard copies of several surveys for my study, *How Black LGBQ Youths' Perceptions of Parental Acceptance and Rejection are Associated with their Self-Esteem and Mental Health*. When this study is completed, I will donate $300 to an organization that provides support to LGBTQ youth.

You can participate in this study if you: 1) identify as a Black male or female, 2) are between ages 14-21, 3) identify as lesbian, gay, bisexual, queer, or otherwise non-heterosexual in terms of your sexual identity, and 4) have told your parents or primary caregivers that you are not heterosexual. We are *not* exploring the experiences of trans* or gender non-conforming youth and young adults, so identifying as trans*, gender non-conforming or otherwise not identifying with a male or female gender identity excludes you from volunteering for this study.

If you decide to volunteer for this study, you will be asked to complete an anonymous web-based (online) survey that includes several questionnaires, which will take about 60 minutes to complete. Participation in this research study is completely voluntary. If you want to stop at any time during the study, you may do so without any penalty. If you feel uncomfortable while completing the surveys, you can stop participating at any time. We also have a list of resources in the survey link that you can contact and you can also contact us directly if you need additional resources or a referral to talk to someone about your experiences completing the surveys (mpd29@drexel.edu; mdw49@drexel.edu).

This survey is completely anonymous so your name, email address, and any other identifiable information will not be linked to your responses. We will store your information on a password protected computer in a locked office so that it is confidential.

If you continue onto the web-link listed below, then you are voluntarily agreeing to participate in this dissertation study.

(http://drexel.qualtrics.com/SE/?SID=SV_3mHIPv9YKvQgBBX)

If you do not fit the study criteria but know of other Black LGBQ youth or young adults who do, we appreciate you forwarding this email to them. If you have any questions or concerns, please feel free to contact me at: mdw49@drexel.edu. Thank you for your help and support.

Sincerely,

Monique Walker, MS, MFT, Doctoral Candidate
Department of Couple and Family Therapy
Drexel University

Appendix C: Measures

Youth Demographic Questionnaire

1. *How old are you currently? _____
2. *How do you identify in terms of gender identity? _____ (e.g., male, female, trans*, gender queer, gender variant, gender non-conforming, other – please identify).
3. *How do you identify in terms of sexual identity/ orientation? _____ (e.g., lesbian, gay, bisexual, queer, other non-heterosexual – please identify, heterosexual)
4. *How do you identify racially? _____ (e.g., Black, White, Biracial, Multiracial, other – please identify)
5. How do you identify ethnically? _____ (e.g., African American, Caribbean-American, Afro-Latina/o, Caucasian, Latina/o/ Hispanic, Native American/ American Indian, Asian/ Pacific Islander, other – please identify)
6. *How out are you in the following areas: Family (at least one parent/caregiver)_____ Religion (at church or place of worship)_____ World (mostly everywhere)_____ (e.g., 1= completely, 2= somewhat, 3= not at all, 4= not applicable in my situation)
7. What is the highest level of education you have completed? _____ (e.g., some HS, received HS diploma or GED, some college, trade/vocational training, received Associate's degree, received Bachelor's degree)
8. What is your religious affiliation? _____ (e.g., Christian, Jewish, Muslim, Hindu, Buddhist, African Traditional, Spiritual, Not religious/ Atheist/ Agnostic, other – please identify)
9. What is your family's religious affiliation? _____ (e.g., Christian, Jewish, Muslim, Hindu, Buddhist, African Traditional, Spiritual, Not religious/ Atheist/ Agnostic, other – please identify)
10. How would you describe your family's level of religiosity? _____ (e.g., how heavily influenced are they by their religious beliefs/ how frequently do they attend a place of worship? – low/ minimally, medium/ occasionally, high/ frequently)
11. How would you describe your family's socioeconomic status (SES) or class? _____ (e.g., 1= low SES/class, 2= low-middle SES/class, 3= middle SES/class, 4= upper-middle SES/class, 5= upper-high SES/class)

12. Who do you currently live with (list all that apply)? _____
    (e.g., 1= Birth parent(s), 2= Step-parent(s), 3= Grandparent(s), 4= Sibling(s), 5= Extended family – Godparents, Aunt/ Uncle, Cousin, 6= Foster family, 7= Adopted family, 8= other – please identify)
13. Have you ever been kicked out of your home, forced to leave your home, or abandoned by a parent or caregiver because of your sexual identity/ orientation? (e.g. yes, no) _____

Cross Racial Identity Scale (CRIS)

Please indicate how strongly you agree or disagree with the statements using the scale below.

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

1. ____ As an African American, life in America is good for me.
2. ____ I think of myself primarily as an American and seldom as a member of a racial group.
3. ____ Too many Blacks "glamorize" the drug trade and fail to see opportunities that don't involve crime.
4. ____ I go through periods when I am down on myself because I am Black.
5. ____ As a multiculturalist, I am connected to many groups (Hispanics, Asian- Americans, Whites, Jews, gays & lesbians, etc.).
6. ____ I have a strong feeling of hatred and disdain for all White people.
7. ____ I see and think about things from an Afrocentric perspective.
8. ____ When I walk into a room, I always take note of the racial make-up of the people around me.
9. ____ I am not so much a member of a racial group as I am an American.
10. ____ I sometimes struggle with negative feelings about being Black.
11. ____ My relationship with God plays an important role in my life.
12. ____ Blacks place more emphasis on having a good time than on hard work.
13. ____ I believe that only those Black people who accept an Afrocentric perspective can truly solve the race problem in America.
14. ____ I hate the White community and all that it represents.
15. ____ When I have a chance to make a new friend, issues of race and ethnicity seldom play a role in whom that person might be.
16. ____ I believe it is important to have both a Black identity and a multicultural perspective, which is inclusive of everyone (e.g., Asians, Latinos, gays & lesbians, Jews, Whites, etc.).
17. ____ When I look in the mirror at my Black image, sometimes I don't feel good about what I see.
18. ____ If I had to put a label on my identity, it would be "American" and not African American.
19. ____ When I read the newspaper or a magazine, I always look for articles and stories that deal with race and ethnic issues.
20. ____ Many African Americans are too lazy to see opportunities that are right in front of them.
21. ____ As far as I am concerned, affirmative action will be needed for a long time.

22. ____ Black people cannot truly be free until our daily lives are guided by Afrocentric values and principles.
23. ____ White people should be destroyed.
24. ____ I embrace my own Black identity, but I also respect and celebrate the cultural identities of other groups (e.g., Native Americans, Whites, Latinos, Jews, Asian-Americans, gays & lesbians, etc.).
25. ____ Privately, I sometimes have negative feelings about being Black.
26. ____ If I had to put myself into categories, first I would say I am an American and second I am a member of a racial group
27. ____ My feelings and thoughts about God are very important to me.
28. ____ African Americans are too quick to turn to crime to solve their problems.
29. ____ When I have a chance to decorate a room, I tend to select pictures, posters, or works of art that express strong racial-cultural themes.
30. ____ I hate White people.
31. ____ I respect the ideas that other Black people hold, but I believe that the best way to solve our problems is to think Afrocentrically.
32. ____ When I vote in an election, the first thing I think about is the candidate's record on racial and cultural issues.
33. ____ I believe it is important to have both a Black identity and a multicultural perspective, because this connects me to other groups (Latinos, Asian-Americans, Whites, Jews, gays & lesbians, etc.).
34. ____ I have developed an identity that stresses my experiences as an American more than my experiences as a member of a racial group.
35. ____ During a typical week in my life, I think about racial and cultural issues many, many times.
36. ____ Blacks place too much importance on racial protest and not enough on hard work and education.
37. ____ Black people will never be free until we embrace an Afrocentric perspective.
38. ____ My negative feelings toward White people are very intense.
39. ____ I sometimes have negative feelings about being Black.
40. ____ As a multiculturalist, it is important for me to be connected with individuals from all cultural backgrounds (Latinos, Jews, Native Americans, Asian-Americans, gays/lesbians etc.).

Lesbian, Gay, and Bisexual Identity Scale (LGBIS)
(incorrect version used in this dissertation study)

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

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

1. ___ I prefer to keep my same-sex romantic relationships rather private.
2. ___ I will never be able to accept my sexual orientation until all of the people in my life have accepted me.
3. ___ I would rather be straight if I could.
4. ___ Coming out to my friends and family has been a very lengthy process.
5. ___ I'm not totally sure what my sexual orientation is.
6. ___ I keep careful control over who knows about my same-sex romantic relationships.
7. ___ I often wonder whether others judge me for my sexual orientation.
8. ___ I am glad to be an LGBQ person.
9. ___ I look down on heterosexuals.
10. ___ I keep changing my mind about my sexual orientation.
11. ___ My private sexual behavior is nobody's business.
12. ___ I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
13. ___ Homosexual lifestyles are not as fulfilling as heterosexual lifestyles.
14. ___ Admitting to myself that I'm an LGBQ person has been a very painful process.
15. ___ If you are not careful about whom you come out to, you can get very hurt.
16. ___ Being an LGBQ person makes me feel insecure around straight people.
17. ___ I'm proud to be part of the LGBQ community.
18. ___ Developing as an LGBQ person has been a fairly natural process for me.
19. ___ I can't decide whether I am bisexual or homosexual.
20. ___ I think very carefully before coming out to someone.
21. ___ I think a lot about how my sexual orientation affects the way people see me.
22. ___ Admitting to myself that I'm an LGBQ person has been a very slow process.
23. ___ Straight people have boring lives compared with LGBQ people.
24. ___ My sexual orientation is a very personal and private matter.
25. ___ I wish I were heterosexual.
26. ___ I get very confused when I try to figure out my sexual orientation.
27. ___ I have felt comfortable with my sexual identity just about from the start.

