FACTORS CONTRIBUTING TO MENTAL HEALTH SERVICE UTILIZATION BY SEXUAL-MINORITY YOUNG ADULTS

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the thesis of CHARLES RUFUS ANDERSON find it satisfactory and recommend that it be accepted.

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Abstract

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The current study identifies reasons that lesbian, gay, bisexual and transgender (LGBT) youth attend therapy. Research has shown sexual-minorities to be at risk for mental health problems, suicidality, and gay-related or minority stress. Previous research has shown sexual minority youth to report increased use of mental health services, even in the absence of depression. Sexual minority youth may face additional obstacles including developing a sexual orientation identity, disclosing their sexual orientation, minority stress and interpersonal sexuality related issues. The research suggests that sexual minority youth may seek counseling for sexuality related reasons in addition to common reasons like depression or interpersonal conflict.

The current study used data from 195 self-identified LGBT young adults, aged 18 to 26 (M = 21.6, SD = 2.34). Self-identified females comprised 47.5% of the sample while 9% of the sample reported a transgender identity. Additionally, 30% of participants reported identifying as an ethnic minority.

Commonalities across four measures of reasons to use mental health services surfaced. Depression was consistently the number one reason LGBT young adults reported attending therapy. Although not consistently the highest ranked, anxiety, family and peer relationships,

help dealing with stress and sexuality and coming out issues also appear as important reasons to attend therapy. Findings show that LGBT young adults are using therapy services for typical reasons like coping with mental health disorders or family issues; however, a large portion (38%) reported using mental health services to help resolve issues relating to sexuality.

Regression analyses were run as a means of documenting predictors of mental health, using mental health services, and amount of services used. Service use was predicted by attitudes toward therapy and having sexuality-related reasons for therapy. More service use was predicted by openness to family and friends, while less service use was predicted by having experienced a positive reaction from family. Negative mental health was predicted by internalized homophobia, harassment, and sexuality-related reasons for therapy. These findings have implications for both clinicians and researchers interested in LGBT wellbeing.

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CHAPTER ONE

INTRODUCTION

Over the past two decades research on sexual minorities has grown, showing a marked increase in awareness regarding mental health issues for same-sex attracted youth with topics ranging from risk-taking behavior to homelessness. Research has shown sexual minorities to be at risk for mental health problems (Meyer, 2003; Lock & Steiner, 1999; Russell & McGuire, 2006; D'Augelli & Hershberger, 1993; Balsam, Beauchaine, Mickey, & Rothblum, 2005), suicidality (Russell & Consolacion, 2003; Russell & McGuire, 2006), and gay-related or minority stress (Meyer, 1995; 2003; Rotheram-Borus, Hunter, & Rosario, 1994). Additionally, research done using the National Longitudinal Study of Adolescent Health (Add Health) has shown sexual minority youth to report increased use of mental health services (McGuire, Russell, & Anderson, 2007). Increased mental health service use is again reported by Balsam and colleagues (2005) who found that lesbian, gay and bisexual adult siblings reported more service use than did their heterosexual brothers and sisters. Throughout this paper, we will distinguish between research conducted with lesbian, gay, and bisexual (LGB) participants, research conducted with lesbian, gay, bisexual, and transgender (LGBT) participants and research conducted with members of the larger sexual-minority or LGBT community.

There are many reasons young adults report utilizing mental health services that are common to both sexual majority and minority young adults; however, little is known regarding specific reasons why sexual minority young adults use these services. Sexual minority young adults face additional obstacles to sexual orientation identity development such as possible conflict and rejection from family and friends (Rotheram-Borus & Fernandez, 1995), rejecting presumed heterosexuality, and hiding one's sexual orientation (Rotheram-Borus & Langabeer,

2001). The challenges associated with developing a sexual minority orientation could influence why sexual minority youth use mental health services. The present study addressed the following questions: 1) why do LGBT young adults use mental health services and what factors predict mental health service use; 2) what factors predict the amount of mental health services ever used by LGBT young adults; 3) what factors are associated with mental health symptoms? Answers to these questions will enhance practitioner and researcher understanding of ways to better assist sexual minority young adults when in therapy, as well as providing therapists with research-based topics for further exploration when working with the LGBT population. This study also hopes to identify factors, other than therapy, that can contribute to the well being of these youth.

The present study was informed by recent research on same-sex attracted adolescent mental health service and depressive symptoms over time. McGuire et al. (2007) utilized data from the Add Health data set, a large, nationally representative sample of adolescents, to analyze youth sexual attraction and mental health service use. That study used a final sample of 10,153 adolescents to examine same-sex romantic attractions in adolescence (at Waves 1 and 2, ages 12-18) and associations with concurrent mental health services use at Waves 1 and 2, and subsequent depressive symptoms at Waves 2 and 3 (6 years later, in young adulthood, ages 18-24). McGuire and colleagues (2007) found that both-sex attracted youth were 80% more likely to have sought mental health services than their opposite sex attracted counterparts. When depressive symptoms were accounted for, both-sex attracted youth were still 64% more likely to have sought mental health services in adolescence than opposite sex attracted youth (McGuire et al., 2007). This finding suggests that some sexual minority youth are using mental health services for purposes other than coping with depression. One possible explanation for using therapy in the absence of depressive symptoms is that LGBT youth have fewer available

emotional resources to devote to coping with daily stress as many resources are already allocated to coping with the additional stress of being a minority. It may be that sexual minority youth seek mental health services as a means to better alleviate heightened stress levels and negative psychological symptoms associated with high levels of distress.

This paper utilizes a convenience sample of 197 LGBT young adults to discuss the influence of sexual orientation identity and personal identity on mental health. Additionally, the paper will address influence of sexual minority stress and its contribution to negative mental health symptoms, as well as the influence of sexual minority attitudes towards therapy and their effects on utilization mental health services. This study was designed to assess reasons LGBT youth use mental health services as well as to identify predictors of service use. It will utilize sexual orientation identity development and minority stress theory as frameworks for describing sexual minority mental wellbeing and mental health service use. Additionally, this study will look at the prevalence of negative mental health symptoms, risk and protective factors among LGBT youth, as well as attempt to establish the importance of understanding the specific needs of LGBT individuals.

CHAPTER 2

THEORETICAL BASIS

According to identity theorists, personal identity development takes years (Morrow, 2006) and typically begins during early adolescence (Rotheram-Borus & Langabeer, 2001). Identity theory has served as the basis for many works exploring various aspects of adolescent development. For the purposes of this paper, classical Eriksonian identity theory is used to conceptualize sexual orientation identity as a subsection of personal identity. Building from Erikson's (1950) work, Marcia (1966) constructed "personal identity statuses" which Rotheram-Borus and Fernandez (1995) applied to sexual orientation identity development. These conceptualizations of identity status act as the foundation for modern identity theory.

Identity Formation

Ego identity. Erikson (1950) envisioned ego identity as forming through conflict. He described crisis as two internal voices competing to be heard, commonly taking the form of an internal dialogue or external societal pressures to conform (Erikson, 1950). Erikson (1950) theorized that this conflict led to a crisis period through which identity formed. For instance, if one were forced to take and maintain a stance during conflict (crisis), one could eventually resolve the conflict and move to a new stage of development (Erikson, 1950).

Erikson's theory of identity development has served as the basis for many modern identity theories. For instance, Marcia's (1966; 1994a) conceptualization of identity development stems from Erikson's ego identity theory. Marcia's theory breaks down Erikson's stages of development into four distinct statuses characterized by the presence or absence of a *crisis period* and *commitment* (Marcia 1966; 1994a; 1994b). Commitment is described as "the degree of personal investment the individual exhibits" (Marcia, 1966, p. 551). *Identity diffusion* is

characterized by a lack of commitment to an identity, regardless of the presence or absence of a crisis period (Marcia, 1966). *Moratorium* is described as experiencing a crisis period while commitment remains undefined, whereas *foreclosure* is commitment without having experienced a crisis (Marcia, 1966). Finally, *identity achievement* is distinguished by having traversed a crisis period during which one evaluates possible alternatives and subsequently commits to an identity (Marcia, 1966). Identity development is a common experience for every adolescent; however, unlike most of their sexual majority peers (whose sexuality is presumed to be heterosexual), sexual minority youth must attend to developing a non-heterosexual sexual orientation (Rotheram-Borus & Langabeer, 2001).

Sexual orientation identity. Rotheram-Borus and Fernandez (1995) use an Eriksonian framework to describe youth sexual orientation identity development, focusing on the presence or absence of exploration and commitment. Rotheram-Borus and Fernandez (1995) altered the classical identity theory idea of crisis and commitment to one of information gathering (exploration) and preference (commitment). Instead of picturing identity development as psychic conflict, Rotheram-Borus and Fernandez envisioned a path of self discovery leading to commitment.

The connection between sexual orientation identity development and classic identity development can be made. Research has shown that developing other domains of identity progresses in much the same way personal identity development progresses (Rotheram-Borus & Fernandez, 1995). Although sexual orientation identity development is more frequently associated with sexual minority youth, both heterosexual and sexual minority youth must traverse different domains and statuses of sexual identity development to arrive at sexual identity achievement.

One of the major developmental tasks during adolescence is establishing an identity (Rotheram-Borrus & Langabeer, 2003); however, while most heterosexual youth are developing various domains of their personal identities, LGB youth must focus on the additional task of developing their sexual orientation identity (Rotheram-Borus & Fernandez, 1995; Remafedi, 1987) and often disclosing that identity or coming out. Throughout this paper, the terms "coming out" and "disclosure of sexual orientation" will be used interchangeably. Exploring one's same-sex sexual orientation and eventually coming out involves the recognition of oneself as different from the majority, defining what it means to be lesbian, gay, or bisexual, and exploring that emerging sexual orientation (Rotheram-Borus & Langabeer, 2001). Application of Erikson's (1950) description of identity formation to sexual orientation identity would predict that sexual minority youth develop their sexual orientation in a process that is very similar to developing a personal identity (Rotheram-Borus & Fernandez, 1995). For youth, identification as a sexual minority begins after the discovery that one's social attractions, emotional commitments, preferred erotica, and sexual partners are not exclusively heterosexual (Rotheram-Borus & Langabeer, 2001). This process frequently involves a time of sexual exploration (crisis period), self-labeling, and eventual disclosure. Sexual exploration can lead youth to an achieved sexual orientation identity, which is part of developing an achieved personal identity. However, the process of exploring one's sexuality is hindered by cultural heteronormativity and negative societal views of alternative sexualities (Rotheram-Borus & Langabeer, 2001). The more difficult task of developing a minority sexual orientation identity may require additional resources to help cope with normal daily stressors in combination with sexual orientation identity development.

The process of developing a minority sexual orientation typically takes years and is a significant period in the adolescent's life (Rotheram-Borus & Fernandez, 1995). Transitioning from identity diffusion to identity achievement may require many cognitive resources which could impact overall wellbeing and mental health service use. Other sexual minority researchers have suggested theories aimed at studying additional processes that could influence mental health and subsequent service use.

Minority Stress

The minority stress model stems from social stress literature (Meyer, 2003) and describes the term minority stress or gay stress as the chronic mental stress placed on persons of a minority group by individuals or society at large simply due to minority status (Meyer, 2003). The model provides a framework for understanding how chronic stress can influence mental health and wellbeing (Meyer, 2003) through the effects of societal stigma, prejudice, and cumulative stressors such as internalized homophobia and victimization, which can combine to contribute to the increased likelihood of negative mental health symptoms (Meyer, 1995). The minority stress model helps to explain the notion that sexual minorities are likely to have lifestyles that are incongruent with dominant cultural and societal expectations, which can lead to conflict between the individual and the dominant culture (Meyer, 1995; 2003). Minority stress processes have also been shown to relate to negative mental health in sexual minorities (D'Augelli & Hershberger, 1993). Researchers studying minority stress believe cumulative distress contributes to an increased likelihood of negative mental health symptoms (Meyer, 2003). Internalized homophobia, stigma, and experiences of discrimination are three of the most important contributing factors in minority stress (Meyer, 1995).

Contributors to minority stress. Internalized homophobia is often cited in the minority stress literature as being a significant predictor of negative minority stress outcomes (Meyer, 1995; 2003). Meyer (1995) describes internalized homophobia as the internalizing of negative societal attitudes toward one's self. Youth who identify as sexual minorities often encounter negative societal stigma (Meyer, 1995). Once youth have self-labeled as LGB, they often experience a time of transition and then disclose their sexual orientation to others. This transition begins in a period of moratorium and ends in identity achievement (Rotheram-Borus & Fernandez, 1995). This time of non-disclosure is a difficult period, in which many sexual minority youth present two personas while their sexual orientation is explored (Rotheram-Borus & Fernandez, 1995). During the process of self-labeling, sexual minority youth may "begin to apply negative attitude[s] to themselves, and [experience] the psychologically-injurious effects of societal homophobia" (Meyer, 1995, p. 40).

Another contributor to minority stress is perceived stigma, which can lead to an increased degree of vigilance. Vigilance is described as elevated levels of real or perceived stigma that can result in higher levels of expected rejection, expected discrimination, and expected violence (Meyer, 1995). Furthermore, vigilance can eventually lead sexual minority individuals to experience "fear and mistrust in interactions with the dominant culture, and a sense of disharmony and alienation with general society" (Meyer, 1995, p. 41).

Finally, experiences of discrimination and violence or prejudice contribute to minority stress. Recent political and cultural movements in American culture (such as the movement to constitutionally define marriage as between a man and a woman and state bans on same-sex marriage) have contributed to sexual minorities' feelings of persecution and marginalization.

Many parts of American culture hold negative opinions and stereotypes of sexual minorities which can contribute to feelings of isolation and condemnation.