Lesbian, Gay, and Bisexual Identity Scale (LGBIS)

(correct version that should have been used in this dissertation study)

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

1----------2----------3----------4----------5----------6----------7

Disagree Strongly — Agree Strongly

1. ___ I prefer to keep my same-sex romantic relationships rather private.
2. ___ If it were possible, I would choose to be straight.
3. ___ I'm not totally sure what my sexual orientation is.
4. ___ I keep careful control over who knows about my same-sex romantic relationships.
5. ___ I often wonder whether others judge me for my sexual orientation.
6. ___ I am glad to be an LGBQ person.
7. ___ I look down on heterosexuals.
8. ___ I keep changing my mind about my sexual orientation.
9. ___ I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
10. ___ I feel that LGBQ people are superior to heterosexuals.
11. ___ My sexual orientation is an insignificant part of who I am.
12. ___ Admitting to myself that I'm an LGBQ person has been a very painful process.
13. ___ I'm proud to be part of the LGBQ community.
14. ___ I can't decide whether I am bisexual or homosexual.
15. ___ My sexual orientation is a central part of my identity.
16. ___ I think a lot about how my sexual orientation affects the way people see me.
17. ___ Admitting to myself that I'm an LGBQ person has been a very slow process.
18. ___ Straight people have boring lives compared with LGBQ people.
19. ___ My sexual orientation is a very personal and private matter.
20. ___ I wish I were heterosexual.
21. ___ To understand who I am as a person, you have to know that I'm LGBQ.
22. ___ I get very confused when I try to figure out my sexual orientation.
23. ___ I have felt comfortable with my sexual identity just about from the start.
24. ___ Being an LGBQ person is a very important aspect of my life.
25. ___ I believe being LGBQ is an important part of me.
26. ___ I am proud to be LGBQ.
27. ___ I believe it is unfair that I am attracted to people of the same sex.

Child Parental Acceptance/Rejection Questionnaire (PARQ-C)

Mother/ Parent 1 (Short Form)
AND
Father/Parent 2 (Short Form)

The following pages contain a number of statements describing the way parents sometimes act toward their children. I want you to think about how each one of these fits the way your mother (or parent 1) treats you.

Four boxes are drawn after each sentence. If the statement is *basically* true about the way your mother (or parent 1) treats you then ask yourself, "Is it almost *always* true?" or "Is it only *sometimes* true?" If you think your mother (or parent 1) almost always treats you that way, put an *X* in the box ALMOST ALWAYS TRUE; if the statement is sometimes tue about the way your mother (or parent 1) treats you then mark SOMETIMES TRUE. If you feel the statement is basically *untrue* about the way your mother (or parent 1) treats you then ask yourself, "Is it *rarely* true?" or "Is it almost *never* true?" If it is rarely true about the way your mother (or parent 1) treats you put an *X* in the box RARELY TRUE; if you feel the statement is almost never true then mark ALMOST NEVER TRUE.

Remember there is no right or wrong answer to any statement, so be as honest as you can. Respond to each statement the way you feel your mother (or parent 1) is rather than the way you might like her/them to be. For example, if she/they almost always hugs and kisses you when you are good, you should mark the item as follows:

	MY MOTHER/ PARENT 1	**TRUE OF MY MOTHER/ PARENT 1**		**NOT TRUE OF MY MOTHER/ PARENT 1**	
		Almost always true	*Sometimes true*	*Rarely true*	*Almost never true*
	Hugs and kisses me when I am good.	X			

	MY MOTHER/ PARENT 1	*Almost always true*	*Sometimes true*	*Rarely true*	*Almost never true*
1	Says nice things about me				
2	Pays no attention to me				
3	Makes it easy for me to tell her/them things that are important to me				
4	Hits me, even when do not deserve it				
5	Sees me as a big nuisance				
6	Punishes me severely when she/they is/are angry				
7	Is too busy to answer my questions				
8	Seems to dislike me				
9	Is really interested in what I do				
10	Says many unkind things to me				
11	Pays no attention when I ask for help				
12	Makes me feel wanted and needed				
13	Pays a lot of attention to me				
14	Goes out of her/their way to hurt my feelings				
15	Forgets important things I think she/they should remember				
16	Makes me feel unloved if I misbehave				
17	Makes me feel what I do is important				
18	Frightens or threatens me when I do something wrong				
19	Cares about what I think, and likes me to talk about it				
20	Feels other children are better than I am no matter what I do				
21	Lets me know I am not wanted				
22	Lets me know she/they loves me				
23	Pays no attention to me as long as I do nothing to bother her/them				
24	Treats me gently and with kindness				

MY FATHER/ PARENT 2		*Almost always true*	*Sometimes true*	*Rarely true*	*Almost never true*
1	Says nice things about me				
2	Pays no attention to me				
3	Makes it easy for me to tell him/them things that are important to me				
4	Hits me, even when do not deserve it				
5	Sees me as a big nuisance				
6	Punishes me severely when he/they is/are angry				
7	Is too busy to answer my questions				
8	Seems to dislike me				
9	Is really interested in what I do				
10	Says many unkind things to me				
11	Pays no attention when I ask for help				
12	Makes me feel wanted and needed				
13	Pays a lot of attention to me				
14	Goes out of his/their way to hurt my feelings				
15	Forgets important things I think he/they should remember				
16	Makes me feel unloved if I misbehave				
17	Makes me feel what I do is important				
18	Frightens or threatens me when I do something wrong				
19	Cares about what I think, and likes me to talk about it				
20	Feels other children are better than I am no matter what I do				
21	Lets me know I am not wanted				
22	Lets me know he/they loves me				
23	Pays no attention to me as long as I do nothing to bother him/them				
24	Treats me gently and with kindness				

Perceived Parental Reactions Scale (PPRS)
Adolescent Version – MOTHER/PARENT 1

Think back **to the week** when this parent first became aware of your sexual orientation. Read the statements and indicate how much you agree or disagree (according to the scale below) with each one by circling a number. Remember, there are no correct or incorrect answers, these are your opinions.

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

The week when I *told* my MOTHER/PARENT 1 that I was lesbian/gay/bisexual/queer (or when she/they *found out* I was lesbian/gay/bisexual/queer) she/they:

1. Supported me	1 2 3 4 5
2. Was worried about what her friends and other parents would think of her/them	1 2 3 4 5
3. Had the attitude that LGBQ people should not work with children	1 2 3 4 5
4. Was concerned about what the family might think of her/them	1 2 3 4 5
5. Was proud of me	1 2 3 4 5
6. Believed that marriage between LGBQ individuals was unacceptable	1 2 3 4 5
7. Was concerned about the potential that she/they wouldn't get grandchildren	1 2 3 4 5
8. Realized I was still 'me', even though I was lesbian/gay/bisexual/queer	1 2 3 4 5
9. Believed that same sex attraction was immoral	1 2 3 4 5
10. Thought it was great	1 2 3 4 5
11. Would have had a problem seeing two LGBQ people together in public	1 2 3 4 5
12. Was concerned about having to answer others' questions about my sexuality	1 2 3 4 5
13. Kicked me out of the house	1 2 3 4 5
14. Didn't believe me	1 2 3 4 5
15. Yelled and/or screamed	1 2 3 4 5
16. Prayed to God (or other deity), asking him to turn me straight	1 2 3 4 5
17. Blamed her/himself	1 2 3 4 5
18. Called me derogatory names, like 'faggot' or 'homo'	1 2 3 4 5
19. Pretended that I wasn't lesbian/gay/bisexual/queer	1 2 3 4 5
20. Was angry at the fact I was lesbian/gay/bisexual/queer	1 2 3 4 5
21. Wanted me not to tell anyone else	1 2 3 4 5
22. Cried tears of sadness	1 2 3 4 5
23. Said I was no longer her/their child	1 2 3 4 5
24. Told me it was just a phase	1 2 3 4 5
25. Was mad at someone she/they thought had 'turned me lesbian/gay/bisexual/queer	1 2 3 4 5
26. Wanted me to see a psychologist who could 'make me straight'	1 2 3 4 5
27. Was afraid of being judged by relatives and friends	1 2 3 4 5
28. Severed financial support	1 2 3 4 5
29. Brought up "evidence" to show that I must not be lesbian/gay/bisexual/queer such as "You had a girlfriend/boyfriend, you can't be lesbian/gay//bisexual/queer"	1 2 3 4 5
30. Was mad at me for doing this to her/them	1 2 3 4 5
31. Wanted me not to be gay/lesbian/bisexual/queer	1 2 3 4 5
32. Was ashamed of my sexual orientation	1 2 3 4 5

Perceived Parental Reactions Scale (PPRS)
Adolescent Version – FATHER/PARENT 2

Think back **to the week** when this parent first became aware of your sexual orientation. Read the statements and indicate how much you agree or disagree (according to the scale below) with each one by circling a number. Remember, there are no correct or incorrect answers, these are your opinions.

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

The week when I *told* my FATHER/PARENT 2 that I was lesbian/gay/bisexual/queer (or when he/they *found out* I was lesbian/gay/bisexual/queer) he/they:

1. Supported me	1 2 3 4 5
2. Was worried about what her friends and other parents would think of him/them	1 2 3 4 5
3. Had the attitude that LGBQ people should not work with children	1 2 3 4 5
4. Was concerned about what the family might think of him/them	1 2 3 4 5
5. Was proud of me	1 2 3 4 5
6. Believed that marriage between LGBQ individuals was unacceptable	1 2 3 4 5
7. Was concerned about the potential that he/they wouldn't get grandchildren	1 2 3 4 5
8. Realized I was still 'me', even though I was lesbian/gay/bisexual/queer	1 2 3 4 5
9. Believed that same sex attraction was immoral	1 2 3 4 5
10. Thought it was great	1 2 3 4 5
11. Would have had a problem seeing two LGBQ people together in public	1 2 3 4 5
12. Was concerned about having to answer others' questions about my sexuality	1 2 3 4 5
13. Kicked me out of the house	1 2 3 4 5
14. Didn't believe me	1 2 3 4 5
15. Yelled and/or screamed	1 2 3 4 5
16. Prayed to God (or other deity), asking him to turn me straight	1 2 3 4 5
17. Blamed him/herself	1 2 3 4 5
18. Called me derogatory names, like 'faggot' or 'homo'	1 2 3 4 5
19. Pretended that I wasn't lesbian/gay/bisexual/queer	1 2 3 4 5
20. Was angry at the fact I was lesbian/gay/bisexual/queer	1 2 3 4 5
21. Wanted me not to tell anyone else	1 2 3 4 5
22. Cried tears of sadness	1 2 3 4 5
23. Said I was no longer his/their child	1 2 3 4 5
24. Told me it was just a phase	1 2 3 4 5
25. Was mad at someone he/they thought had 'turned me lesbian/gay/bisexual/queer	1 2 3 4 5
26. Wanted me to see a psychologist who could 'make me straight'	1 2 3 4 5
27. Was afraid of being judged by relatives and friends	1 2 3 4 5
28. Severed financial support	1 2 3 4 5
29. Brought up "evidence" to show that I must not be lesbian/gay/bisexual/queer such as "You had a girlfriend/boyfriend, you can't be lesbian/gay//bisexual/queer"	1 2 3 4 5
30. Was mad at me for doing this to him/them	1 2 3 4 5
31. Wanted me not to be gay/lesbian/bisexual/queer	1 2 3 4 5
32. Was ashamed of my sexual orientation	1 2 3 4 5

Center for Epidemiologic Studies Depression Scale (CES-D)

Below is a list of ways you might have felt or behaved. Please tell me how often you've felt this during the past week.					
During the past week…		*Rarely or none of the time* (Less than 1 day)	*Some of the time* (1-2 days)	*Occasionally* (3-4 days)	*Most of the time* (5-7 days)
1	I was bothered by things that usually don't bother me				
2	I did not feel like eating; my appetite was poor.				
3	I felt that I could not shake off the blues even with help from my family or friends.				
4	I felt that I was just as good as other people.				
5	I had trouble keeping my mind on what I was doing.				
6	I felt depressed.				
7	I felt that everything I did was an effort.				
8	I felt hopeful about the future.				
9	I thought my life had been a failure.				
10	I felt fearful.				
11	My sleep was restless.				
12	I was happy.				
13	I talked less than usual.				
14	I felt lonely.				
15	People were unfriendly.				
16	I enjoyed life.				
17	I had crying spells.				
18	I felt sad.				
19	I felt that people disliked me.				
20	I could not get "going".				

Rosenberg Self-Esteem Scale (RSES)

Below is a list of statements dealing with your general feelings about yourself. If you strong agree, circle **Strongly Agree.** If you agree with the statement, circle **Agree**. If you disagree, circle **Disagree**. If you strongly disagree, circle **Strongly Disagree**.

1. *On the whole, I am satisfied with myself.*

Strongly Agree Agree Disagree Strongly Disagree

2. *At times, I think I am no good at all.* *

Strongly Agree Agree Disagree Strongly Disagree

3. *I feel that I have a number of good qualities.*

Strongly Agree Agree Disagree Strongly Disagree

4. *I am able to do things as well as most other people.*

Strongly Agree Agree Disagree Strongly Disagree

5. *I feel I do not have much to be proud of.* *

Strongly Agree Agree Disagree Strongly Disagree

6. *I certainly feel useless at times.* *

Strongly Agree Agree Disagree Strongly Disagree

7. *I feel that I am a person of worth, at least on an equal plane with others.*

Strongly Agree Agree Disagree Strongly Disagree

8. *I wish I could have more respect for myself.* *

Strongly Agree Agree Disagree Strongly Disagree

9. *All it all, I am inclined to feel that I am a failure.* *

Strongly Agree Agree Disagree Strongly Disagree

10. *I take a positive attitude toward myself.*

Strongly Agree Agree Disagree Strongly Disagree

Appendix D: Participants' Responses to Open-Ended Narrative Questions

Question #1: Are there any other factors that have influenced your feelings of safety or acceptance within your family?

Not really to be honest
I'm not close to my family so that plays a role in me not feeling accepted
Yes, as a child I was sexually abused by someone my mother was dating and ever since I came out and told her about it she she's always denied her feelings toward the situation. So when I told her I was into girls, she denied it to the fullest and so did my step-dad, but as time went on she has tried to "convert" me over to men and realized that I am the way I am, she's accepted me. But everyone else in my family (other than my siblings) don't want to hear it or talk it, they don't believe me and thinks it's a sin.
I feel completely safe at home even though my mom can seem a little mean sometimes and I think it may be because I'm a lesbian but she's never said any slurs that would confirm my thoughts
No, rarely have I ever felt unsafe. The only factor the contributed to my acceptance was whether I was attracted to men or not.
Uncle
My sister outed me.
My father is hyper-masculine, and any mention of gay males makes him sneer and call them "unnatural" and "overly feminine". He says it's a sin against God. The thought of letting him know I'm attracted to more than the opposite gender is terrifying.
I don't feel 100% safe in my family because my family is not too approving of my lifestyle, though we do not talk about it. I can only talk about it with my 13 year old nephew, who surprisingly understands more about acceptance than the adults of our family.
Parent 1 is very closed minded and we didn't get along before I can out to them, so I know I'm not the one that needs help mentally, they are. I'm not generally bothered by their
Religion and morals
Where we grew up, IE a major suburban city
That someone in my family would kill me
I am afraid to come out to any of them.

My family are homophobes. They're closed minded and ignorant. I don't even seek acceptance because I don't want to be disappointed when I don't get it.
My family and friends have been very loving and understanding.
The amount of acceptance I have felt by family has been influenced by long term involvement within the LGBT community. My parents still are not involved with any support groups nor do they advocate for same sex relationships or for the acceptance of homosexuality. This can be hard because I see/hear other parents reading books, asking me questions, joining PFLAG, researching or even talking about it with others. But my parents inevitably have not done any of these things and it makes me feel like they are significantly disconnected from a important part of who I am.
My dating life, I know that my mother will NEVER accept me. Today I made a comment about a future marriage and she turned around saying, "And who are you going to marry?" I told her, whoever made me happy...she didn't seem to like that. My family never asks about who I'm dating after I was outed.
Poor familial relationships
My parents are both immigrants from Africa while I was born in America so our cultures clash a lot.
My mother and older sister have said they're proud of me. They support my LGBT advocacy.
I had a baby at 15.
The religious belief of many of my family members has allowed me to only selectively come out to some individuals some are accepting and others make disparaging comments. I have a hard time standing up for myself with family members because I know that regardless of how much I try to make them understand that they will not necessarily be receptive to what I have to say.
Parents separation, being the first born
My mother has threatened violence against me and my partners
My sister, who is also Queer. My parents' commitment to supporting me in general as long as I'm happy.
Previous comments, when we're in public and my mother sees lgbtqia people, her reactions to them.
I am pansexual but I have a boyfriend so I believe my parents think that there is no chance of me dating a girl or trans person in the future and therefore find it more acceptable. Additionally, my brother is gay so they are openminded.