Effects of minority stress. Meyer's (1995) work with 741 gay men in New York is one of the seminal articles discussing sexual minority stress and its effects on mental health. Studies looking at mental health in sexual minorities have considered feelings of internalized homophobia, perceived stigma, and prejudice events (Meyer, 1995) as factors contributing to minority stress. Meyer found that, when combined, internalized homophobia, stigma and prejudice events significantly predict negative psychological outcomes, suggesting that sexual minority stress does indeed have negative mental health effects. Though much of Meyer's work has been completed with gay male samples, minority stress theory can be generalized to other sexual minority populations (Meyer, 1995)

The effects of minority stress paired with assumptions that normal development occurs along a heterosexual trajectory (heteronormativity), dominate majority culture and fuel concealment of sexuality. Fear of family or peer rejection and previous experiences of discrimination can contribute significant psychological stress for sexual minority youth (Meyer, 2003) which may contribute to mental health service use. Additional theories analyzing reasons for service use among the LGBT population look toward social norms for answers.

Cultural Attitudes Toward Therapy.

Along with identity development and minority stress, cultural views of therapy may predict therapy use. Fewer cultural biases against therapy may translate into fewer barriers accessing those services. There is some evidence to support the idea that there are fewer norms against using mental health service within the sexual minority community (Morgan, 1992), which could explain the increased use of psychological services.

In a study of 100 lesbians and 309 non-lesbians, Morgan (1992) found that within the lesbian community, there was a significant difference in how therapy was perceived. The lesbian group reported more positive perceptions of therapy on all five subscales of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) than did a non-lesbian comparison group (Morgan, 1992). Following these results, Morgan (1992) also found that most lesbians in their sample (77%) reported having utilized psychotherapy or counseling in the past. This finding might suggest that increased community support leads to fewer barriers accessing mental health services in the lesbian community than in the heterosexual community. Another explanation might be that sexual minorities are more likely to experience distress which increases the likelihood of attending therapy and contributes to more positive attitudes toward therapy. Although these findings were about lesbians and non-lesbians, they may also be applied to the LGBT community in general. In either case, attitudes toward therapy are likely to be significant predictors of therapy use.

Increased service use. It may be that self-identified LGBT youth attend therapy more often for two reasons. First, self-identified LGBT youth may value introspection as well as be more accustomed to self exploration (Morgan, 1992), as they have already rejected the societal assumption of heterosexuality and arrived at their current sexual orientation identity. Additionally, self-identified LGBT youth have successfully traversed challenges specific to their sexual minority status as part of their identity search (Rotheram-Borus & Fernandez, 1995) and have committed to their sexual orientation (Meyer, 2003). This process of increased introspection and commitment may facilitate use of and disclosure to mental health professionals (Meyer, 2003) as LGBT young adults may be more comfortable with the introspective process of therapy. Second, LGBT youth may require help coping with the increased stress associated with

being a sexual minority (Morgan, 1992). As discussed earlier, LGB individuals frequently suffer from stress associated with being a minority. Meyer, (1995) documented decreased mental health associated with minority stress processes. It is possible that LGB individuals may also seek therapy as a way of coping with the minority stress processes.

Understanding sexual-minority attitudes toward therapy use could play an important part in understanding reasons LGBT youth use psychological services and identifying barriers to utilizing these services. Individuals who hold more positive perceptions of psychological services in their own lives may facilitate positive perceptions of mental health services to the LGBT community as a whole, and contribute to Morgan's (1992) finding that suggests fewer biases against mental health services.

Concepts such as sexual orientation identity development, minority stress, and attitudes toward psychological services all contribute information to understand reasons LGBT youth use mental health services. Minority stress theory touts communal norms or societal pressures as contributors to increased use. Living in a society that houses negative views about belonging to a sexual minority group contributes to psychological stress through experiences of harassment and victimization and feelings of self-loathing. Additionally, identity theory focuses largely on self-identifying as a sexual minority and the increased risk for mental health disorders associated with that process. Each theory contributes unique information, but by combining theories the proposed study hopes to paint a clear picture of why LGBT youth use mental health services.

CHAPTER 3

LITERATURE REVIEW

LGBT Mental Health

Across studies, sexual minorities have been shown to be at increased risk for mental health disorders (D'Augelli, 2002; Balsam et al., 2005) including suicidal thoughts, anxiety and depression (Russell & Consolacion, 2003). The prevalence of negative mental health symptoms for sexual minority individuals speaks to the importance of educating practitioners about working with sexual-minority clientele.

In a study of 542 self-identified LGB youth, D'Augelli (2002) reported that overall, LGB individuals had higher scores than a heterosexual comparison group on five of the nine Brief Symptom Inventory (BSI) scales which assesses mental health difficulties. D'Augelli's (2002) research showed that lesbian and bisexual females reported more symptoms on seven of the nine BSI scales (Depression, Anxiety, Somatization, Obsessive-Compulsiveness, Interpersonal Sensitivity, Phobic Anxiety, and Psychoticism) compared with the female heterosexual comparison group, while gay and bisexual males displayed more symptoms on three of the nine BSI scales (Depression, Obsessive-Compulsiveness, and Psychoticism) compared with the male heterosexual comparison group.

Much of what has been written about the same-sex oriented population has focused on measuring suicidality and self-harmful behaviors as proxies for mental health. Balsam et al. (2005) recently published research that compared the mental health of heterosexual adults and their sexual-minority siblings. Using a sample with an average age of 36, researchers compared 533 heterosexual siblings with 163 self-identified bisexual and 558 self-identified lesbian and gay participants. The authors examined prevalence rates for utilization of mental health

professionals among siblings (Baslam, et al., 2005). Their study found that LGB individuals reported suicidal ideation, self injurious behavior, suicide attempts, history of psychotherapy and psychiatric medication use more often than did their heterosexual siblings (Balsam et al., 2005). Balsam et al. (2005) also found that as a group, lesbians, gay men and bisexuals reported more risk for suicidality and self-injury than heterosexuals, though bisexuals were more likely to report self-injury than were lesbians or gay men. The overall findings suggest that LGB individuals experience more distress and utilize mental health services more than do sexual-majority individuals (Balsam et al., 2005). Though Balsam's sample was older than the 18-25 year-olds the proposed study used, the information reported is easily generalized to a younger sample.

The results of these studies indicate that many sexual minorities suffer from more negative mental health symptoms than do heterosexual peers and siblings. The increased rate of mental health symptoms may contribute to sexual-minorities increased use of psychological services; however, it is not the sole reason sexual minority young adults seek services.

Developmental Experiences

The literature indicates that sexual-minority mental health is correlated with minority stress and identity development. Specifically researchers have looked at the effects of moratorium identity status on sexually confused young adults, coming out as a sexual minority, family and friend reactions to coming out, harassment and victimization, and developmental experiences and processes that may contribute to decreased mental health.

Moratorium. Rose, Rodgers and Small (2006) reported on sexual identity confusion and problem behaviors using a sample of 299 sexually confused and 278 randomly selected non-confused 7^{th}-12^{th} graders. Their findings showed that sexually confused young adults (young

adults in moratorium) were more at risk for problem behaviors such as delinquency, substance use, running away, depression, and suicidal thoughts than were non-confused peers (Rose, Rodgers & Small, 2006). Their findings are consistent with Erikson's expectation of increased negative outcomes for young adults in moratorium. Minority stress may also play a part in explaining some of their findings. The literature states that minority stress is correlated with negative mental health symptoms (Meyer, 1995; 2003). Rose and colleagues' findings may illustrate that although sexually confused young adults do not identify as LGBT, they still might feel pressure from society to conform to a heterosexual developmental trajectory. This societal stigma could act as a contributing factor to minority stress for sexually confused young adults.

Coming out experiences. Academics who study sexual minorities agree that coming out is a significant transitional period in the life of an LGB adolescent that has important effects on mental health (Russell & McGuire, 2006). Disclosing one's sexual orientation is a process many sexual minority young adults go through in an attempt to reduce the stress associated with hiding a non-heterosexual orientation. A study conducted with 2,401 sexual-minority women found that coming out was negatively correlated with psychological distress (Morris, Waldo, & Rothblum, 2001). Additionally, this study found that lesbians who had disclosed their sexual orientation reported that coming out was important and that they were not afraid of others discovering their sexual orientation (Morris et al., 2001). Other researchers have found that LGB individuals who are not out may hide their sexual orientation because of internalized self-loathing or fear of violence from others (Meyer, 1995; 2003) both of which negatively affect mental health (Meyer, 1995).

A study done by D'Augelli (2006) using a 543 person sample (62% male) found that on average 14-21 year-olds in his study were aware of their same-sex attraction at approximately

age 10, self labeled approximately five years after initial awareness, and disclosed their sexual orientation at age 17. The current literature puts forth a theory stating that the longer one is self-identified as LGBT the more likely he or she is to come out. This theory also suggests that young adults who are open about their sexuality, and who are self assured enough to take place in a survey, may also be at less risk for mental disorders than a closeted peer (D'Augelli, 2002).

Morris et al. (2001) theorize that "outness" affects mental health because of developmental milestones individuals must reach before they are ready to disclose their sexual orientation, such as questioning their sexual orientation. Research conducted using 2,401 lesbian and bisexual women has shown that the more supported by and involved in the LGBT community these women were, the more likely they were to be out (Morris et al., 2001). Researchers reported that developmental issues, identity, and awareness of a larger community were all related to being out (Morris et al., 2001). It is possible that coming out is positively correlated with mental health not simply as a result of disclosing sexual minority status, but by the process of growth and self-discovery along the way. In this sense coming out could be viewed as a symptom of developmental maturity. Those who have openly self-identified as LGBT are more likely to have traversed sexual orientation milestones (Morris et al., 2001), thus facilitating greater mental health (D'Augelli, 2002).

Family and peer reactions. Much of an adolescent's environment is composed of family and peers, and their perceptions and opinions can have a significant influence. For example, D'Augelli's (2002) study of 542 LGB young adults indicated that when parents or peers reacted negatively to coming out as a sexual minority, young adults were more likely to display negative mental health symptoms. Although family reactions are important, young adults commonly rely on their peers for social support. A small study of 12 LGBT 18-21 year-olds found that family

only provided minimal support while non-family members (peers and non-family adults) provided more emotional and instrumental support (Mufioz-Plaza, et. al., 2002). This information indicates that peer reactions to coming out are an important part of the larger coming out process. Although these findings are important, this study is small and should be replicated with a more diverse and larger sample size.

Family relationships may also affect youths' decision to come out. Surprisingly, D'Augelli, Grossman, & Starks (2005) found that of their 293 self-identified LGB youth, those who experienced more verbal victimization from parents were more likely to disclose their sexual orientation. The researchers suggest that atypical gender presentation (e.g. a boy's interest in fashion or a girl's interest in carpentry) may play a part in this association and that more atypical gender-typed behavior is predictive of parental suspicion of a minority sexual orientation (D'Augelli, et al., 2005). The researchers believe that the more gender atypical behavior youth present, the more this behavior provokes negative comments from parents which can lead to coming out (D'Augelli, et al., 2005). Although these situations may not facilitate positive family interactions immediately, they do facilitate disclosure of sexual orientation which D'Augelli and colleagues (2005) suggest might improve parents' responses over time. Additionally, the researchers found that children of parents who were aware of their child's sexual orientation showed less internalized homophobia and may receive less verbal victimization as a result of the disclosure. When sexual orientation is disclosed to parents and friends, the effects on mental health can be positive (D'Augelli, 2002; Morris et al., 2001).

Victimization. Experiences of harassment and victimization can also influence the mental health of sexual minorities. D'Augelli and Hershberger (1993) used a primarily (73%) male sample of 194 LGB young adults aged 21 and younger to look at mental health outcomes in

community settings. The researchers identified a number of barriers to disclosing sexual orientation, including fear of job loss, losing friends, verbal harassment at home and school, and physical abuse at home and school (D'Augelli & Hershberger, 1993). Most (95%) of the young adults in the sample were in varying stages of coming out, which shows that most of the sample had overcome some barriers to coming out. D'Augelli and Hershberger (1993) found that of the entire sample, 22% feared verbal abuse from parents compared with the 42% of undisclosed young adults. A later report written by Hershberger and D'Augelli (1995) using the same dataset stated that the combination of family support and self acceptance mediated the relation between victimization, negative mental health, and suicide. The researchers posit that family support increases self acceptance, which, in turn, reduces the negative outcomes of mental health problems and suicide (Hershberger & D'Augelli, 1995).

A small, exploratory study of seven females and five males found that school climate and peer reactions contribute to LGBT young adults' feelings of alienation (Mufioz-Plaza et al., 2002). Feelings of alienation were not elicited by specific comments from others, but rather derived from negative messages about homosexuality in school (Mofioz-Plaza, et al., 2002). One young adult reported wanting to disclose his sexual orientation, but feared the verbal victimization he witnessed directed toward other openly gay students (Mofioz-Plaza et al., 2002). As shown in the minority stress literature, feelings of societal disapproval and previous experiences of discrimination can contribute significant psychological stress to sexual minority young adults (Meyer, 2003) which may lead to decreased mental health (Meyer, 2003).

Social relationships. Research on adolescent dating relationships has emphasized the developmental importance of dating during adolescence (Collins, 2003; Brown, 1999) and has indicated that heterosexual youth who forego romantic relationships may face a deficit in

psychosocial development (Diamond, 2003; Collins, 2003; Graber & Archibald, 2001). These findings may also be generalizable to same-sex romantic relationships. In navigating the developmentally normal trials associated with relationship, sexual majority teens learn how to manage a wide range of emotional complexities (Diamond, 2003). Diamond, Savin-Williams, and Dubé (1999) suggest that youth with fewer romantic experiences (e.g. adolescents who are unfamiliar with the opposite sex or who are especially shy) may exhibit decreased social competence (Diamond, et al., 1999) and emotional health (Russell & Consolacion, 2003).

Sexual minorities, especially in more rural communities, do not frequently have the same opportunities to date their chosen partners as many heterosexual youth do (Diamond, et al. 1999), in part because there are low numbers of available companions but also because of fear of retaliation if their sexuality is discovered. Sexual minorities may lack the skills (Diamond et al., 1999; Diamond, 2003) and knowledge (Collins, 2003) typically gained from developmentally normal experiences associated with romantic relationships (Russell & Consolacion, 2003). Cultural norms regulating acceptable romantic partnerships can affect romantic relationships and subsequent development (Collins, 2003). As such, dating may be an underdeveloped custom among sexual minorities (Diamond, et al., 1999).