Additionally, my brother is gay so they are openminded.
My younger brother was really supportive of me.
No
My parents are abusive sometimes, but not because of homophobia. There's a history of mental disorders and abuse on both sides of my family.
I came out to my sister, who was my second primary caretaker, and she is the one who told my mother. I have less trust in her and in my mother for not speaking to me about it.
I'm confident saying/doing certain things because I have many places to go if I have to leave.
My mother has always been somewhat abusive. She has always made her negative feelings about LGBT people known. I was scared. It took me a long time to come out to my family.
I have a lot of older family members from third-world countries, so I suppose their "old-world"/ traditional values have stopped me from coming out to them.
Not really they just look at me with disgust an completely ignore my existence
Love
I lived with my cousin for a while and while they were accepting, they tended to belittle my identity. I didn't mention them, however, because I only spent the last two years with them.
I'm Nigerian and in our country they're increasing penalties for being lgbt or being a supporter & at cultural religious conferences they have been very outspoken against "the Homosexuals and Lesbians"
media portrayals of "coming out"
Me being non-religious and my family being full of former ministers and people who claim to be Christian
No one talks about MY sexuality. It's as if they don't think about it.
Traditional Gender Roles
I am currently failing my junior year of high school which was very unexpected and a disappointment to a lot of people including myself
My mother had physically harmed me when I first came out
Both of my parents came out to me as queer when I came out to them. My current issues with depression and anxiety have nothing to do with my family, I am an activist (for LGBT and POC

rights) and after receiving death and rape threats for my activism, as well as being sexually assaulted 4 times I was diagnosed with PTSD.
My mother is a lesbian who is married to a woman and has always been accepting of my sexuality.
Religion/spirituality: not being a Christian, or accepting typical Christian views of sexuality, women, and homosexuality.
death of my father
It has helped, tremendously, that although my family may not agree with my sexuality, they never make me feel less of a person because of it.
No, I have a good family and supportive parents.
My grandmother is accepting to a certain extent. My family wants to keep my lifestyle to myself instead of being open.
Me and my mom talked, she still loves me just the same and just don't like the lifestyle. But she wants me to be happy.
My religion because my family doesn't accept gay people because we're Muslim.
Some parts of my family find it that it would be easier (not just for me, but for them) if I was straight. I don't let that influence how I live and think.

Question #2: Have your parent(s) or caregiver(s) ever said anything about feeling a sense of "grief" or "loss" after your came out OR talked about struggling with acceptance due to their religious/spiritual beliefs?

Yes all the time why gay like thats so wrong like stfu
No. Yes.
My mother said she doesn't think it's natural and my dad doesn't, either. She said "Do you think God is okay with this?"
yes and no
Yes, unlike my father who reacted in rage, and who I haven't seen since he found out. My mother was conflicted with her spiritual and personal beliefs.
my mother told me" God doesn't love you that way."
My mom has told me that she is going to have to accept me as I am, because I am her child, even though God may not accept me.
No. My mother, while maintaining her Christian beliefs, is especially tied to them either. She doesn't grieve my heterosexuality, if I ever had it. She doesn't use religion as an excuse to not accept me.
Surprisingly no, although after coming out I was forced to go to church more and given the option to move out though I was still a minor.
My family is extremely religious. They sat me down and made me read scriptures for hours daily. Parent 1 verbalized their conflict with homosexuality and their religious beliefs repeatedly
yes, Christian beliefs have hindered acceptance
yes, my mother now hates me and said to me she is dead.
I bet they all would, to some extent.
My parents just believe it's wrong. The whole Adam and Steve debate. The fact that it's just disgusting to them. etcetera etcetera.
No, they have been very supportive.
My mother has increasingly become more and more religious than she was before I came out. She references God and the bible a lot more than she used to and even has been influencing my siblings to think about spirituality which was something she never did when I was growing up. With this increase she seems to feel that there's a level of repent I will have to go through in order to get to Heaven because she doesn't condone my behavior or "choices" as moral. My

father is not spiritual or religious at all however he also does not condone my behavior or "choices" as moral.
a bit
My mother was very accepting from the start even though her religous beliefs seem to contrast my lifestyle.
My father (a retired pastor) has come around because he is in school to be a counselor. My mother has not said anything to me at all. Ever since I was outed I notice that my parents don't really show spirituality anymore. Sometimes I think I had something to do with it.
No, my family isn't super religious, so it hasn't been an issue they've expressed to me
no, but I got really depressed when my girlfriend/love of my life dumped me and that's when I came out to my mom and she just didn't like my ex
My mother specifically spoke about having to go through a process of grieving for the wedding and children that I won't have, but I tried my best to make her understand that just because I am a lesbian does not mean that I will not be in a committed relationship or that I will not eventually want to have children.
Yes
yes, both of my parents are extremely religious, and most of their opinions about sexuality are informed by religion. so they have talked to me about how they have "lost a child" and how they cannot accept me because it's "adam and eve, not adam and steve." my mother is particularly hostile; my father, while ill-informed from time to time, is more accepting.
Yes. My mom feels it is a phase and wonders what she did to get two Queer daughters.
My mother insists on me being closer to god/more involved in her church.
no. they didn't really care either way as long as I'm not showy with it.
no, but my mom told me that she knew in her "spirit" that I was gay.
I have been told that she was disappointed.
My mom said I was too cute to be gay. But she said it's not like I could change and it didn't really bother her.
My secondary caretaker said that I couldn't be asexual if related to her because I was 'too cute.' Neither of them mentioned religion.

My mother always talks about how being a Christian prevents her from "understanding" and accepting queerness.
My mother still likes to pretend I never came out. That hurts the most I think.
Yeah.
Not really but my mother sometimes says things about "luckily having two daughters". She also has difficulty realizing that I am bisexual not just a lesbian
My mother says "there are some things I gotta stand for" saying that she will not come to my wedding if I marry a woman.
Yes my father is devastated he's an active member of the church but he's homophobic. isn't that ironic
My mother would anyways complain. My father didn't know my sexuality but he thinks we (lgbt community) are disgusting
nope, both of them have discussed how my coming out has given them the space to process much of the grief and loss they felt from being closeted and having more conservative families when it came to sexuality mostly due to religion
My mother feared I would go to hell
She blamed herself
She said I was a disappointment. It's hard hearing that from the most important person in the world.
absolutely not, it's not like them to be that way.
That I have lost my innocence because I've had sex.
No. I come from a family that allows me to make my own life choices. I am viewed as an adult, I can depend on them for guidance but ultimately the decisions are mines to make
yes
No, my mom and I are spiritual but we don't let it be a focus. Everyone makes mistakes.

Question #3: Is there anything that I *did not* ask about that you think is important to share about your racial identity, sexual identity, or experiences with depression or low self-esteem?

No maybe how you feel being a black gay man
Queer as a political identity.
No but, if I do think of anything is there a number/website I can contact?
personally identity is something that is more than race or multiculturalism its how we id ourselves and that has something to do with personality and as for experiences you get that growing up and depression has happened to me once and i know how to deal with life now so I have no reason to have low self-esteem.
I just get really angry and or depressed sometimes or I'm really happy and on top of the world I have some crazy mood swings and I've low self-esteem before it comes and goes it takes someone to say something to me to make me feel bad about myself
I'm first generation to strict West Indian parents
I have depression and have had depression among other emotional issues for years before coming out, so coming out and having to deal with my sexuality has certainly increased those feelings.
I suppose a distinction or question about "African American" versus "Black" could've been made--a "do you feel this way or that way" sort of question; for me, there's a difference.
I have low self-esteem and bouts of depression because of my racial identity that go along with my sexuality. I am African American, but prefer women from races and ethnicity's of my own. I feel upset at times because I find it difficult to find others who are interested in interracial relationships. As well as my physical appearance but mainly because of my skin color, though I have dated women in the past who are Caucasian and one who is of my race.
The way I have managed not to slip into depression is to have an outlet. I am 100% sure that if I didn't play guitar or was into photography, I would be struggling with depression right now
how friends or partners may effect identity and self-esteem
I think you should realize that being black in America is, in fact,, a task. The way some of the questions sound, it's as if you believe black people create their own misery. Just imagine growing up knowing that you're the other. Knowing that people will hate you no matter what. But that's not the scary part. The scary part is knowing that hurting people like you is so much a part of history that people think it's okay. And even people like you hate you because you are a reflection of them. Now imagine that two fold. That's how being gay has felt to me. I make the best of my circumstances. But life isn't fair to everyone. Not even close.

No. I think everything was covered.
No I feel great
Yes
Maybe some questions about gender too?
1. A question on how our sexual orientation was introduced to others. I was outed to my family on someone else's terms. 2. Our current relationship status would determine if we felt sad or etc. (I was broken up with by my ex gf two weeks ago, hence the sadness). 3. Suicide questions: whether we've thought about it, know an lgbtqa...person who has attempted, etc.
how do you think race affects the way people treat you within the LGBT community?
I have chronic depression.
I openly refer to myself as a "Triple Minority": a black, gay, woman. I would have expected this survey to ask which adjective I would list first when describing myself and which do I see as most important, valuable, ect. I, personally, like to make my lesbianism more known, because anyone can look at me and see a black woman. People don't see me and think "she's gay", so I verbalize it more often. That does not mean I don't love my blackness or embrace it, I do. I just feel like I've got to go out of my way to express my gayness, if you will, because it isn't as obviously so.
my depression is getting better, and I only have low self esteem because of my break up. my moms okay with me being gay but my dad doesn't know
no. i think you covered most of your bases.
The racial/ethnic questions were a little confusing. I didn't know exactly what to pick considering the fact that I don't necessarily see myself in those categories. I see myself as a black hispanic, not black and hispanic, the difference being, I do not consider myself to be biracial, just a black man who is hispanic.
I have one Black(father) and one White(mother) parent so I am biracial, but id primarily as Black and was raised to understand that society very much views me thru a lens of Blackness. I used to id as Bi as a teen, but Queer is more accurate for my attractions/politics/perspectives/etc. plus its more open-ended.
Being black is my visible identity and its easy to identify other black people and feel community but i cannot visually identify queer people so sometimes i feel alone.

a lot of people feel like black people are mostly straight, or that we are not as accepting as other races. but...we make up a large percentage of the lgbq community and from what I've seen are more accepting than white people.
When I came out at the age of 16 I was depressed, suffering through low self-esteem but it did not pertain to my sexuality.
There weren't many questions about factors other than orientation that would contribute to depression and low self esteem, but this section sort of allows for people to mention those
those.
It would be interesting to see how many people suffer with mental illness and how many actually were able to seek professional help.
Nope, I think you about covered it. You brought up some difficult emotions.
I have had trouble coming out to my black friends, some have even rejected me, which has not happened at all when I've come out to people of other races. I think it has to due with traditional views and religion.
Seeing a therapist for depression? Have always had low self-esteem, but at least in terms of looks, it has gotten better recently...
No you got it there was a lot of repetition though, I really don't think Caucasians are horrible. that kinda bugged me what does that have to do with anything.
I think everything was well covered!
Not that I can recall.
My Blackness has made me feel insecure about prospective partners as I feel people do not notice Black women with the influence of the hegemonic white beauty standard
The only reason I suffer with low self-esteem and have moments of depression is due to insecurity over my weight. As far as my sexuality goes, my mom doesn't really care. Sometimes she says homophobic things without thinking of how I would feel. For example, my baby brother kissed my younger cousin (who's a boy) and my mom said "no, on't do that. we don't kiss boys." I think it was very careless and it hurt my feelings. When I called her out on it, she responded with, "you made your own choices, so don't force anything onto your brother." So sometimes my mom is a little insensitive, but she hasn't made me feel unloved for my sexuality.
What location is like (small town vs. city, conservative vs. liberal, etc.)
Do you live in an area where you experience black people everyday? How many of your friends are black and share your views? At school how many students are black? At school how many

students are LGBQ? How often do you interact with other LGBQ people your age? Are you the first person in your family to come out as gay?
My self-esteem isn't high.
as I stated before, my family has been great through the coming out process, my anxiety comes from my PTSD which is unrelated to my coming out process.
self-harm
I think being both black and gay, two identities that are marginalized, has only made my depression worst.
Sometimes I'm a little bit insecure about myself physically.
Nope, I think you covered everything.
Social status plays a big role in the influence of drugs, alcohol, and crime when it comes to racial issues in my opinion.
yes, there are times when I want to give up on my hopes and dreams
No, I just don't see why people would hate other racial groups.
I feel as though everything has been covered

Question #4: Do you have any additional feedback or suggestions about how to make this survey better? Was there anything that you did not like about it?

No. The survey was very comprehensible.
I fell in love with the survey and the questions that were being asked. Made me feel as if there was a heavy burden lifted from my shoulders when these questions were brought up front .
sk more about other than just mother and father..ask if they even have a father in there lives and or mother. They may have step parents
please spell check some of the questions and they are also repetitive.
The whole hating white people thing and how black people turn to drugs to make money that was ridiculous to me but I guess some really might feel that way so I guess got to clear all areas not everyone thinks the same
It was a great survey. Thanks
It was very long.
I think this survey was incredibly thorough and helpful, but it just felt really intense at times and brought back memories of when I had just come out, and I was immediately brought back to those awful times.
I wasn't exactly clear if you did or didn't want to know about the parent who I hadn't told about my queerness, but otherwise, everything was understandable.
Try not to repeat questions, I believe I found some that repeated although I could be mistaken.
The questions seemed to be very depression centric. I don't have a problem with that btw. I would suggest adding questions about siblings and other out LGBTQ in the family (if there are any)
Very useful survey
None at this time
No. I realize you were confronting stereotypes. It sucks that so many of them are true.
No additional comments or feedback.
did not feel entirely included in the survey's questions about "hating White people", etc, as a person of mixed race. Though I identify as black, I still love my white family and accept that they are part of me and my experience, and I felt that the survey asked many questions which excluded the experience of someone who is part white.

No problems.
Few typos and questions were very repetitive in an insulting way…
I didn't like how I was only black. I am bi racial and I favor my other side. So answering some of these questions was hard not to pick some things because I think I'm more spanish than black. I only took this survey to help.
Nah it was fine
Thank you for having this survey specifically for Black LGBTQA..youth. Our experience is a lot different than other races. Spirituality is a huge part of being African-American and a lot of us or our family might feel betrayed or striped by our...queerness.
Maybe put in a section with gender? Just a suggestion though it was really good.
I enjoyed taking this survey. There's nothing I would change. It has been a pleasure.
some of the questions were odd and repeated,
I must admit, the "true, not true" section was a bit confusing initially.
The questions about racial and ethnic identities could be more straight forward such as: are you hispanic or latino? and Regardless of the previous question, how do you identify your race? and then proceed to list the universally known races.
The repetition of many questions of the feelings about racial identity page. Some were also very loaded. Maybe define some of the terms used..for example, how is Afrocentricity being defined w/in the conetxt of this survey?
I'm African
No, it was pretty okay.
No, it was great.
I did not like the questions like "Agree of Disagree: I hate white people" the context of the question and the phrasing is off putting
The survey was fine
Perhaps more questions about multi-racial people in their positioning in America and less on White Americans. It seems weird that White people make up the majority of the questions of inclusion in a survey about Black American youth. Perhaps more questions on Latino/as and their inclusion/exclusion in the community.

Survey was 10/10
The only thing I didn't like was thinking about things I didn't want to. Great survey though. Keep up the good work.
The layout was quite confusing and should have had more consistency e.g one page had strongly agree on the right, the next page it was on the left. Could bias your findings in regards to less attentive participants.
It was fine.
already said it
Transgender is not a gender identity. There are trans men and trans women, and a spectrum of non-binary individuals. The wording of that threw me off a little.
the gender options should let you choose more than one box (transgender is not a gender - it's a gender identity) and African should have been an ethnic option along with African American (I'm ethnically Nigerian and nationally American)
it was good
The survey was good.
I think these results are going to be very insightful and can't wait to read your dissertation :)
it would be a good idea to ask the sexual orientation of parents
All the repeated questions
No. The survey was clearly well planned and thought out.
No I'm good for now!
This was something that made me think about a lot of certain things like how I can spread love.
really enjoyed the experience and what it was about.
No. I enjoyed it. I hope my feedback is at least a little helpful in your research efforts.
Some questions were a little uncomfortable (the racial group questions) but it's a survey so I didn't mind.
I found the survey interesting, but I easily picked up the point of the survey.
It was annoying. Totally annoying.

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Curriculum Vita

EDUCATION

PhD February 2015 — **Couple and Family Therapy**
Magna Cum Laude — Drexel University
Philadelphia, Pennsylvania

Dissertation Title: *How Black LGBQ Youths' Perceptions of Parental Acceptance Rejection are Associated with their Self-Esteem and Mental Health*

MS May 2009 — **Marriage and Family Therapy**
East Carolina University
Greenville, North Carolina

BA May 2007 — **Psychology**
The Pennsylvania State University
University Park, Pennsylvania

CLINICAL EXPERIENCE

January 2012-Present — Individual, Couples, Family & Group Psychotherapist
Therapy Center of Philadelphia (formerly Women's Therapy Center)
Philadelphia, Pennsylvania

I provide individual, couples, and group therapeutic services from a feminist and culturally-informed perspective, to empower women and trans* individuals to live their best, healthiest and most powerful lives. I work with a variety of presenting issues, such as depression, anxiety, trauma, body image, sexual and gender identity/orientation, domestic violence, attachment, and infidelity. I am certified in Eye Movement Desensitization Reprocessing (EMDR), an empirically validated trauma therapy. I also consistently volunteer to participate in other activities to help improve the overall functions of the agency.