Peers and older mentors sometimes act as an informal socialization network providing sexual-minority young adults with important developmental experiences (Diamond, et al., 1999). Because sexual-minority young adults lack access to the same kinds of interpersonal relationships their heterosexual peers have, they may be less knowledgeable of socio-cultural norms. Experiences with same-sex dating may provide young adults with functional, hands-on experiences (Diamond et al. 1999), such as romantic breakups and fights with friends. These

experiences, though not pleasant, contribute to a crucial understanding of social mores and provide tools to cope effectively with interpersonal turbulence (Diamond, 2003).

As previously discussed, not only has coming out been shown to decrease the effects of some minority stressors, but also to reduce negative mental health symptoms (Morris et al., 2001). It is possible that the interpersonal support received from friends and family as a result of coming out could increase emotional wellbeing by allowing young adults to express distress and receive support. We see this same type of protective support expressed through romantic relationships that were once inaccessible. As dating increases, so does access to community resources and social networks (Diamond, et al., 1999). It may seem counterintuitive that a sexual-minority young adult in a same-sex relationship would be protected by the very thing that is making his or her separation from sexual majority peers more salient (Russell & Consolacion, 2003). It is possible, however, that the same-sex romantic partner functions as a supporter and confidant.

There is some contention among researchers about the effect of adolescent dating on emotional development. Some researchers say that sexual-minority young adults are deprived of normal developmental experiences, while others claim that heterosexuals who participate in romantic relationships experience negative emotional effects (Joyner & Udry, 2000).

There are many factors that contribute to increased mental health symptoms among LGBT young adults. When looking at minority populations, there are sometimes unique issues that can affect mental wellbeing. The current literature on sexual minority mental health provides a sense of the primary contributors to negative outcomes. The effects of moratorium identity status on sexually confused young adults, concealing one's sexual orientation, negative family

and friend reactions to coming out, harassment and victimization, and fewer developmental experiences have all been shown to relate to decreased mental health.

Limitations of LGBT Research

Much of the current psychological literature available on the LGBT population primarily focuses on the narrow topic of increased risk for suicide and self-injurious behavior. Only limited research is available that addresses other factors that influence sexual minority mental health. However, with more research being published on LGBT individuals, it seems that clinicians remain ill-equipped to help their sexual-minority clientele. Sexual-minority individuals report decreased satisfaction with mental health services (Avery, Hellman, & Suddeth, 2001). Research on 67 sexual-minority adults who used mental health services showed that LGB individuals were more dissatisfied with their experience in therapy than were a group of 301 control participants (Avery et al., 2001). The decreased satisfaction with therapy may be because of therapists' lack of education in minority issues and lack of empathy, as many therapists have not had the training needed to effectively address the specific need of the sexual minority population. The proposed study hopes to provide practitioners with much needed information regarding reasons sexual-minority young adults attend therapy and outline needs specific to LGBT young adults.

As outlined earlier, research has shown that sexual-minority young adults have an increased prevalence of mental disorders, increased use of professional mental health services, and increased emotional wellbeing correlated with coming out. If research can determine what factors lead sexual-minority young adults to seek mental health services and why there are significantly greater numbers of these young adults attending therapy, then school officials,

policy makers, clinicians, parents, and peers can be educated about what can be done to foster mental health.

The study of LGBT young adults is an emerging area of research and because of the recent surge in interest, the literature that is available is still limited on a variety of subjects. Obtaining a representative sample is the most common limitation in the literature for sexual minority research. Moreover, differentiation of self-identified from non-self-identified LGBT population poses problems. Simply locating the non-self-identified populations is difficult, which often leads to small sample sizes.

Overall, the proposed study hopes to look at links between mental health, and stressors associated with a same-sex sexual identity. The proposed study seeks to answer the following questions: (a) why do LGBT young adults use mental health services and what factors predict mental health service use; (b) what factors predict the amount of mental health services ever used by LGBT young adults; (c) What factors are associated with mental health symptoms?

The current study hopes to document reasons sexual-minority young adults use mental health services by reporting descriptive statistics for reasons they have used or would consider using therapy.

H1: It is hypothesized that coming out, attitudes toward therapy, and sexuality-based reasons for therapy will predict *any* mental health service use above and beyond the influence of mental health and demographic factors.

H2: It is hypothesized that sexuality-based reasons for therapy use, coming out experiences and minority stress experiences will predict the *amount* of mental health service use above and beyond the influence of demographic factors and mental health.

H3: It is hypothesized that minority stress experiences and sexuality-based reasons for therapy will predict decreased mental health above and beyond the influence of demographic factors.

CHAPTER 4

METHOD

Participants

The original sample for the current study was comprised of 212 17-41 year-olds (M = 21.7, SD = 3.55). Of the original sample 104 participants identified as male (49%), 90 identified as female (42.5%) and 18 identified as transgender or gender questioning (8.5%). There was good diversity represented among racial groups with 69% reporting European American, 7.1% Hispanic/Latino/a, 6.2% African American, 3.3% American Indian, 1.9% Asian American and Pacific Islander and 12.3% other or mixed race.

A total of 15 participants were excluded (10 males and 5 females) from analysis because they did not fall within the desired age range (18-26). An independent samples t-test showed that there were some significant differences between the analytic sample and the omitted 15 participants. The omitted sample was statistically different with regards to their city of residence $t(20) = -2.44$, $p < .05$, their transgender identity, $t(195) = -4.44$, $p < .001$, and their number of same sex sexual partners, $t(208) = 2.47$, $p < .05$. Therefore, the current study utilized an analytic sample of 197 self-identified LGBT young adults, aged 18 to 26 (M = 21.1, SD = 2.34) who lived in Washington State/Idaho (66%), Arizona (21%), and Washington D.C. (10%). Self-identified females comprised 43.1% of the sample while 9% of the sample reported a transgender or questioning gender identity. Additionally, 30% of participants reported identifying as an ethnic minority composed of Hispanic/Latino/a (7.1%), African American (6.6%), American Indian (2.6%), Asian American and Pacific Islander (2%) and other or mixed race (11.7%).

Participants were recruited from pride festivals and other LGBT community events, from advertisements on public bulletin boards, and from existing university-sanctioned LGBT student

groups. Contacts in the LGBT community were also asked to distribute surveys to acquaintances. Approximately 50% of the sample was enrolled in school at the time of sampling. Although data were collected in a number of locations throughout the country, there were only a few differences in the samples surveyed at different locations. A one-way Analysis of Variance (ANOVA) indicated that there were significant differences in experiences of harassment, internalized homophobia, ever having used therapy and amount of therapy between the sampling areas (see Table 1). However, when survey location was entered into the regression models for hypothesis testing, location was non-significant as a predictor of outcomes and was omitted.

Procedures

In order to maintain participant anonymity, implied consent (which does not require a participant's signature) was used rather than standard informed consent forms. Washington State University Institutional Review Board agreed that the use of implied consent procedures would provide the most accurate data with the least risk to participants. Participants were given a letter informing them of the study's aims and possible risks. The participants were also informed that by completing the survey they were providing consent for the use of their data (see Appendix A for IRB approval and consent material). A nine page, self-report questionnaire was administered, taking approximately twenty minutes to complete (see Appendix B for the measures). Upon completing the survey, participants were offered a gift of $5.00 and were provided a list of local and national resources including counseling centers, support groups, health services, and crisis hotlines. Of those who completed surveys, 29 participants (14.5%) did not take the $5 gift.

The coding scheme for qualitative data was developed based on established findings from existing literature, theoretical frameworks such as identity theory or minority stress, and other participant responses that did not fit into either of the previous categories (see Appendix C for

the coding scheme). Initial inter-rater reliability established a 99.4% agreement among three coders across the entire survey; however, agreement among the open-ended responses was lower. To accommodate the open ended responses, all 212 surveys were double coded. Discrepancies between the coders were discussed until consensus was reached. All surveys were then double entered by two research assistants into the statistical analysis program SPSS, and discrepancies corrected. The two SPSS files were compared and cleaned by merging the two datasets into one file. The process involved comparing each case from the two separate datasets. Each case with no discrepancies was copied to a new dataset. Each case with a discrepancy between dataset 1 and dataset 2 was imported twice, one line being dataset 1 and the other line being dataset 2. Each of the mismatched cases was flagged and the two cases compared to the original survey and corrected. This process was repeated until there were no discrepancies. Most of the errors in the data entry were due to column shift errors.

Measures

Demographics. Participants were asked to write in their age, race, and average grades (see Table 2 for descriptive statistics on variables). A dichotomous ethnic minority variable was created by coding race into two groups. Participants who identified as mixed race or a racial minority were coded as 1 (30%) while participants who identified as European American were coded 0 (70%). Additionally, a dichotomous good student variable was created by coding participants into two groups. Participants who reported receiving average grades of B or better were coded as 1 (26.9%) while average grades of below B were coded as 0 (73.1%). Participants were asked to indicate their gender from a list (male, female, transgender – male to female (MtF), transgender – female to male (FtM), questioning, or other). A dichotomous gender variable was created by coding participants who identified as female as 1 (43.1%) and anyone

who identified as not female as 0 (56.9%). A dichotomous transgender variable was created. Participants who marked MtF, FtM, gender questioning, or filled in other gender were coded as 1 or transgender (9.1 %) while anyone who did not identify as transgender, questioning or other were coded as 0 or not transgender (90.9%). Sexual orientation was measured using a modified version of the Kinsey scale (Kinsey, Pomeroy, & Martin, 1949). The Kinsey scale used a 7-point Likert-type scale with three anchor points: "exclusively heterosexual" = 0, "bisexual = 3, and "exclusively homosexual" = 6 (M = 4.2, SD = 1.82). Participants were asked to write in how many same-sex sexual partners they have had in their lifetime. A dichotomous variable was created identifying participants with a high number of same-sex sexual partners. Participants who reported seven or more same-sex sexual partners were coded as 1(26.4%), while participants who had fewer than seven same-sex sexual partners were coded as 0 (73.6%). The dichotomous variable assessing current school enrollment status was coded 1 if the participant was currently enrolled (49.2%) and 0 if they were not enrolled (50.8%). A dichotomous variable was created documenting current city of residence. Participants who lived Idaho or Washington were coded as 1 (66.5%) while participants who lived in Arizona or Washington D.C. were coded as 0 (33.5%). Finally, the dichotomous variable assessing monogamous relationship status was coded 1 if the participant was currently in a monogamous relationship (43.1%) and 0 if they were not in a monogamous relationship (56.9%).

Depression. The current study utilized an eight-item version of the Center for Epidemiological Studies Depression Scale known as the CES-D8 (Wight, Sepúlveda, & Aneshensel, 2003). Initially developed for use with an older sample, the full version of the Center for Epidemiological Studies Depression Scale (CES-D) has been found to be reliable in junior high school aged samples (Radloff, 1991). Radloff (1991) reported a coefficient alpha of

.81 for the CES-D using a college-age sample. In an attempt to shorten the full CES-D, researchers created the CES-D8, which consists of eight items from the larger 20-item scale which represents the larger construct of depression (Wight et al., 2003). Wight and colleagues (2003) found the 8-item version of the CES-D to correlate strongly with the full version of scale using the National Health and Nutrition Examination Survey (NHANES) dataset, a nationally representative adult sample, as well as correlate strongly with a 16-item version from the Add Health data set, a nationally representative young adult sample. Additionally, Wight and colleagues (2004) found the CES-D8 maintains internal consistency reliability using both the NHANES and Add Health reporting coefficient alphas of .76 and .79 respectively.

Participants were asked to report how often they felt or experienced each scale item in the past week (Radloff, 1991). Items included: "rarely or none of the time (less than 1 day)," "some or little of the time (1-2 days)," "occasionally or a moderate amount of time (3-4 days)," or "most or all of the time (5-7 days)" (Radloff, 1991). One item was from the somatic and retardation subscale, "I did not feel like eating; my appetite was poor"; two items were from the happiness subscale, "I felt happy" and "I enjoyed my life"; two items were from the interpersonal subscale, "people were unfriendly" and "I felt that people disliked me"; three items were from the depressed affect subscale, "I felt depressed," "I felt lonely," and "I felt sad" (Wight et al., 2004). The two positively worded items, felt happy and enjoyed life, were reverse scored to yield a depression score (Wight et al., 2004).

Anxiety. Participants answered questions taken from the anxiety subscale of the Brief Symptom Inventory (Derogatis, & Melisaratos, 1983). Derogatis and Melisaratos (1983) reported significant correlations with other measures of anxiety, demonstrating high convergent validity as well as a Chronbach's α of .81. Participants were asked to "indicate how much [each]

problem has bothered or distressed [them] during the past week, including today." Specific items for this subscale included: "nervousness or shakiness inside," "suddenly scared for no reason," "feeling fearful," "feeling tense or keyed up," "spells of terror or panic," and "feeling so restless you could not sit still" (Derogatis, & Melisaratos, 1983). Responses were provided using a 5-point Likert-type scale: not at all = 0, a little bit = 1, moderately = 2, quite a bit = 3, extremely = 4, and a "refuse to answer" option.

A principle components factor analysis was conducted with the CES-D8 and the anxiety subscale of the BSI which yielded three potential factors with eigenvalues above one. However, based on the theoretical reasoning behind the two separate scales, a factor analysis with two specified factors was performed. This structural factor analysis showed two distinct factors, one comprised of the items in the CES-D8 and the other factor comprised of items in the anxiety BSI (see Table 3). Reliability for the CES-D8 produced a Chronbach's α of .82 and an α of .87 for the anxiety scale of the BSI. Two new scales were created by finding the averages of each item in the CES-D8 (M = .85, SD = .61) and the anxiety BSI subscale (M = 1.22, SD = .95) respectively. Additionally, the present study calculated a combined scale by computing the means of the standardized Z-scores of each item in the CES-D8 and anxiety subscale of the BSI (M = .003, SD = .64). A factor analysis with two specified factors was performed which showed two distinct factors, one comprised of the items in the standardized CES-D8 and the other factor comprised of items in the standardized anxiety BSI (see Table 4).The scale assessing mental health maintained good reliability with a coefficient alpha of .88.