Nov 2011-Present — Individual, Couples, Family, and Group Psychotherapist
Attic Youth Center – Counseling Services Department
Philadelphia, Pennsylvania

I provide therapy, crisis management, and assessment services to LGBTQ youth, couples, and their families, as well as facilitate groups on a wide range of topics including gender and sexuality, sexual and gender identity, race and ethnicity, religion, and relationships. Occasionally, I assist with program development and grant writing. I adhere to CBH insurance and credentialing standards for documentation.

September 2012-July 2014 — Counseling Services Coordinator

In addition to my duties as a Psychotherapist, as the Coordinator, I provide administrative oversight of the Counseling department, including but not limited to, completing intakes for and assigning new clients to therapists, orienting new therapists, reviewing charts for agency and insurance/funder compliance, and serving as a liaison between full-time Attic staff and the Counseling staff.

June 2011-December 2011 — Mental Health Professional (In-Home Family Therapist)
Child Guidance Resource Centers – Family First Program
Havertown, Pennsylvania

I primarily worked with low-income, minority families who had children and adolescents at risk for out-of-home placement providing individual and family therapy, case management, psychiatric consultation, family support services, and crisis intervention. I also gained further experience collaborating across disciplines and with other service systems, as well as facilitating groups. Additionally, I participated in Ecosystemic Structural Family Therapy Intense Training, and adhered to rigorous MBH insurance and credentialing standards.

(Clinical Experience continued)

July 2010-March 2011 Couple and Family Therapist
Family Therapy Treatment Program
Philadelphia, Pennsylvania

I worked primarily with low-income, minority, underserved couples and families in their homes and in the traditional office setting; as well as briefly providing services at Interim House West (a substance abuse treatment facility for women in recovery and their children). I maintained a consistent caseload of clients, while adhering to CBH insurance and credentialing standards.

January 2009-May 2009 Family Therapy Intern
Migrant Farmworker Outreach Program
Snow Hill, North Carolina

I worked with a team of outreach professionals to provide mental healthcare to Hispanic migrant farm-workers and their families. I collaborated with physicians, school systems, and other larger systems to implement services that the families may need and have limited access to, particularly when language, finances, and/or transportation was a barrier.

October 2008-May 2009 Medical Family Therapy Intern
Bernstein Community Health Center
Greenville, North Carolina
August 2008-May 2009 Snow Hill Medical Center
Snow Hill, North Carolina

At both of these health centers, I provided integrated care to patients during routine medical visits, and was available for traditional therapy for patients in need of ongoing sessions. I collaborated regularly with physicians, physician assistants, and nurses to establish and carry out proper treatment plans for patients.

April 2008-May 2009 Family Therapy Intern
East Carolina University Family Therapy Clinic
Greenville, North Carolina

I maintained a consistent caseload of clients and provided individual, couple, and family therapy services, as well as intake assessments to primarily low-income, underserved populations. I also participated in a weekly practicum course, including supervision, reflecting team, and theory of change enhancement.

April 2008-September 2008 Family Therapy Intern/ Substitute Teacher
PORT Adolescent Residential Treatment Program
Greenville, North Carolina

I conducted strength-based assessments with new clients upon entering the program. I co-facilitated group therapy sessions at least once a week with PORT teachers. As a substitute teacher, taught topics such as family education and sexuality education. I also participated in weekly staff clinical meetings and treatment team meetings with therapists, teachers, administrators, and other larger systems involved with client's case. I facilitated family meetings for clients and their families whenever necessary.

TEACHING EXPERIENCE

3/30/2015- 6/10/2015 Adjunct Professor Palo Alto University (Virtual)
CLIN 622: Family Therapy Theory III: Whole Family

I prepared and (virtually) taught an 11-week family therapy theory course to graduate (Masters and PhD) students on working with the *whole* family system in therapy. Theories covered included: Narrative, Multicultural/Critical, Feminist, Contextual, Emotionally Focused and Solution Focused Therapies.

(Teaching Experience continued)

2/18/2015- Adjunct Professor Montgomery County Community College
5/13/2015 ESW/PSY 255: Human Sexuality
I prepared and taught a 12-week course in Human Sexuality to undergraduate community college students and adult learners.

5/22/2013 La Salle University PCMF 603: Human Sexuality
Instructor Christiana, Awosan Guest Lecture on Working with LGBTQ Youth
I guest lectured to a class of Masters level couple and family therapy students about clinical considerations in working with LGBTQ individuals (specifically youth), couples, and families.

Fall 2012 East Carolina Univ. Clinical Work with Same Gender Couples and Families
ECU Reps Drs. Angela Lamson LMFT & Lisa Tyndall, LMFT
I developed a Continuing Education module to be housed at the Redditt House/ ECU Family Therapy Clinic and accessed by military behavioral health providers seeking CE credits.

Fall 2010 Drexel University FMTH 520S: Historical and Sociocultural Influences
Instructor Dr. Marlene Watson

Responsibility for writing all powerpoint notes for the class, developing the exam for class, as well as grading evaluating student performance in the class along with the primary instructor.

10/22/2010 Drexel University FMTH 520S: Historical and Sociocultural Influences
Instructor Dr. Marlene Watson Guest Lecture on Class and Classism
I guest lectured to a class of Masters level couple and family therapy students about class/classism, poverty, and oppression experienced by financially marginalized families over the life cycle.

RESEARCH EXPERIENCE

Drexel University

September 2012-February 2015 Doctoral Candidate, Chaired by Dr. Maureen Davey
Couple and Family Therapy Department
Completed all of the requirements for the doctoral degree in Couple and Family Therapy, including dissertation titled, *How Black LGBQ Youths' Perceptions of Parental Acceptance Rejection are Associated with their Self-Esteem and Mental Health*. Degree conferral and graduation is in June 2015.

September 2009-June 2011 Graduate Research Assistant for Dr. Marlene Watson
Professor, Couple & Family Therapy Department
College of Nursing & Health Professions
I assisted with ongoing research related to African American women, obesity and breast cancer. I performed literature searches and reviews or literature for grant-writing or general writing purposes. I devised a questionnaire used to gather data for a project on diversity representation in CFT programs. I completed other duties related to research and teaching as requested.

East Carolina University

August 2007-May 2009 Graduate Assistant for Dr. David Dosser, Jr.
Faculty Athletics Representative
Chancellor's Office
I assisted with the preparation of reports to the Faculty Senate, the Chancellor, the Provost, the Director of Athletics, the University Athletics Committee, C-USA, and the NCAA. I maintained records associated

(Research Experience continued)

with NCAA research, missed class time reports, agent correspondence, academic integrity, and continuing and initial student-athlete eligibility.

August 2007-June 2008 Co-Study Coordinator and Research Assistant
INSIGHT PLUS Project – PI: Dr. D. Elizabeth Jesse
School of Nursing

I recruited and maintained participants in a study to determine the effectiveness of a Cognitive Behavioral Therapy-based educational class in decreasing the occurrence of postpartum depression in minority, low-income pregnant women. I helped to revise chapters for the book used in the classes, and assisted with other research responsibilities, such as participant tracking and payment, data entry, and delegating duties.

The Pennsylvania State University

December 2006-August 2007 Research and Lab Assistant
Adult Cognitive Development Project
PI: Dr. K. Warner Schaie and Dr. Sherry Willis
Gerontology Center

I reviewed and scanned participant data into computer databases. I also cleaned participant data by reviewing scanned data to check for errors.

May 2005-September 2006 Certified Peer Counselor and Research Assistant
GOALS Project – PI: Dr. Robert Turrisi and Dr. Mary Larimer
January 2006-May 2006 & Skin Cancer Prevention Project – PI: Dr. Robert Turrisi
Alcohol and Skin Cancer Prevention Research Center

With the GOALS Project, I provided psychoeducation on the risks and consequences of binge drinking, as well as peer counseling to new college freshmen in a study designed to test the effectiveness of a peer intervention aimed at curbing binge drinking behavior. I conducted literature reviews for ongoing research, assisted with data collection and data entry, and assisted with recruiting participants, preparing mailings, and participant tracking and payment. With the Skin Cancer Prevention Project, I provided psychoeducation on skin cancer and the risks or indoor/outdoor tanning, as well as peer counseling to college students in a study designed to test the effect of a peer intervention on student's tanning use.

June 2005-September 2005 Research and Lab Assistant
PROmoting School-community-university Partnerships to Enhance Resilience (PROSPER) In-Home and In-School Projects
Penn State Survey Research Center – Supervisor: Janis Fisher

The goal of this NIDA-funded project was to promote the development of sustainable partnership among schools, communities, and universities, in order to facilitate the delivery of evidence-based interventions aimed at strengthening families, reducing adolescent substance use and behavioral issues, and to promoting youth competence. I assisted with data entry, organizing research information, and coding videotapes of home interviews. I also reviewed tapes, and coded and transcribed data for further analysis.

PEER-REVIEWED JOURNAL ARTICLES

Pratt, K.J., Palmer, L., & **Walker, M.D.** (2015). Approaches to weight-related problems: A narrative intervention for overweight youth. *Journal of Family Psychotherapy* Special Issue: The Intervention Interchange*, 26*(1), pg. 19-24 doi: 10.1080/08975353.2015.1002738

Walker, M.D. (2013). When clients want your help to "pray away the gay": Implications for couple and family therapists. *Journal of Feminist Family Therapy*, *25*(2), pg. 112-134. doi: 10.1080/08952833.2013.777875

(Peer-Reviewed Journal Articles continued)

Walker, M.D., Hernandez, A., & Davey, M. (2012). Childhood sexual abuse and adult sexual identity formation: Intersection of gender, race, and sexual orientation. *American Journal of Family Therapy, 40*(5), pg. 385-398. doi: 10.1080/01926187.2011.627318

Walker, M.D. & Davey, M.P. (in progress). The role of spirituality and religiosity in understanding Black LGBQ youths perceptions of parental acceptance and rejection.

Walker, M.D. & Davey, M.P. (in progress). The importance of the primary attachment figure: How mothers' acceptance protects Black queer youth from depression and low self-esteem.

Walker, M.D. (in progress). Research informing practice: Clinical, research, and policy implications for couple and family therapists' working with Black LGBQ youth and their families.

Russon, J., **Walker, M.D.**, Wilkins, E., & Moncrief, A. (in progress). Lesbian, gay, and bisexual clients: Understanding attitudes and self of the therapist.

Walker, M.D. (in progress). Psychotherapy as a meeting: Implications for the therapeutic relationship.

Walker, M.D. (in progress). On becoming a socially just, culturally aware, and affirming couple and family therapist: Beyond the one course model.

Walker, M.D., & Riley, T.M. (in progress). Say my name: Explorations of the labels that confine queer womyn of color.

BOOK CHAPTERS

Lewis, M., Myhra, L., & **Walker, M.D.** (2014). Advancing health equity in medical family therapy research. In J. Hodgson, A. Lamson, T. Mendenhall, & R. Crane (Eds.) Medical family therapy: Advanced applications. (pp. 319-340). New York: Springer Publishing.

Walker, M.D., & Hernandez, A. (2014). Challenging heterosexual and cisgender privilege in clinical supervision. In R.A. Bean & M.A. Davey (Eds.). Clinical supervision activities for increasing competence and self-awareness (pp. 239-246). Hoboken, NJ: Wiley.

PRESENTATIONS

International

Walker, M.D., (2014, June). How Black LGBQ Youths' Perceptions of Parental Acceptance Rejection are Associated with their Self-Esteem and Mental Health: Preliminary Results of Dissertation Study – Chaired by Dr. Maureen Davey. Paper presented at the 45th Annual Meeting of the Society for Psychotherapy Research in Copenhagen, Denmark.

Walker, M.D., & Russon, J. (2012, March). Female Same-Sex Couples in Therapy: Get Real, Get Educated. Poster presented at XX World Family Therapy Congress in Vancouver, Canada.

Walker, M.D., Hardy, K.V., Allen, A., Northey, W., Curiel, Y., & Mendez, N. (2011, March). Race, Gender, Justice, & Therapy: Where Do We Draw the Line? Workshop presented at the XIX IFTA World Family Therapy Congress in Noordwijkerhout, the Netherlands.

(Presentations continued)

Walker, M.D., Henry, R.R., & Hernandez, A.M. (2011, March). Beyond Theory: The Use of Self in Family Therapy. Workshop presented at the XIX IFTA World Family Therapy Congress in Noordwijkerhout, the Netherlands.

National

Walker, M.D. (2015, May). Intersections and Identities: Black LGBQ Youths' Perceptions of Parental Acceptance/Rejection and Psychological Wellbeing – Chaired by Dr. Maureen Davey. Presentation given at the 3rd Annual LGBT Research Symposium in Urbana-Champaign, IL.

Walker, M.D. (2015, October). Intersectional Identities: Black LGBQ Youths' Experiences of Parental Rejection and Psychological Wellbeing – Chaired by Dr. Maureen Davey. Presentation given at the 1st Annual Black Families, Black Relationships, and Black Sexuality Conference in Philadelphia, PA.

Walker, M.D. (2015, October). Intersectional Identities: Black LGBQ Youths' Experiences of Parental Rejection and Psychological Wellbeing – Chaired by Dr. Maureen Davey. Presentation given at the 3rd Annual Black Doctoral Network Conference in Atlanta, GA.

Walker, M.D. (2014, November). Black LGBQ Youths' Perceptions of Parental Acceptance and Psychological Well-being: Preliminary Results of Dissertation Study – Chaired by Dr. Maureen Davey. Paper presented at the 76th Annual NCFR Conference in Baltimore, MD.

Russon, J.M., & **Walker, M.D.** (2014, November). Promoting the Health of Transgender and Intersex People. Paper presented at the 76th Annual NCFR Conference in Baltimore, MD.

Gerig, A., Green, E.R., & **Walker, M.D.** (2014, June). Bridging Feminism: Creating Trans-Affirming Feminist Spaces. Workshop presented at the 13th Annual Philadelphia Trans Health Conference.

Walker, M.D. (2014, June). Parental Acceptance/ Rejection of LGBQ Youth in Black Families: Preliminary Results of Dissertation Study – Chaired by Dr. Maureen Davey. Presentation given at AFTA's 36th Annual Meeting in Athens, GA.

Walker, M.D., Awosan, C.I., Curiel, Y.S., Henry, R., Cooper, C.P., & Hernandez, A (2014, June). Health and Wellbeing Beyond the Therapeutic Encounter. Roundtable presented at AFTA's 36th Annual Meeting in Athens, GA.

Walker, M.D., & Russon, J. (2013, Nov). "Lord, Not in My Family!" Black Families Raising an LGBTQ Child. Poster accepted at the 75th Annual NCFR Conference in San Antonio, TX

Walker, M.D., & Carniero, R. (2013, Nov). Embracing Love Across the Rainbow in Families and Communities. Poster symposium accepted at the 75th Annual NCFR Conference in San Antonio, TX

Carniero, R., & **Walker, M.D.** (2013, June). Embracing Love Across the Rainbow. Poster presented at AFTA's 35th Annual Meeting in Chicago, IL.

Russon, J., **Walker, M.D.**, & Wilkins, E. (2012, May). Lesbian, Gay and Bisexual Clients: Understanding Attitudes and Self of the Therapist. Poster presented at AFTA's 34th Annual Meeting in San Francisco, CA.

Walker, M.D., & Riley, T... (2011, October). Say My Name: Explorations of the Labels that Confine Queer Womyn of Color. Paper Presentation/ Workshop presented at the 3rd Annual Elements LGBTQ Womyn of Color Conference in Philadelphia, PA.

(Presentations continued)

Walker, M.D., & Riley, T. (2011, July). Say My Name: Explorations of the Labels that Confine Queer Womyn of Color. Paper Presentation/ Workshop presented at the 2011 SisterSong Let's Talk About Sex National Conference in Miami Beach, FL.

Walker, M.D., & Riley, T. (2011, February). Say My Name: Explorations of the Labels that Confine Queer Womyn of Color. Paper Presentation/ Workshop presented at the 19th Annual Lavender Languages & Linguistics Conference at American University in Washington, DC.

Walker, M.D., Henry, R.R., & Hernandez, A.M. (2010, April).Beyond Theory: The Use of Self in Family Therapy. Poster presented the 13th Annual Council on Contemporary Families Conference at Augustana College in Rock Island, IL.

Local

Walker, M.D. (2011, March). Say My Name: Explorations of the Labels that Confine Queer Womyn of Color. Paper Presentation/ Workshop presented at Drexel University CFT Program Professional Development Series in Philadelphia, PA.

Submitted Abstracts

Gerig, A., **Walker, M.D**, & Women's Therapy Center Staff. (2014, August). Vision, Visibility and Voice: A Feminist Psychotherapy Center's Journey Towards Trans-Inclusivity. Collaborative (Divisions 35 & 44) workshop proposal submitted to the 2014 APA Annual Conference in Washington, DC.

Walker, M.D., & Russon, J. (2012, October). "Why does it have to be me?" Families Raising an LGBTQ Child. Workshop proposal submitted to the 2013 AAMFT Annual Conference in Portland, OR.

Walker, M.D., & Taitt, T. (2011, March). The New Lesbian Woman: Sexually Fluid and Heteroflexible. Workshop proposal submitted to the 2011 SisterSong National Conference in Miami Beach, FL.