Internalized homophobia. The proposed study assessed levels of internalized homophobia using the Internalized Homophobia Scale or IHP (Herek, Cogan, Gillis, & Glunt, 1998). Participants reported their feelings using a 5-point Likert-type scale ranging from "disagree

strongly" to "agree strongly (Herek, et al., 1998). Herek, et al. (1998) reported a separate reliability for the men's scale (α = .83) and women's scale (α = .71) using the original 150 person sample. Nine items from the original gender specific scales were modified for the proposed study to be gender neutral. Items that specified a sex, gender, or gendered sexual orientation (e.g. lesbian, or gay) were altered to create a universal format. For example, a question reading: "I have tried to stop being attracted to women in general" (Herek, et al., 1998) was changed to read: "I have tried to stop being attracted to the same sex in general."

Harassment and victimization. Scales derived from the California Safe Schools Coalition survey (CSSC) were used to assess harassment based on gender presentation and sexual orientation (O'Shaughnessy, Russell, Heck, Calhoun, Laub, 2004). Participants were asked to rate how often they hear others make negative comments based on sexual orientation and gender presentation. Participants responded with "never," "rarely," "sometimes," or "often" on a 0-3 Likert-type scale (O'Shaughnessy et al., 2004). Participants were also asked "during the past 12, months how many times were you harassed for any of the following reasons," "because you are gay, lesbian, bisexual or someone thought you were," "because you weren't 'masculine enough,'" "because you weren't 'feminine enough,'" and "because you didn't fit in" on a 0-3 Likert-type scale. Possible responses were "0 times," "1 time," "2-3 times," or "4 or more times" (O'Shaughnessy et al., 2004).

A principle components factor analysis was conducted on the IHP and the harassment and victimization scales which yielded six potential factors with eigenvalues above one. However, because these two scales were used as proxies for measuring minority stress, combined with the theoretical reasoning behind using the two scales, a factor analysis with two specified factors was performed. This structural factor analysis showed two distinct factors, one

comprised of the items in the IHP and the other factor comprised of items in the harassment and victimization scale (see Table 5). Reliability analysis for the IHP produced a Chronbach's α of .87 and reliability for the harassment and victimization scale yielded a coefficient α of .74. Two new scales were created by finding the averages of each item of the IHP (M = .74, SD = .76) and the harassment and victimization scales (M = 1.07, SD = .68) respectively.

Attitudes toward psychological help. Young adults' attitudes toward psychological services were measured using a version of the Attitudes Toward Seeking Professional Psychological Help Scale or the ATSPPHS (Fischer & Turner, 1970). The ATSPPHS has been used to measure attitudes of self identified lesbians toward mental health services (Morgan, 1992). A 10-item, modified version of the scale, the ATSPPHS-10, was published with Fischer and Farina (1995) revising the longer version (Fischer & Turner, 1970). The new measure reduced the scale from the original 29-items to 10-items while preserving the scale's validity. Example items from the scale include: "I would want to see a therapist if I were worried or upset for a long period of time" or "personal and emotional troubles, like many things, tend to work out by themselves" (Fischer & Farina, 1995). Participants were asked to rate how much they agreed or disagreed with the various statements regarding therapy using a 4-item Likert-type scale. The original scale had an internal reliability score of .86 and .83 in two samples (Fischer & Turner, 1970) and the ATSPPHS-10 yielded an α of .83 which is comparable to the older version of the test (Fischer & Farina, 1995). Of the 10 items, five were reverse scored with higher numbers indicating more positive feelings toward therapy. When a factor analysis was run with all 10 items the factors loaded into two constructs: positively worded attitudes toward therapy and negatively worded attitudes toward therapy. Because the scale has been previously validated and published, and based on the original concept of the scale, all ten item means were combined

into one scale measuring attitudes toward therapy (see Table 6 for unrotated principal components analysis; $M = 1.53$, $SD = .52$, $\alpha = .66$).

Use of services. Participant history of mental health service use was assessed using items based on Balsam and colleagues (2005) report examining LGBT individuals and their heterosexual siblings mental health service use. This measure identified the frequency, length and severity of mental health symptoms and history of service use. Participants were asked four questions: "are you currently in counseling or therapy," "do you feel these services have helped you to resolve the issues," "have you ever been in counseling or therapy," and "did you feel these services helped to resolve the issues." Respondents answered with either "yes," "no," or "don't know," with skipped or don't know responses omitted from analysis. Finally, open ended questions asked participants "approximately when was your last therapy visit" and "approximately how many total months did you see a therapist." Both of these variables were coded into months since last therapy visit and months in therapy respectively.

For the purposes of this study, only two of the above items were used. Participants were coded 1 if they had ever been to therapy (50%) and 0 if they had not ever been to therapy. Participants also indicated, in months, how long they had been in therapy. Because approximately half of the sample had not been to therapy and the other half reported a large range of months they had attended therapy (1-180 months), we split the responses into three groups. A new variable was created where 0 = no months of therapy (50%), 1 = 1-4 months (26%) and 2 = five or more months of therapy (24%)

Reasons for therapy use. Measures developed for the current study assessed reasons participants reported using mental health services in the past, reasons they think they *might* use services hypothetically, and reasons they think *other* sexual minorities might use services.

Participants were asked to "talk about why you went to therapy" in a short paragraph with the option of checking "not applicable." Based on participant responses to the open ended question, larger categories for reasons of service use were developed. Coders grouped responses into themed categories. Participant responses could be grouped into multiple categories to more accurately reflect multiple reasons for use. For example, if a participant wrote they went to therapy because a school counselor told them they had to attend therapy after a suicide attempt, then that would be coded as "suicidality" and "recommendation." Discrepancies were discussed until consensus was reached.

Next, participants were asked to select the top five reasons, from a list of thirteen, they had attended therapy in the past. Participants could choose from: "issues relating to family/friends," "help coming out/sexual orientation identity," "desire to talk with an advocate," "a friend recommended therapy," "conflict between moral beliefs or religion and sexuality," "romantic relationships," "self-esteem/body image," "depression," "anxiety," "harassment/victimization," "help dealing with stress," "drugs/substance use," an open ended "other" category and "not applicable (I did not attend therapy)." Next, participants were asked, "thinking hypothetically, if you were to attend therapy, how likely would the following be reasons for using mental health services?" Participants provided scores from their personal (self) perspective as well as why they believed another LGBT young adult (other) would use therapy. Participants responded using the same categories as the thirteen reasons for therapy listed above. Participant responses were reported using a Likert-type scale ranging from "not at all likely" (1) to "extremely likely" (7).

Using open ended, list, and Likert-type questions, large themed variables were computed. Based on the frequencies and the theoretical basis behind the current study, we organized

responses into three primary categories LGBT young adults reported attending therapy: Sexuality related reasons for attending therapy, mental health reasons for attending therapy and general reasons for attending therapy. Participants' hypothetical responses for why they thought other LGBT young adults would attend therapy were omitted in the interest of tapping into actual reasons participants had or would attend therapy rather than perceptions of reasons others went to therapy. Three themes emerged for reasons for mental health. One theme that emerged was based on reports of attending therapy for mental health reasons like: Attention Deficit Disorder, self-mutilation, Bipolar Disorder, anger management, suicidality, substance use/abuse, depression, and anxiety. Another theme that emerged was based on reports of attending therapy for sexuality related reasons like: conflict between religion, transitioning to new gender, gender presentation, sexual identity, parental education, recommendation from others, romantic relationships, reparative therapy to "fix" sexuality, coming out to parents and family, and sexual orientation identity. The last theme that emerged was based on reports of attending therapy for general reasons like: school problems and achievement, desire to talk to an advocate, harassment, stress, personal identity, parent's divorce, death, parent neglect/abandonment, parental abuse, partner abuse, and reasons explicitly not about sexuality. Each variable was coded as 1 if the reason indicated as an actual or hypothetical reason for therapy and 0 if it was not. For the purposes of the current study, the three larger themes were dummy coded into one dichotomous variable. If participants reported sexuality related reasons for attending therapy they were coded as 1 and were coded 0 if they reported other non-sexuality related reasons for attending therapy.

Support for coming out. Participants were asked how open they are about their sexuality with their family using a 4-point Likert scale (D'Augelli, 2002). Answers could range from "I'm closeted from them all" = 1 to "They all know" = 4 (D'Augelli, 2002). Similarly, participants

were asked about their openness relating to their sexual orientation with their mother, father, sibling(s), and friends on a 4-point scale with choices of, “Definitely knows and we have talked about it” = 3 to “Does not know or suspect” = 0. Furthermore participants were asked if they had disclosed their sexual orientation to their mother, father, sibling(s) or friends and how they had reacted to the disclosure. Participants provided responses to these items on a 4-point scale ranging from 1, accepting, to 4, rejecting.

A principle components factor analysis was conducted on the openness and reaction items which yielded three potential factors with eigenvalues above one. However based on the structure of the items and the theoretical framework behind the questions, items were computed into two variables measuring openness about sexuality to family and friends and reactions from family about coming out (see Table 7). The items measuring openness to family and friends were computed into one variable ($M = 2.25$, $SD = .75$, $\alpha = .82$) combining family in general, mother, father, sibling(s) and friends. The other items measuring mother, father and sibling(s) reaction to coming out were computed into one variable ($M = 2.28$, $SD = .75$, $\alpha = .66$) providing researchers with a general idea of the family’s acceptance of the participant’s sexuality.

CHAPTER 5

ANALYSIS

First Research Question

One goal of the proposed study is to identify reasons LGBT young adults attend therapy. From this goal the proposed study attempted to answer the following research questions: Why do LGBT young adults use mental health services and what factors predict mental health service use? Hypothesis one is formed from research question one.

> **H1**: It is hypothesized that coming out, attitudes toward therapy, and sexuality based reasons for therapy will predict *any* mental health service use above and beyond the influence of mental health and demographic factors.

Descriptive statistics. Frequencies and descriptive statistics were used to analyze reasons for mental health service use. Information assessing the likelihood of participants attending therapy, possible reasons other LGBT young adults might attend therapy, top five reasons they attended therapy, and participant generated themes of reasons why they attended therapy were used to calculate these statistics.

Logistic regression. We considered a myriad of factors simultaneously to determine what predicted service use. A logistic regression was conducted with services ever used as the dependent variable. The initial equation for the plan of analysis read: services ever used = (female + transgender + number of same sex sexual partner + residency + good student + monogamous relationship + Kinsey score + age + depression + anxiety) + (internalized homophobia + victimization + sexual orientation identity) + (attitudes toward therapy+ sexuality reasons for therapy) + (openness + reaction). To conserve degrees of freedom and to reduce the likelihood that variables would interfere with each other's estimated variability, items that were

not correlated at the bivariate level were left out of analyses (see Tables 8 and 9 for correlations of variables). Additionally, if neither variable in a proposed step was significant, the step was removed.

After non-correlated variables were removed, the regression model retained demographics and concurrent mental health symptoms entered in the first step, attitudes toward therapy and sexuality related reasons for therapy in the second step, and openness to family and friends and family reaction to coming out in the third step. The final analytic structure of the regression is summarized by the following equation: service ever used = (depression + anxiety + ethnic minority + number of same-sex sex partners) + (attitudes toward therapy + sexuality reasons for therapy) + (openness + reaction). The analyses were run in this order in hopes of describing significant reasons LGBT young adults use therapy. Controlling for demographics, depression, and anxiety by entering those variables first, the analyses entered attitudes toward therapy and sexuality reasons for therapy as predictors of therapy use. These variables were entered next because LGBT young adults may experience fewer barriers to utilization of services and have already considered or attended therapy will likely predict current or future therapy use. Finally coming out factors were entered last as they were expected to account for variability in service use above and beyond that already estimated by the combined other steps.

Second Research Question

What factors predict the amount of mental health services ever used by LGBT young adults? Hypothesis two stems from research question two.

> **H2**: It is hypothesized that sexuality reasons for therapy use, coming out experiences and minority stress experiences will predict amount of mental health

service use above and beyond the influence of demographic factors and mental health.

Multinomial regression. We considered a myriad of factors simultaneously to determine what predicted amount of service use. A multinomial regression was conducted with amount of services used as the dependent variable. Amount of service use was divided into three groups: no therapy, 1-4 months of therapy, and five or more months of therapy. For the multinomial regression, no therapy and 1-4 months of therapy were compared to five or more months of therapy. This means that the likelihood each variable predicting amount of service use was compared to no therapy versus five or more months of therapy, or 1-4 months of therapy versus five or more months of therapy.

The initial equation for the plan of analysis read: amount of service ever used = (female + transgender + number of same sex sexual partner + residency + good student + monogamous relationship + Kinsey score + age + depression + anxiety + internalized homophobia + victimization + sexual orientation identity + attitudes toward therapy+ sexuality reasons for therapy + openness + reaction). To conserve degrees of freedom and to reduce the likelihood that variables would interfere with each other's estimated variability, items that were not correlated at the bivariate level were left out of analyses. Additionally, if neither variable in a proposed step was significant, the step was removed. After non-correlated variables were removed, the regression model retained demographics, coming out variables, and sexuality related reasons for attending therapy. LGBT attitudes toward therapy significantly correlated with amount of therapy use, however, attitudes toward therapy is so proximal to amount of therapy ($r = .43$, $p < .001$) that when it was included in the model it did not allow other effects to show. Because we

were most interested in coming out and minority stress as predictors of amount of therapy, we omitted it from analysis

The final analytic structure of the regression is summarized by the following equation: amount of service used = (good student + number of same-sex sex partners + sexuality reasons for therapy + openness + reaction). The analyses were run in this order in hopes of identifying the likelihood of the independent variables predicting amount of therapy use.

Third Research Question

What factors are associated with mental health symptoms? Hypothesis three stems from question three:

> **H3**: It is hypothesized that minority stress experiences and sexuality reasons for therapy will predict decreased mental health above and beyond the influence of demographic factors.