Ajayi, C., Curiel, Y., Diggles, K., Lewis, M., Taitt, T., & **Walker, M.D.** (2010, December). The Heart of the Matter: Minority Fellows and MFT Education. Panel discussion proposal submitted to the 2011 AAMFT Annual Conference in Fort Worth, TX.

Walker, M.D. (2009, December). Marriage: Socio-Cultural Perspectives. Workshop proposal submitted to the 2010 AAMFT Annual Conference in Atlanta, GA.

PANEL DISCUSSIONS

Walker, M.D., Awosan, C.I., Curiel, Y., Cooper, C.P., & Hernandez, A.M. (2015, October). Soliciting Support and Conducting Research with a Social Justice Focus. Moderated panel discussion presented at the 3rd Annual Black Doctoral Network Conference in Atlanta, GA.

Brown, A., Curiel, Y.C., Hines, P., Jonathan, N., Kim, L., King, J., Landsman-Wohlsifer, D., **Walker, M.D.,** & Winawer, H. (2015, June). Be the Change: Nurturing Connections and Directions for the Future. Moderated panel discussion presented at AFTA's 37th Annual Meeting in Vancouver, WA.

Walker, M.D., & Ashton**,** D. (2014, June). Family Health & Wellbeing among LGBTQ Communities through the Lens of Intersectionality. Moderated a dialogue with Anneliese Singh, PhD and Ana M. Hernandez, MA, MFT at AFTA's 36th Annual Meeting in Athens, GA.

(Panel Discussions continued)

Walker, M.D., & Bonnett, D. (2012, March). Calling All Seasoned Lesbians, Butches, and Young Dyke Queers Across Cultures. Panel discussion at the 2nd Annual Elements Bridges and Divides Focus Group Series for Womyn's History Month Celebration in Philadelphia, PA.

Walker, M.D., Hernandez, A.M., & Galloway, R. (2010, October).Parenting in the LGBTQ Community: Issues and Questions. Panel discussion at the 2nd Annual Elements LGBTQ Womyn of Color Conference in Philadelphia, PA.

EXTERNAL GRANTS AND CONTRACTS SUBMITTED

Davey, M.P. (PI),, & **Walker, M.D. (Co-PI)**. (Submitted 2011, November). *How Black LGBQ youths' experiences of parental acceptance and rejection are associated with their racial and sexual identity development, and mental health.* Fahs-Beck Fund for Research and Experimentation – Doctoral Dissertation. $5,000 (over one year)

PROFESSIONAL AFFILIATIONS

The Association of Black Sexologists and Clinicians – Current Member
Black Doctoral Network (BDN) – Current Member
Society for Psychotherapy Research (SPR) – Current member
American Psychological Association (APA) – Current member
Societies: Psychological Study of Social Issues (9), Community Research and Action: Div of Community Psychology (27), Psychotherapy (29), Psychology of Women (35), Child and Family Policy and Practice (37), Family Psychology (43), Psychological Study of LTBT Issues (44), Psychological Study of Culture, Ethnicity and Race (45), Group Psychology and Group Psychotherapy (49), Clinical Child and Adolescent Psychology (53), Trauma Psychology (56)
American Family Therapy Academy (AFTA) – Current member
Committees: Cultural and Economic Diversity, Family Policy
Interest Groups: Couples Therapy, Mindfulness, Narrative Therapy
International Family Therapy Association (IFTA) – Current member
National Conference on Family Relations (NCFR) – Current member
Sections: Family & Health, Religion & Family Life, Family Policy, Education & Enrichment, Ethnic Minorities, Family Therapy, Feminism & Family Studies, Research & Theory
Focus Groups: Co-parenting/Divorce Education, Family Economics, GLBTSA, Latino(a) Research, Qualitative Family Research Network, Sexuality
American Association for Marriage and Family Therapy (AAMFT) – Current member
Family TEAM (Family Therapy Education & Advocacy Movement) – Current member
Pennsylvania Association for Marriage and Family Therapy (PAMFT) – Current member
North Carolina Association for Marriage and Family Therapy (NCAMFT) – Past member
American Group Psychotherapy Association (AGPA) – Past member
Philadelphia Area Group Psychotherapy Society (PAGPS) – Past member
Council on Contemporary Families (CCF) – Past member
The Association of LGBT Addiction Professionals (NALGAP) – Past member
National Association for Addiction Professionals (NAADAC) – Past member

PROFESSIONAL CERTIFICATIONS

April 2014 **Eye Movement Desensitization Reprocessing (EMDR) – Trauma Recovery Humanitarian Assistance Programs**

From February – April 2014, I completed EMDR Level I and II Basic Training, including a total of 50 hours of didactic instruction and experiential practice over two three-day intensive weekends. I also completed the mandatory 10 hours of consultation as I incorporated EMDR into my practice, and became fully certified.

(Panel Certifications continued)

Consultation is ongoing as I work toward completing the requirements to become an EMDR Approved Consultant.

December 2012 Bryn Mawr College Contemporary Approaches to Group Treatment
From October – December 2012, I completed a 15-hour didactic training to partially fulfill the requirements to become a Certified Group Psychotherapist (CGP).

May 2009 Substance Abuse Counseling Certificate
I completed coursework at ECU that leads to North Carolina certification as either a Certified Substance Abuse Counselor (CSAC) or Certified Clinical Addictions Specialist (CCAS).

July 2005 Peer Counselor (Motivational Interviewing)
I became a certified peer counselor through my work at the Alcohol and Skin Cancer Prevention Research Center at Penn State University.

SERVICE and LEADERSHIP

March 2015-present	Conference Planning Committee Member Philadelphia Family Pride: Family Matters Conference
March 2014	Annual Conference Proposal Reviewer National Council on Family Relations (NCFR) Ethnic Minorities Section
March 2013	Annual Conference Proposal Reviewer National Council on Family Relations (NCFR) Family Therapy Section
2010-2013	Volunteer and Outreach Team Member Elements LGBTQ Womyn of Color Organization
March 2010	Annual Conference Proposal Reviewer National Council on Family Relations (NCFR) Family Therapy Section
January 2009	College of Human Ecology Office of the Dean Honored as an Outstanding Student Leader East Carolina University
Sept 2007-May 2009	Child Development and Family Relations Graduate Student Association East Carolina University Member, August 2007-May 2009 Secretary, September 2007-November 2008
Aug 2007-May 2009	Child Development and Family Relations Graduate Student Association Secretary from September 2007-November 2008 East Carolina University
February 2006	Dance Marathon (THON) Athlete Hour – Women's Track and Field The Pennsylvania State University
Fall 2004-Spr 2007	Penn Pal Program – Women's Track and Field The Pennsylvania State University

(Service and Leadership continued)

Aug 2003-July 2007	Women's Varsity Track and Field Team Team Captain during Senior Year The Pennsylvania State University
Aug 2003-May 2004	Student-Athlete Advisory Board (SAAB) Women's Track and Field Team Representative The Pennsylvania State University

HONORS and AWARDS

Drexel University

2015	**Graduation Honor: Magna Cum Laude (for overall GPA over 3.7)**
2014	**North American Society for Psychotherapy Research (NASPR), Sol Garfield Memorial Student Travel Award, Value $1000**
2014	Dean's Award for International Travel, Value: $800
2014	Office of International Programs International Experience Funding, Value: $700
2014	Office of Graduate Studies Travel Award, Value: $225
2012-2014	**Health Resources & Services Administration Scholarship, Value: $7,890**
2013	Office of Graduate Studies Travel Award, Value: $225
2011 & 2012	Office of Graduate Studies Travel Award, Value: $200/each year
2011	Office of International Programs International Travel Award, Value: $500
2011	Dean's Award for International Travel, Value: $500
2009-2011	**AAMFT/SAMHSA Minority Fellow, Value: $20,000/ year (max 3 years)**
2009-2011	**Graduate Assistantship Appointment, Value $20,000**

East Carolina University

2008-2009	Golden Key International Honour Society, East Carolina University Chapter
2008-2009	**Kappa Omicron Nu Honor Society, Nu Iota Chapter**
2008-2009	College of Human Ecology Outstanding Student, Centennial Legacy of Leadership, Office of the Dean
2008-2009	Marriage and Family Therapy Alumni Scholarship, Value: $1,000
2008-2009	Bloxton-Strawn Scholarship, Value: $1,000

The Pennsylvania State University

2006-2007	Arnelle and Hugh Lynn J. Scholarship, Value: $1,100
2006-2007	Dean's List (maintaining 3.5 GPA)
2003-2007	Bunton-Waller Academic Scholarship, Value: $2,500/year (max 4 years)
2003-2007	**Big Ten Conference Scholar-Athlete Award**
2003-2007	Academic All-Big Ten Team

(Honors and Awards Continued)

Other

2011 Edition	Stanford Who's Who Professional Organization (membership by invitation only)
2006 Edition	Who's Who Among Students in American Universities and College
2002 & 2003	Who's Who Among American High School Students
Spring 2002	Selected as one of Loudoun County's Future Leaders