Multiple linear regression. We considered a myriad of factors simultaneously to determine what predicted negative mental health symptoms. A linear regression was conducted with negative mental health symptoms as the dependent variable. The initial equation for the plan of analysis read: negative mental health symptoms = (female + transgender + number of same sex sexual partner + residency + good student + monogamous relationship + Kinsey score + age) + (sexual orientation identity + internalized homophobia) + (disclosure to family + disclosure to friends + support for coming out) + (attitudes toward therapy + reasons for therapy). To conserve degrees of freedom and to reduce the likelihood that variables would interfere with each other's estimated variability, items that were not correlated at the bivariate level were left out of analyses. Additionally, if neither variable in a step were significant, steps were removed.

After non-correlated variables were removed, the regression model retained demographics entered in the first step, minority stress variables in the second step, and sexuality reasons for therapy entered in the third step. The final analytic structure of the regression is summarized by the following equation: negative mental health = (number of same-sex sexual partners + female) + (internalized homophobia + harassment) + (sexuality reasons for therapy). The analyses were run in this order in hopes of describing significant predictors of negative mental health among LGBT young adults. Controlling for demographics by entering those variables first, the model added minority stress variables because research has shown that minority stress is correlated with mental health outcomes. Next sexuality reasons for therapy was entered as a predictor of negative mental health because LGBT young adults experience frequently cope with daily difficulties that sexual majority young adults do not face.

CHAPTER 6

RESULTS

Reasons for Attending Therapy

Reasons to attend therapy were measured using three different approaches. One measure consisted of an open-ended response where participants wrote reasons they attended therapy. Another was a list from which participants could choose the top five reasons they attended therapy. The third measure was comprised of 12 Likert-type scales that asked participants how likely the reasons provided would be a reason they might go to therapy. These three measures were later combined into three categorical measures documenting the primary reasons LGBT young adults attended therapy. This section will first discuss the primary, categorical reasons for therapy and will then talk about each contributing scale as reasons for therapy.

Combined categorical reasons. Open-ended response reasons, top five listed response reasons, and Likert scale hypothetical reasons were grouped into three primary categories of reasons for using mental health services. These categories were: sexuality related reasons, mental health related reasons, and general reasons. Specific items addressing sexuality related reasons for the top five listed reasons and the Likert scale reasons were: "help coming out/sexual orientation identity," "conflict between moral/religious beliefs and sexuality," and "issues relating to romantic relationship." Specific items addressing mental health reasons were: "issues relating to body image/self image," "issues relating to anxiety" and "issues relating to depression." Specific items addressing general reasons were "issues relating to family/friends," "a friend recommended I talk to a therapist," "desire to talk to an advocate (someone supportive)," "issues relating to harassment/victimization," "help dealing with stress," and "issues relating to drug/substance use." If a participant's response indicated they had sought or

would seek therapy for a reason included in a category, they were coded as yes (1) or no (0). The dummy coded variables offer some insight as to the principal reasons LGBT young adults attend therapy. Of the composite variables, general reasons to use mental health services was the most frequently reported with 118 people (60%) indicating they have or might in the future use mental health services for this reason. Specific mental health issues was the next most reported with 103 people (52%) reporting that they have used or might in the future use mental health services for this reason. Finally, 75 people (38%) reported sexuality related issues as a reason they have or might use mental health services. These findings show us that LGBT young adults are indeed using therapy services for common reasons like coping with specific mental health disorders or a parent's divorce; however, a large portion (38%) reported using mental health services to help resolve issues relating to their sexuality. This is significant because it shows the important role sexuality plays in the lives of LGBT young adults and why mental health workers must be informed on sexual minority issues.

Open-ended response reasons. Participants reported reasons they used therapy by describing, in a paragraph, why they sought mental health services (see Table 10). The top five reasons LGBT young adults reported attending therapy were: depression (22.2% of therapy users), family and peer relationship issues (20.2%), someone recommended therapy (10.1%), help developing a sexual orientation identity (9.0%) and anxiety (8.0%). Responses coded as depression required an explicit reference of depression as a reason they attended therapy (see Appendix C for coding the scheme) Researchers coded responses as interpersonal family and peer relationship issues when participants expressed family (both immediate and extended family) or peer difficulties as a reason they sought therapy. Although family and peer reasons were initially coded separately, family and peers were combined to represent the larger idea of

young adults using therapy as a means of coping with interpersonal relationship struggles. Participants who indicated that someone, often a family member or school counselor, suggested they attend therapy were coded as a recommendation for therapy. Therapy was recommended for dealing with everything from suicide attempts to coping with and developing sexual orientation identity and even "fixing" sexual orientation. Finally, responses coded as anxiety required an explicit reference of anxiety as a reason they attended therapy. Sexual assault, specific mental health disorders, and suicidality were all closely grouped with 7.0% of therapy users reporting them as reasons for attending therapy. Interestingly, some participants noted that they attended therapy for reasons other than relating to sexuality, sometimes not specifying any further reasons.

Top five listed reasons. Participants were asked to check their top five reasons for attending therapy from a list of 13 including an open-ended "other" item. Responses were coded yes if the participant marked a reason, or no if it was left blank. Seven responses emerged as important reasons for attending therapy based on participants having indicated that reason as one of the most important (see Table 11 for percentages). Among those who used therapy, "Depression" was most frequently ranked with 71% of participants responding that depression was in their top five reasons for attending therapy. Sixty-one percent of participants ranked "issues relating to family and friends" as an important reason for therapy. Third was "anxiety," with 56% ranking it as one of their top five reasons for therapy. Next was "help dealing with stress" with 47%, "self and body-image" with 33%, and "harassment and victimization" with 26% of participants ranking it as an important reasons for attending therapy. Finally, 21% of participants reported "romantic relationships" as one of the top five reasons for attending therapy.

Self and other reasons. Participants were asked to rank on a scale from 0-6, the likelihood they and another hypothetical LGBT young adult might attend therapy from a list of 12 reasons (see Table 12). "Depression" ($M = 3.37$, $SD = 2.18$), "help dealing with stress" ($M = 3.32$, $SD = 2.03$), "anxiety" ($M = 3.26$, $SD = 2.17$), "issues relating to family and friends" ($M = 2.84$, $SD = 2$), and "desire to talk with an advocate" ($M = 2.62$, $SD = 2.08$) were the most likely reasons for attending therapy when rating themselves. A similar pattern emerged for participant ratings of hypothetical other LGBT young adults. "Depression" ($M = 4.17$, $SD = 1.88$), "anxiety" ($M = 3.92$, $SD = 1.94$), "help dealing with stress" ($M = 3.85$, $SD = 1.74$), "conflict between religious beliefs and sexuality" ($M = 3.82$, $SD = 1.86$), and "help coming out" ($M = 3.80$, $SD = 1.88$) were the five most likely reasons participants thought others might attend therapy

Synthesis of all reasons. Commonalities across all four measures surfaced with analysis (see Table 13). The top six reasons LGBT young adults attended therapy were calculated by comparing frequency analyses of the four reasons for therapy measures (open response paragraph, top 5 checklist reasons, likelihood of self seeking therapy Likert scale and likelihood of hypothetical other seeking therapy) and were computed to document the most common reasons LGBT young adults attend therapy. Depression was consistently the number one reason LGBT youth reported attending therapy. Although not consistently the highest ranked, anxiety and family and peer relationships are among the most frequently cited reasons to attend therapy as they are ranked in the top six across all four measures. Help dealing with stress as well as sexuality issues emerged as important reasons to attend therapy as they were ranked among the top reasons across three of the four reasons for therapy measures. Harassment and assault, recommendation from others, interpersonal romantic issues, conflict between religion and

sexuality, and body image also surfaced as important reasons LGBT young adults have used or would use therapy.

Attitudes toward therapy. There was a significant correlation between LGBT young adult attitudes toward therapy and having ever attended therapy ($r = .35$, $p < .001$). Additionally, results from a paired samples t-test indicated that LGBT young adults who had more positive attitudes toward therapy were also more likely to have attended therapy, $t(190) = 5.09$, $p < .001$.

Predictors of Therapy Use

A logistic regression was calculated with all demographic and predictor variables included; however, the current study will be working with a more parsimonious model because the larger model was cumbersome and masked some of the findings. Depression, anxiety, racial minority identity, having a high number of same-sex sex partners, attitudes toward therapy and sexuality related reasons for attending therapy all correlated with whether or not participants had ever been to therapy and were thus included in the first block.

Results from the first block (see Table 14) showed that LGBT young adults were about 51% more likely to attend therapy for anxiety however when later blocks were added this association became non-significant (odds ratio [OR] 1.21 [95% confidence interval (CI), .78-1.91], $p = ns$) and were about four times more likely to attend therapy if they reported having a high number of same-sex sexual partners (OR 3.99 [95% CI, 1.67-9.56], $p < .01$). When attitudes toward therapy and sexuality related reasons to attend therapy were added in the second block, LGBT young adults were nearly four times more likely to attend therapy if they had positive attitudes toward therapy (OR 3.92 [95% CI, 1.72-8.93], $p = .001$) and were about three times more likely to attended if they said they had or would attend therapy for sexuality related reasons (OR 2.68 [95% CI, 1.24-5.83], $p < .05$). Finally, when openness to family and friends and family

reaction to coming out were entered, the results showed a trend suggesting that LGBT young adults may be only 68% more likely to attend therapy if their parents had reacted positively to their coming out (OR 1.68 [95% CI, .97-2.90], $p < .10$). Even though there was no bivariate correlation between family reaction and therapy use, when positive attitudes toward therapy and sexuality related reasons for therapy are parceled out, results suggested that some people may be more likely to attend therapy when their parents react positively. Additionally, LGBT young adult openness about sexuality correlated at the bivariate level; however, when considered with depression, anxiety, ethnic minority identity, high number of same-sex sexual partners, attitudes toward therapy, sexuality reasons for therapy, and family reaction to coming out, it was not a major contributor to therapy use. This model suggests that LGBT young adults attend therapy for more common reasons like anxiety or depression; however, those reasons become less significant when one considers attitudes toward therapy and sexuality related reasons for therapy.

Predictors of Amount of Therapy Used

A multinomial regression was used to document predictors to amount of therapy used (see Table 15). Correlations were run as a means of selecting demographic and predictor variables to be included in the multivariate model. Openness to family and friends, family reaction to coming out, being a good student, sexuality reasons for therapy and having a high number of same-sex sexual partners all correlated with amount of therapy used and were thus included in analysis.

Results from the multinomial regression showed that students with below a B average were three times more likely to be in the "no therapy" group than in the "five or more months of therapy" group (OR 3.20 [95% CI, 1.12-9.19], $p < .05$). Participants who had fewer than seven same-sex sexual partners were more likely to be in the "no therapy" group than in the "five or

more months of therapy" group (OR 3.05 [95% CI, 1.21-7.70], $p < .05$). Finally, participants who did not report sexuality-based reasons for therapy were six times more likely to be in the "no therapy" than in the "five or more months of therapy" group (OR 5.68 [95% CI, 2.35-13.72], $p < .001$). Among therapy users, participants who were open with their family and friends showed a trend suggesting they were half as likely to attend 1-4 months of therapy compared with five or more months of therapy (OR .42 [95% CI, .17-1.05], $p < .10$). Participants whose family had a more positive reaction to their coming out were twice as likely to attend 1-4 months of therapy compared with five or more months of therapy (OR 1.98 [95% CI, 1.02-3.88], $p < .05$). Finally, the results showed a trend that participants who were poor students were three times as likely to attend 1-4 months of therapy compared with five or more months of therapy (OR .2.80 [95% CI, .95-8.29], $p < .10$). Among students with below a B average who do attend therapy, they are more likely to attend therapy for only one to four months rather than five or more months.

Predictors of Negative Mental Health

A multiple linear regression was calculated with all predictor variables included; however, the current study will be working with a more parsimonious model because the larger model was cumbersome and masked some of the findings. Correlations were used to select which variables would be included in the regression. Having a high number of same-sex sexual partners, being female, internalized homophobia, harassment and sexuality related reasons for therapy were all correlated with mental wellbeing.

The regression was entered in three steps (see Table 16) with the standardized, combined scales of depression and anxiety as the dependent variable. Results from the first step of the multiple linear regression revealed that having seven or more same-sex sexual partners predicted

a .15 unit increase in negative mental health outcomes. Additionally, being female significantly predicted a .18 unit increase in negative mental health. The second step added minority stress variables, which showed both internalized homophobia and harassment to be significant predictors of negative mental health. Every unit increase in internalized homophobia was linked to a .15 unit increase in negative mental health symptoms. Similarly, every unit increase in harassment was linked to a .19 unit increase in negative mental health symptoms. Interestingly, with the addition of minority stress variables, high number of sex partners became statistically significant. Finally, the third step found that sexuality related reasons for therapy was a significant predictor of negative mental health outcomes. The results showed that every unit of increase in sexuality reasons to attend therapy was linked to .22 unit increase in negative mental health symptoms.

CHAPTER 7

DISCUSSION

The results of this study have indicated that sexual-minority young adults utilize therapy for different reasons than do sexual majority young adults. This discussion section synthesizes the results suggesting reasons LGBT young adults attend therapy. This section applies the results to the frameworks of identity theory, minority stress theory and LGBT attitudes toward professional psychological help. Limitations, strengths and implications of the current research are outlined and discussed.

LGBT Service Use and Mental Health

This study sought to answer the question: "Why do LGBT young people use therapy?" The study was initially informed by research with the Add Health dataset that found sexual-minority youth reported utilizing mental health services even in the absence of depressive symptoms (McGuire, et al., 2007). Although there has been substantial research documenting increased rates of depression and anxiety for LGBT individuals, increased rates of service use have not been fully explained. The current study also found high rates of depression and anxiety among LGBT young adults. Frequencies corroborated previous studies suggesting that LGBT young adults are attending therapy to help them cope with depression and anxiety. Clearly there are more reasons to attend therapy than simply seeking to alleviate depressive symptoms, although, depression was the number one reason LGBT young adults reported seeking services.

Based on our findings, more therapy use is predicted by being a good student, having a high number of same-sex sexual partners, and having sexuality related reasons for attending therapy. Multinomial findings suggesting that young people who receive positive reactions from family use less than five months of therapy, which corresponds with the literature suggesting that

positive family reaction to coming out are correlated with better mental health outcomes and subsequently less therapy use (D'Augelli et al., 2005). Additionally, these results support D'Augelli's (2002) findings that suggests a negative parental reaction to coming out is correlated with poorer mental health. Similarly, previous research has suggested a positive relationship between level of coming out and mental health service use (Morris et al., 2001). Indeed, the results showed that LGBT young adults who had disclosed their sexual orientation were less likely to use 1-4 months of therapy than five or more months of therapy supporting the hypothesis that out young adults use more therapy. These results corroborate existing evidence that coming out and reactions to coming out can significantly affect mental health service utilization.

Sexuality related reasons played an important role in predicting whether or not LGBT young adults attended therapy as well as predicting mental health. In addition to depression, LGBT youth reported attending therapy for issues relating to anxiety, family and peer relationships, stress, sexuality and coming out, and harassment. Although some of these reasons may be common to those encountered by sexual-majority young adults, sexuality and coming out issues may be more common or have more salience to sexual-minorities (Rotheram-Borus & Fernandez, 1995). Similarly, family and peer issues as well as harassment and abuse issues may be compounded by exhibiting a sexual minority orientation because of societal norms against LGBT individuals. Typically through adolescence and into young adulthood, sexual-minority individuals struggle with developing a sexual orientation identity (Rotheram-Borus & Fernandez, 1995). Further complications may come as LGBT young people begin disclosing their sexual orientation identity. Coping with such difficult life issues may be eased with support from an

educated advocate. Luckily about half of the LGBT youth surveyed in the current study had sought therapy.

Identity service use. Developing a sexual orientation identity has been associated with therapy use (Morris et al., 2001) and wellbeing (Rose et al., 2006). Contrary to much of the literature, the current study did not find that openness to family and friends predicted mental health or mental health service use. Openness to family and friends was correlated at the bivariate level with service use; however, when entered into the regressions it emerged as non-significant. This may suggest that another variable in the regression was accounting for the variance often associated with coming out. Nonetheless, openness was associated with amount of service used and was correlated with using mental health services. These findings corroborate the research suggesting that coming out is positively correlated with therapy use (Morris et al., 2001) possibly because LGBT individuals are more comfortable with and value self-exploration. Additionally, the results showed that positive family reactions to coming out showed a trend toward predicting service use. Additionally, family reactions significantly predicted using 1-4 months of therapy rather than five or more months of therapy. This finding suggests that LGBT young adults are using therapy after positive reactions from family, possibly as a means of coping with minority stress. One participant aptly states, "My mother sent me. Not as an anti-gay thing but more so I could deal with being gay in an anti-gay world." Obviously this experience is not common for most LGBT young adults; however, it seems that there is a group of young adults who have had similar experiences.

Minority stress and mental health. Previous research has shown that minority stress is a significant contributor to negative mental health outcomes (Meyer, 1995). Using internalized homophobia and harassment experiences as proxies for minority stress, the current study

confirmed the relation between minority stress and negative mental health symptoms. It may be that negative experiences of harassment combine with fear of coming out to partially explain the association between harassment, coming out and negative mental health outcomes. Similarly, minority stress research on internalized homophobia has indicated that youth in the early stages of sexual orientation development sometimes internalize negative societal messages of homophobia (Meyer, 1995). Although previously studied in the context of minority stress, the current study indicates that internalized homophobia, independent from other minority stress factors, is a significant predictor of negative mental health. Surprisingly, minority stress did not predict therapy use or amount of time in therapy. Although researchers initially thought predictors to negative mental health would also predict therapy use, findings suggest otherwise.

The current study extends the literature on minority stress beyond Meyer's (1995) initial gay male sample by testing minority stress with an LGBT sample. The results suggest that minority stress can be applied to many sexual minorities, although more research should be done to understand if the interaction of gender and sexual orientation affects experiences of minority stress.

Attitudes toward therapy and service use. Clearly the effect of societal norms and values can have an influence on behavior and mental health. The current research has documented societal influences on mental health vis-à-vis minority stress and LGBT attitudes toward therapy. LGBT young adults' attitudes predicted having ever used therapy and positively correlated with amount of therapy use. The results demonstrate the importance of community norms on mental health service use. The literature suggests that lesbians have more positive attitudes toward therapy than do non-lesbians (Morgan, 1992). Because this study had a within group design, it is not possible to say whether LGBT young adults hold more positive attitudes toward therapy than

sexual-majority young adults. However, the current findings suggest that positive attitudes toward therapy exist in the LGBT community. More research should be done on this subject to document if variations within LGBT subgroups exist and how mental health professionals can capitalize on this norm facilitating service use.

Limitations

Research on hidden or small populations often has limitations with representativeness, especially when studying sexual-minority populations. One of the most daunting tasks facing sexuality researchers is figuring out how to obtain a sample of non-self-identified, undisclosed self-identified and self-identified LGBT participants. Non-self-identified sexual-minority youth are adolescents who may have homoerotic fantasies or desires for the same sex, but have not identified their feelings or refuse to identify their feelings as lesbian, gay or bisexual. Undisclosed self-identified adolescent have identified their desires for the same sex and have come to the realization that they are LGB, but have not told anyone. Finally, self-identified adolescents have identified their feelings as LGB and have told at least one other person about their sexual-minority identity. This broad range of identities cannot be measured using the typical techniques of collecting data at LGBT gatherings or through snowball sampling. Much more creative techniques are needed to access the full spectrum of sexual orientation identities. The current study utilized pride festivals, LGBT student groups and snowball sampling to collect data. These gatherings are unlikely to house anyone who is questioning their sexuality or who does not want others to know about their sexual orientation. As a result most of the participants of this study were self-identified and had disclosed their sexual orientation. This could have an effect on the results as research has shown that undisclosed (Morris et al., 2001) and non-self-identified or sexually confused youth are at increased risk for negative outcomes (Rose et al.,

2006). Obtaining a more representative sample of the LGBT population might significantly affect the findings of the current study.

As described above, having same-sex attractions versus identifying as LGBT poses different risks to wellbeing; however, the source of risk is still unknown. More research needs to be conducted before researchers can hypothesize whether it is actually having same-sex attractions or identifying as LGBT that relates to increased risk. Unfortunately, the current study is not able to distinguish between self-identified and non-self-identified sexual-minority young adults. Much more sophisticated triangulation would be needed to effectively identify those two groups. Nevertheless, findings from the current study on the effects of coming out suggest that disclosing one's sexual orientation is protective and the risk may lie in the unidentified population.

Age can also have a significant impact on outcomes. The current study focused on young adults as it is a significant transitional life period. Thus, by design, the current sample had a fairly limited age range. Research has documented that much of identity development takes place throughout adolescence; however, the majority of participants in the current study are transitioning from adolescence to young adulthood. Focusing on a younger sample may provide researchers with more detailed information on the process of developing a sexual orientation identity, and the trials and risks associated with that process. Retrospective data, even recent retrospection, cannot as accurately relate the daily difficulties faced by LGBT youth. Additionally, utilizing qualitative data would provide researchers with a more in-depth understanding of how adolescents and young adults move through the process of developing a minority sexual orientation identity.

Scale creation is frequently wrought with decisions that can affect later results. One weakness of the current study lies with the scale assessing reasons for therapy use. The scale included both people who attended therapy as well as people who predicted why they might hypothetically attend therapy. Combining actual therapy users and hypothetical therapy users into one scale and using that scale to predict therapy use could act as a confound. Because some of the participants had already been to therapy or were currently in therapy, it stands to reason that the simple action of being in therapy could affect their perceptions of past and future therapy use. Combining hypothetical and actual therapy users reduced problems of collinearity. It is likely that actual users on the open-ended and the top five checklist items would report the same responses; however, by including hypothetical responses, researchers reduced the collinearity between the items in the scale.

Strengths

Among the strengths of the current study is its sample size. Collecting approximately 212, nine-page surveys from LGBT young adults is a difficult task. Many researchers studying sexual minorities often contend with limited sample sizes. The current 212 person sample is a moderately sized sample population for LGBT research which allows for the deletion of some data without significant negative impacts. The medium sample size also allowed us to include more variables and steps in the regressions without sacrificing statistical power. Both of these improved the study by allowing for a more in-depth understanding of which factors relate to therapy use. Finally the sample size helped to provide more representative data for young adults who had attended therapy. Having a higher number of participants who reported using therapy increased the range and variability of reasons young adults reported attending therapy. Although

we collected a moderate sample size, to include all of the variables that might affect the hypotheses, we would need a significantly larger sample.

Diversity and generalizeability are common limitations to research. However, the current study was both racially and geographically diverse. Approximately 30% of participants reported an ethnic minority identity which is comparable national demographics of ethnicity (U.S. Census Bureau, 2000). Additionally, data were collected throughout the western region of the United States and Washington D.C. This variation in location was further accentuated by collecting data in both rural and urban populations. This geographic diversity helped to mitigate the likelihood of finding significant results because of local influences. Overall, the diversity of the sample allows for increased generalizability of findings among the LGBT population.

Future Research

There are numerous research projects that could further this area of study. One such project could be to assess reasons middle and high school aged LGBT or sexual-minority youth use therapy. This population is often overlooked for sexuality research because of difficulty of access; however, this age group may offer a unique perspective as well as the prospect of preventing or minimizing future negative outcomes. Additionally, future research should work toward collecting data on undisclosed LGBT individuals. Although difficult to access, the internet has opened many doors for researchers to access this hidden population. There are many websites that cater to undisclosed LGBT people which could be utilized to reach these individuals.

Finally, research assessing mental health professionals' assumptions, knowledge and resources for working with members of the LGBT community would contribute to both the applied and research sides of LGBT mental wellbeing. The current literature suggests that

practitioners remain relatively uninformed about the best ways to meet the mental health needs of the LGBT population (Avery et al., 2001). Documenting the current standard procedures and resources offered to both novice and experienced practitioners would offer insight into the established norms of the profession.

Implications. Simply understanding reasons LGBT youth attend therapy will be valuable for mental health practitioners. Understanding the most common reasons LGBT people attend therapy will allow practitioners to have an improved background in LGBT issues prior to meeting with LGBT clients. Understanding that sexuality and coming out issues are among the most common reasons LGBT young adults report therapy should alert practitioners to the importance of knowing the more subtle distinctions between sexual majority and sexual-minority clients. Furthermore, indicating which topics are most likely to relate to mental health lets mental health workers carefully research and guide sessions in the direction that will likely provide the most benefit. For instance, understanding that minority stress and sexuality related reasons for therapy contribute significantly to negative mental health outcomes in LGBT youth highlights areas that practitioners can explore further and that may contribute to improved client outcomes.

Additionally, this study is valuable to sexuality researchers as it adds to the literature on the LGBT community. Understanding which factors contribute to the wellbeing of this largely understudied group has implications for future research, public policy and family relationships. Researchers are only beginning to study the underlying causes of the mental health phenomena that have been documented in the past 30 years. Looking at the relation between negative mental health and contributing factors provides the groundwork for possible prevention programs. Additionally, this research adds to the larger body of literature studying sexual-minority populations and factors that influence outcomes. A significant amount of research has been done

on LGBT adolescent suicidality, however, much less research has been published suggesting ways to improve outcomes for those youth as suicide prevention. The current research also lends itself well to education programs aimed at improving local norms and assumptions of the LGBT community. Showing empirically that minority stress is predictive of subsequent negative mental health highlights the influence communities can have on an entire sub-group or even an individual. Researchers interested in ways to improve outcomes for LGBT young adults should begin by documenting the influences of community norms on a larger scale and then studying effective ways to alter harmful perceptions. This research shows the importance of support for sexual-minority adolescents and young adults during identity development and coming out. Educating parents, teachers, policy makers, and clinicians is vital to improving outcomes for LGBT young adults.

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Table 1

Analysis of Variance Summary for Differences in Predictor Variables across Locations (N=182)

	Idaho & Washington	Flagstaff	Washington D.C.	
	M	*M*	*M*	*F*
Sexuality reasons[a]	.37	.43	.42	.21
Poor mental health[b]	-.031	.18	-.10	1.90
Attitudes toward therapy[c]	1.52	1.65	1.32	2.74†
Harassment[d]	$.99_a$	1.11_{ab}	1.53_b	5.72**
Internalized homophobia[e]	.61	.87	1.46_a	11.39***
Ever therapy[f]	.52	.58	$.21_a$	3.82*
Amount of therapy[g]	.76	.90	$.26_a$	4.00*
Openness[h]	2.34	1.99	2.01	4.13*
Reaction[i]	2.26	2.28	2.47	.39

Note. Subscripts denote significant differences among groups using Bonferroni post hoc tests. All groups with the same letter showed no difference.

[a]Reasons for therapy: 0 = *not sexuality related reasons for therapy*, 1 = *sexuality related reasons for therapy*. [b]Poor Mental Health: -1 = *better mental health,* 2 = *worse mental health.* [c]Attitudes Toward Therapy: 0 = *negative attitudes toward therapy,* 3 = *positive attitudes toward therapy.* [d]Harassment: 0 = *no harassment experiences*, 1 = *frequent harassment experiences*. [e]Internalized Homophobia: 0 = *low internalized homophobia,* 4 = *high internalized homophobia*. [f]Ever Therapy: 0 = *no therapy,* 1 = *has attended therap.* [g]Amount of Therapy: 0 = *no therapy,* 1 = *1-4 months,* 2 = *5 or more months.* . [h]Openness: 0 = *family and friends do not know*, 3 = *family and friends definitely know*. [i]Reacton: 0 = *rejecting of sexuality*, 3 = *accepting of sexuality.*

† $p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

Table 2

Descriptive Statistics and Reliability Scores for Dependent and Independent Variables (N = 197)

Variables	*M*	*SD*	Range	alpha
Age	21.06	2.34	18 – 26	-
Ethnic minority[a]	.3	.46	0 – 1	-
Good student[b]	.73	.45	0 – 1	-
Gender[c]	.43	.50	0 – 1	-
Transgender[d] (n = 18)	.09	.29	0 – 1	-
Kinsey scale[e]	4.23	1.82	0 – 6	-
High number of same-sex partners[f]	.26	.44	0 – 1	-
Depression[g]	.85	.61	0 – 3	.82
Anxitey[h]	1.22	.95	0 – 4	.87
Mental health[i]	.003	.64	-1 – 2	.88
Internalized homophobia[j]	.74	.76	0 – 4	.87
Harassment[k]	1.07	.68	0 – 3	.74
Ever attended therapy[l]	.50	.50	0 – 1	-
Months in therapy[m]	.74	.82	0 – 2	-
Reasons to attend therapy[n]	.38	.49	0 – 1	-
Openness[o]	2.25	.75	0 – 3	.82
Reaction[p]	2.28	.75	0 – 3	.66
Attitudes toward therapy[q]	1.53	.52	0 – 3	.67

[a]Ethnic minority: 0 = *Not an ethnic minority*, 1 = *Ethnic Minority*. [b]Good student: 0 = *below B average*, 1 = *B average of above*. [c]Gender: 0 = *not female*, 1 = *female*. [d]Transgender: 0 = *Not transgender*, 1 = *Transgender.* [e]Kinsey: 0 = *exclusively heterosexual*, 6 = *exclusively homosexual*. [f]Number of same-sex partners: 0 = *Fewer than 7*, 1 = *7 or more*. [g]Depression: 0 = *not depressed*, 3 = *depressed*. [h]Anxiety: 0 = *not anxious*, 4 = *anxious*. [i]Mental Health: -1 = *low depression and anxiety*, 2 = *high depression and anxiety*. [j]Internalized Homophobia: 0 = *low*

Table 2

Continued

internalized homophobia, 4 = *high internalized homophobia*. [k]Harassment: 0 = *no harassment experiences*, 1 = *frequent harassment experiences*. [l]Ever in therapy: 0 = *no therapy*, 1 = *therapy*. [m]Months in therapy: 0 = *no therapy*, 1 = *1-4 months of therapy,* 2 = *5+ months of therapy*. [n]Reasons for therapy: 0 = *not sexuality related reasons for therapy*, 1 = *sexuality related reasons for therapy*. [o]Openness: 0 = *family and friends do not know*, 3 = *family and friends definitely know*. [p]Reacton: 0 = *rejecting of sexuality*, 3 = *accepting of sexuality.* [q]Attitudes toward therapy: 0 = *negative attitudes toward therapy,* 3 = *positive attitudes toward therapy.*

Table 3

Structural Factor Analysis for Depression and Anxiety Subscales

	Component	
	1	2
I felt depressed	.767	-.437
I felt sad	.741	-.406
I felt lonely	.736	-.372
I felt people disliked me	.648	-.433
I did not feel like eating; my appetite was poor	.635	-.298
I enjoyed life reversed	.580	-.271
People were unfriendly	.579	-.215
I felt happy reversed	.495	-.325
Feeling fearful	.448	-.820
Nervousness or shakiness inside	.452	-.799
Suddenly scared for no reason	.317	-.797
Spells of terror or panic	.445	-.790
Feeling tense or keyed up	.386	-.757
Feeling so restless you could not sit still	.399	-.734

Note. R = -.505 for factors 1 and 2. eigenvalues for factor 1 = 5.516 for factor 2 =1.640.

Table 4

Structural Factor Analysis for Mental Health Composed of Standardized Depression and Standardized Anxiety Subscales

	Component	
	1	2
Nervousness or shakiness inside	.452	-.799
Suddenly scared for no reason	.317	-.797
Feeling fearful	.448	-.820
Feeling tense or keyed up	.386	-.757
Spells of terror or panic	.445	-.790
Feeling so restless you could not sit still	.399	-.734
I felt happy reversed	.495	-.325
I felt depressed	.767	-.437
I felt lonely	.736	-.372
I felt sad	.741	-.406
I did not feel like eating; my appetite was poor	.635	-.298
People were unfriendly	.579	-.215
I felt people disliked me	.648	-.433
I enjoyed life reversed	.580	-.271

Note. R = -.505 for factors 1 and 2. eigenvalues for factor 1 = 5.516 for factor 2 =1.640

Table 5

Structural Factor Analysis for Minority Stress Composed of Harassment and Internalized Homophobia Subscales

	Component	
	1	2
I wish I weren't LGB	.822	.048
If someone offered me the chance to be heterosexual, I would accept	.778	.000
I wish I could develop erotic feelings about the opposite sex	.769	.082
I have tried to become attracted to the opposite sex	.733	.092
I feel that being LGB is a personal shortcoming	.717	.010
I feel alienated from myself because of being LGB	.675	.241
I often feel it best to avoid contact with LGBs	.643	.266
I would like to get professional help to change my orientation	.632	.189
I have tried to stop being attracted to the same sex	.618	.016
Harassed because LGB	.018	.759
How often do you hear negative comments based on sexual orientation	.063	.694
Harassed because didn't fit in	.205	.671
Harassed because not masculine enough	.081	.597
How often do you hear negative comments based on gender presentation	.082	.562
Harassed because not feminine enough	.078	.507

Note. R = .138 for factors 1 and 2. eigenvalues for factor 1 = 4.69 for factor 2 = 2.436.

Table 6

Principle Component Factor Analysis for Attitudes toward Therapy

	Component 1
A person is more likely to solve problems with professional help than without	.745
I would want to see a therapist if I were upset for a long time	.736
I might want to have therapy in the future	.696
I would be confident that I could find relief in psychotherapy	.653
My first inclination would be to seek therapy if I had an emotional crisis	.608
Personal troubles tend to work themselves out	-.460
It is admirable to cope with problems without therapy	-.391
A person should work out their own problems, therapy should be a last resort	-.352
Considering the time and expense involved in therapy, I doubt it would be useful	-.330
Talking with a psychologist seems like a poor way of reducing emotional conflict	-.207

Note. eigenvalues = 3.02

Table 7

Structural Factor Analysis for Openness to Family and Friends and Family Reaction to Coming Out

	Component 1	Component 2
How open about your sexuality are you with your mother	.774	-.154
How open about your sexuality are you with your father	.744	-.287
How has your father reacted to your disclosure	.626	-.335
How has your mother reacted to your disclosure	.573	-.320
How open about your sexuality are you with your family	.560	.121
How has your sibling(s) reacted to your disclosure	.371	-.826
How open about your sexuality are you with your sibling(s)	.368	-.751
How open about your sexuality are you with your friends	.014	-.718

Note. R = -.23 for factors 1 and 2. eigenvalues for factor 1 = 2.89 for factor 2 = 1.32.

Table 8

Correlations between Demographic and Dependent Variables (N = 197)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Female[a]	–														
2. Transgender[b]	-.28***	–													
3. Same-sex partners[c]	-.17*	-.03	–												
4. Residency[d]	.08	-.26***	-.01	–											
5. Good student[e]	-.00	-.13	-.08	.05	–										
6. Ethnic minority[f]	.01	.14	-.01	-.31***	-.08	–									
7. Monogamous[g]	.01	.00	.07	.23**	.04	-.14*	–								
8. Kinsey[h]	-.21**	-.05	.22**	.17*	.15*	-.16*	.12	–							
9. Age	-.08	-.04	.35***	.17*	-.04	-.15*	.12	.20**	–						
10. Depression[i]	.11	-.02	.13	-.02	-.08	-.05	-.22**	.05	-.02	–					
11. Anxiety[j]	.15*	.03	.08	-.10	.06	-.06	-.17*	.08	-.07	.56***	–				
12. Poor Mental Health[k]	.15*	.01	.12	-.08	-.01	-.06	-.21**	.07	-.05	.86**	.90**	–			
13. Ever Therapy[l]	.09	.07	.18*	.05	.06	-.15*	-.01	.05	.03	.18*	.21**	.23**	–		
14. Amount of Therapy[m]	.08	.06	.18*	.04	.09	-.19**	.02	.11	.04	.18*	.21**	.23**	.89**	–	
15. In School[n]	.08	.03	-.22**	-.25**	.36**	.02	-.10	.09	-.27**	-.02	.11	.05	.04	.04	–

Table 8

Continued

[a]Female: 0 = *not female*, 1 = *female*. [b]Transgender: 0 = *not transgender*, 1 = *transgender*. [c]Same sex partners: 0 = *less than 7 partners*, 1 = *7 or more partners.* [d]Residency: 0 = *not an Idaho or Washington resident*, 1 = *Idaho or Washington resident*. [e]Good Student: 0 = *below B average*, 1 = *B average of above*. [f]Ethnic minority: 0 = *not an ethnic minority*, 1 = *ethnic minority*. [g]Monogamous: 0 = *not in a monogamous relationship*, 1 = *in a monogamous relationship*. [h]Kinsey: 0 = *exclusively heterosexual*, 6 = *exclusively homosexual*. [i]Depression: 0 = *less depressed*, 3 = *more depressed.* [j]Anxiety: 0 = *less anxious*, 4 = *more anxious.* [k]Poor Mental Health: -1 = *better mental health*, 2 = *worse mental health.* [l]Ever Therapy: 0 = *no therapy*, 1 = *has attended therapy.* [m]Amount of Therapy: 0 = *no therapy*, 1 = *1-4 months*, 2 = *5 or more months.* [n]In School: 0 = *not currently enrolled*, 1 = *currently enrolled.*

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 9

Correlations between Dependent and Predictor Variables (N = 197)

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Poor Mental Health[a]	–								
2. Ever Therapy[b]	.23**	–							
3. Amount of Therapy[c]	.23**	.89***	–						
4. Internalized Homophobia[d]	.16*	-.06	-.07	–					
5. Harassment[e]	.27***	.07	.10	.05	–				
6. Openness[f]	.00	.18*	.20**	-.39***	.03	–			
7. Reaction[g]	-.13	.06	.01	-.21**	-.04	.37***	–		
8. Attitudes Toward Therapy[h]	.19*	.35***	.43***	.02	.08	.16*	.04	–	
9. Sexuality Reasons[i]	.25***	.28***	.32***	.09	.20**	.04	-.13	.26***	–

[a]Poor Mental Health: -1 = *better mental health,* 2 = *worse mental health.* [b]Ever Therapy: 0 = *no therapy*, 1 = *has attended therapy*

[c]Amount of Therapy: 0 = *no therapy,* 1 = *1-4 months,* 2 = *5 or more months.* [d]Internalized Homophobia: 0 = *low internalized homophobia,* 4 = *high internalized homophobia*. [e]Harassment: 0 = *no harassment experiences*, 1 = *frequent harassment experiences*.

[n]In School: 0 = *not currently enrolled,* 1 = *currently enrolled.* [f]Openness: 0 = *family and friends do not know,* 3 = *family and friends definitely know*. [g]Reacton: 0 = *rejecting of sexuality*, 3 = *accepting of sexuality.* [h]Attitudes Toward Therapy: 0 = *negative attitudes toward therapy*, 3 = *positive attitudes toward therapy*. [i]Reasons for therapy: 0 = *not sexuality related reasons for therapy*, 1 = *sexuality related reasons for therapy*. [j]Residency: 0 = *not an Idaho or Washington resident*, 1 = *Idaho or Washington resident*. [k]In School: 0 = *not currently enrolled,* 1 = *currently enrolled.* [l]Monogamous: 0 = *not in a monogamous relationship*, 1 = *in a monogamous relationship*.

Table 10

Frequencies among Therapy Users for Open-ended Reasons to Use Therapy (n= 99)

	Frequency	Percent among therapy users
Depression (M)	22	22.2%
Family/Peer Relationships (S or G)	20	20.2%
Recommendation from others (S or G)	10	10.1%
Sexual Orientation Identity (S)	9	9.0%
Anxiety (M)	8	8.0%
Sexual Assault (G)	7	7.0%
Other Specific Mental Health Disorders (M)	7	7.0%
Suicidality (M)	7	7.0%
Explicitly Not About Sexuality (G)	6	6.0%
Romantic Relationships (S)	6	6.0%

Note. S = Sexuality reason, M = Mental health reason, G = General reason. Items coded S or G were coded by participant to separate sexuality and general reasons within the larger category.

Table 11

Percentage of Top 5 Checklist Reasons LGBT Youth Reported Attending Therapy (N = 99)

	Among therapy users
	% who endorsed
Depression (M)	70.7
Issues relating to family/friends (S or G)	60.6
Anxiety (M)	55.6
Help dealing with stress (G)	46.5
Self image/Body image (M)	33.3
Harassment/Victimization (G)	26.3
Romantic Relationships (S)	21.2
Other (G)	18.2
Help coming out (S)	18.2
Desire to talk with an advocate (G)	18.2
A friend recommended therapy (S or G)	14.1
Conflict between religious beliefs and sexuality (S)	13.1
Drugs/Substance use (G)	13.1

Note. S = Sexuality reason, M = Mental health reason, G = General reason. Items coded S or G were coded by participant to separate sexuality and general reasons within the larger category.

Table 12

Likelihood of Reasons to Attend Therapy for Self vs. Hypothetical Other LGBT Young Adult (N = 177)

	Self		Other		
	M	*SD*	*M*	*SD*	*t*
Depression (M)	3.37	2.18	4.17	1.88	-4.90***
Help dealing with stress (G)	3.32	2.03	3.85	1.74	-3.64***
Anxiety (M)	3.26	2.17	3.92	1.94	-4.21***
Issues relating to family/friends (S or G)	2.84	2.00	3.79	1.81	-5.57***
Desire to talk with an advocate (G)	2.62	2.08	3.76	1.88	-6.82***
Romantic Relationships (S)	2.60	2.14	3.70	1.78	-6.62***
Self image/Body image (M)	2.56	2.21	3.63	1.88	6.13***
Harassment/Victimization (G)	2.49	2.12	3.73	1.81	-7.76***
A friend recommended therapy (S or G)	1.87	1.84	2.98	1.86	-7.36***
Drugs/Substance use (G)	1.83	2.14	3.46	1.95	-9.79***
Help coming out (S)	1.48	1.85	3.80	1.88	-13.46***
Conflict between religious beliefs and sexuality (S)	1.45	2.05	3.82	1.86	-13.10***

Note. S = Sexuality reason, M = Mental health reason, G = General reason. Items coded S or G were coded by participant to separate sexuality and general reasons within the larger category.

Likelihood scale is a Likert-type scale 0-6: 0 = *not at all likely,* 1 = *extremely likely*

† $p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

Table 13

Synthesis of Most Frequently Reported Reasons for Therapy Use

Open-ended reasons	Top checklist reasons	Likely reasons for self	Likely reasons for other
1. Depression	**1. Depression**	**1. Depression**	**1. Depression**
2. Family/peer relations	**2. Family/peer relations**	2. Stress	**2. Anxiety**
3. Recommended	**3. Anxiety**	**3. Anxiety**	3. Stress
4. Sexual orientation	4. Stress	**4. Family/peer relations**	4. Religion & sexuality
5. Anxiety	5. Self/body image	5. Need an advocate	5. Coming out
6. Sexual assault*	6. Harassment	6. Romantic relationships	**6. Family/peer relations**

Note. *Sexual assault, specific mental health disorders, and suicidality were tied with 7.0% of participants reporting as reasons for therapy use. Bolded items appear across all four measures. Underlined items appear across three measures.

Table 14

Summary of Logistic Regression Analysis for Variables Predicting Past or Present Therapy Use (N=164)

	Step 1			Step 2			Step 3		
Predictor	*B*	*SE B*	e^B	*B*	*SE B*	e^B	*B*	*SE B*	e^B
Depression	.12	.33	1.13	.00	.36	1.0	.16	.37	1.18
Anxiety	.41†	.21	1.51	.24	.23	1.27	.20	.23	1.22
Ethnic minority	-.19	.37	.83	-.23	.41	.80	-.33	.42	.72
Same-sex partners	.84*	.38	2.32	1.27**	.43	3.57	1.39**	.45	3.99
Attitudes toward therapy	-	-	-	1.35**	.42	3.86	1.37**	.42	3.92
Sexuality reasons for therapy	-	-	-	.86*	.38	2.37	.99*	.40	2.68
Openness	-	-	-	-	-	-	-.20	.34	.82
Reaction	-	-	-	-	-	-	.52†	.28	1.68
Constant	-.54			-2.73***			-3.58**		
χ^2	13.53			34.80			38.42		
df	4			6			8		

† $p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

Table 15

Summary of Multinomial Regression Analyses for Variables Prediction Amount of Therapy Use (N = 155)

	No Therapy			*1-4 Months in Therapy*		
Variable	*B*	*SE B*	e^B	*B*	*SE B*	e^B
Openness	-.62	.45	.54	-.86†	.47	.42
Reaction	-.03	.31	.98	.69*	.34	1.98
Below B average student	1.16*	.54	3.20	1.03†	.55	2.80
Non-sexuality reasons	1.74***	.45	14.9	.70	.45	2.02
Low same-sex partners	1.11*	.47	.56	.25	.48	1.29
Nagelkerke R^2		.213				
Pearson χ^2 goodness-of-fit		274.75				
Percent correctly classified		54.9%				

Note. The comparison group is 5 or more months of therapy.

† $p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

Table 16

Summary of Linear Regression Analysis for Variables Predicting Negative Mental Health (N = 157)

	Model 1			Model 2			Model 3		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Same-sex partners	.19	.11	.13†	.21	.10	.14*	.21	.10	.15*
Female	.24	.10	.19*	.23	.09	.18*	.23	.09	.18**
Internalized homophobia	-	-	-	.15	.06	.17*	.13	.06	.15*
Harassment	-	-	-	.22	.07	.24**	.18	.07	.19**
Sexuality reasons for therapy	-	-	-	-	-	-	.29	.09	.22**
ΔR^2		.44			.09			.05	
F for change in R^2		4.23*			9.32***			10.08**	

† $p < .10$. *$p < .05$. **$p < .01$.

APPENDIX A

CONSENT MATERIALS

WASHINGTON STATE UNIVERSITY
Research Compliance Office

MEMORANDUM

TO: Jenifer McGuire
Human Development, WSU Pullman (4852)

FROM: Malathi Jandhyala (for) Kris Miller, Chair, WSU Institutional Review Board (3140)

DATE: 24 January 2007

SUBJECT: Approved Human Subjects Protocol - New Protocol

Your Human Subjects Review Summary Form and additional information provided for the proposal titled *"Mental Health and Well Being Among Sexual Minority Young Adults,"* IRB File Number **9532**-a was reviewed for the protection of the subjects participating in the study. Based on the information received from you, the WSU-IRB **approved** your human subjects protocol on **24 January 2007**.

IRB approval indicates that the study protocol as presented in the Human Subjects Form by the investigator, is designed to adequately protect the subjects participating in the study. This approval does not relieve the investigator from the responsibility of providing continuing attention to ethical considerations involved in the utilization of human subjects participating in the study.

This approval expires on 23 January 2008. If any significant changes are made to the study protocol you must notify the IRB before implementation. Request for modification forms are available online at http://www.ogrd.wsu.edu/Forms.asp.

In accordance with federal regulations, this approval letter and a copy of the approved protocol must be kept with any copies of signed consent forms by the principal investigator for THREE years after completion of the project.

Washington State University is covered under Human Subjects Assurance Number FWA00002946 which is on file with the Office for Human Research Protections.

If you have questions, please contact the Institutional Review Board at (509) 335-9661. Any revised materials can be mailed to the Office of Research Assurances (Campus Zip 3140), faxed to (509) 335-1676, or in some cases by electronic mail, to *irb@wsu.edu*.

Review Type: NEW
Review Category: XMT
Date Received: 16 January 2007

OGRD No.: NF
Agency: NA

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WASHINGTON STATE UNIVERSITY
CONSENT FORM
Mental Health & Wellness Among Sexual Minority Young Adults

Researchers: Dr. Jenifer K. McGuire, Assistant Professor, Department of Human Development, (509) 335-2130, jkmcguire@wsu.edu

Charles R. Anderson, Graduate Student, Department of Human Development, (509) 335-2923, charles_anderson@wsu.edu

Researchers' statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all of your questions, you can decide if you want to be in the study or not. This consent form if for you to keep for your records

PURPOSE AND BENEFITS

This study seeks to better understand how LGBT young adults experience mental health, personal relationships and social environments.

PROCEDURES

You will be asked to complete a 30 minute survey. This study will be asking for information regarding your prior sexual experiences, use of mental health services, and experiences of harassment and victimization.

RISKS, STRESS, OR DISCOMFORT

When dealing with personal issues such as sexual orientation or mental health there is a possibility that you could feel distress or discomfort when answering personal questions.

OTHER INFORMATION

Your name will never be recorded. This survey is completely anonymous. Participants may refuse to answer any question or may withdraw completely.

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have general questions about the research, I can ask one of the researchers listed above. If I have questions regarding my rights as a participant, I can call the WSU Institutional Review Board at (509)335-1585. This project has been reviewed and approved for human participation by the WSU IRB. I will receive a copy of this consent form. By completing the attached survey, I understand that am providing implied consent for the use of this data.

Thank you for agreeing to take part in the survey, we appreciate your time and effort.

APPENDIX B

MENTAL HEALTH & WELLNESS AMONG SEXUAL MINORITY YOUNG ADULTS SURVEY

Mental Health & Well Being Among Sexual Minority Young Adults

About Yourself

Please answer the questions honestly and to the best of your ability

1. What is your age? _____

2. What is your race? _____

3. Are you currently enrolled in school? ____Yes ____ No

If Yes, what year/grade are you _____

4. What kind of grades do you **usually** get in school? (mark one) ___ A's ___ B's ___ C's ___ D's ___F's

5. Have you received your high school diploma? ____Yes ____No Equivalency Degree (GED)? _____

6. What language do you speak **most often?**

___ English ___ English and Spanish equally ___ Spanish ___ Other: _____

7. What city do you live in? _____

8. What is your current living situation? (mark one)

____ I live with roommates in a house or apartment

____ I live alone

____ I live with my romantic partner

____ I live in the residence halls

____ I live with my family (parents or step-parents)

____ Other: _____

9. What is your biological sex? ____ Male ____ Female ____ Intersex ____ In transition

10. What is your gender?

____ Male ____ Female ____ Transgender MTF ____ Transgender FTM ____ Questioning

____ Other: Please specify _____

11. What is your sexual orientation?

___ Gay ___ Lesbian ___ Bisexual ___ Straight/Heterosexual ___ Queer ___ Questioning

___ Other: Please specify_____

Sexual Identity Development & Sexual Experience

Please answer the questions honestly and to the best of your ability. Mark or fill in the answer that best describes you.

1. Would you say that you are

0----------1----------2----------3----------4----------5----------6

Exclusively Heterosexual Bisexual Exclusively Homosexual

2. How would you rate your gender conformity to standards of masculinity? ____N/A

0----------1----------2----------3----------4----------5----------6

Not Gender Conforming (Masculine) Very Gender Conforming (Masculine)

3. How would you rate your gender conformity to standards of femininity? ____N/A

0----------1----------2----------3----------4----------5----------6

Not Gender Conforming (Feminine) Very Gender Conforming (Feminine)

4. At what age were you first **aware** of sexual attraction? Age: ___ don't know___ N/A ___

5. At what age were you first **aware** of your same-sex attraction? Age: ___ don't know___ N/A ___

6. At what age did you first **self-label** as lesbian/gay/bisexual? Age: ___ don't know___ N/A ___

7. At what age did you **first tell someone** you were lesbian/gay/bisexual? Age: ___ don't know___ N/A ____

8. How many **same-sex** sexual partners have you had? _____

9. How many **opposite-sex** sexual partners have you had? _____

10. Are you currently in a monogamous relationship?____ yes ____ no ____ don't know

11. In the past 6 months how many sexual partners have you had? _____

12. Have you ever had vaginal intercourse?____ yes ____ no ____ don't know/ not applicable

13. Have you ever had anal intercourse?____ yes ____ no ____ don't know/ not applicable

14. If you have anal intercourse, do you practice receptive anal intercourse?___ Always ___ Sometimes __ Never

15. Have you ever given/received fellatio (male oral sex)?____ yes ____ no ____ don't know/ N/A

16. Have you ever given/received cunilingus (female oral sex)?____ yes ____ no ____ don't know/ N/A

17. Have you ever give/received manual stimulation (hand to genital)?____ yes ____ no ____ don't know /N/A

18. When you have sex, do you use barrier methods (condoms, dental dams, etc.) to avoid Sexual Transmitted Diseases? ___ Always ____ Almost always ____ Sometimes ____ Never

Coming Out

*Circle the **number** that best describes you. Please answer the questions honestly and to the best of your ability*

1. As a whole, how open about your sexuality are you with your family?
I'm closeted from them all 0----------1----------2----------3 They all know

2. How would you describe your relationship with your **mother**? ____ don't know /N/A
0----------1----------2
We hardly talk We get along fairly well We are very close

3. How open about your sexuality are you with your **mother**? ____ don't know /N/A
0----------1----------2----------3
Does not know or suspect | Probably knows or suspects | Definitely knows but have never talked about it | Definitely knows and we have talked about it

4. If you have disclosed your sexual orientation, how has your **mother** reacted? ____ don't know /N/A
0----------1----------2----------3
Rejecting Intolerant Tolerant Accepting

5. How would you describe your relationship with your **father**? ____ don't know /N/A
0----------1----------2
We hardly talk We get along fairly well We are very close

6. How open about your sexuality are you with your **father**? ____ don't know /N/A
0----------1----------2----------3
Does not know or suspect | Probably knows or suspects | Definitely knows but have never talked about it | Definitely knows and we have talked about it

7. If you have disclosed your sexual orientation, how has your **father** reacted? ____ don't know /N/A
0----------1----------2----------3
Rejecting Intolerant Tolerant Accepting

8. How would you describe your relationship with your **sibling(s)**? ____ don't know /N/A
0----------1----------2
We hardly talk We get along fairly well We are very close

9. How open about your sexuality are you with your **sibling(s)**? ____ don't know /N/A
0----------1----------2----------3
Does not know or suspect | Probably knows or suspects | Definitely knows but have never talked about it | Definitely knows and we have talked about it

10. If you have disclosed your sexual orientation, how has your **sibling(s)** reacted? ____ don't know /N/A
0----------1----------2----------3
Rejecting Intolerant Tolerant Accepting

11. Generally how open about your sexuality are you with your **friends**? ____don't know/N/A
0----------1----------2----------3
Does not know or suspect | Probably knows or suspects | Definitely knows but have never talked about it | Definitely knows and we have talked about it

12. If you have disclosed your sexual orientation, how have your **friends** reacted? ____don't know/ N/A
0----------1----------2----------3
Rejecting Intolerant Tolerant Accepting

Parental Support

Please answer the questions honestly and to the best of your ability.

This section asks questions about your parents' support for your sexual orientation and gender presentation. To answer these questions, think of the one parent (or parent figure) your have spent the most time with. What is that parent to you? (ex: mom, dad, uncle, etc.) _____	If you had a relationship with a second parent (or parent figure) while growing up, please answer those same questions regarding that parent. What is that parent to you? (ex: mom, dad, uncle, etc.) _____
1a.What are ways that parent shows **support** for your sexual orientation?	1b. What are ways that parent shows **support** for your sexual orientation?
2a. What are ways that parent shows **discouragement or lack of support** for your sexual orientation?	2b. What are ways that parent shows **discouragement or lack of support** for your sexual orientation?
3a. What are ways that parent shows **support** for your gender presentation?	3b. What are ways that parent shows **support** for your gender presentation?
4a.What are ways that parent shows **discouragement or lack of support** for your gender presentation?	4b. What are ways that parent shows **discouragement or lack of support** for your gender presentation?

Feelings About Sexuality

*Circle the **number** that best describes you. Please answer the questions honestly and to the best of your ability*

1. I have tried to stop being attracted to the same sex in general. _____N/A

0----------1----------2----------3----------4

Disagree Strongly Disagree Neither agree nor Disagree Agree Agree Strongly

2. If someone offered me the chance to be completely heterosexual, I would accept the chance. _____N/A

0----------1----------2----------3----------4

Disagree Strongly Disagree Neither agree nor Disagree Agree Agree Strongly

3. I wish I weren't gay/lesbian/bisexual. _____N/A

0----------1----------2----------3----------4

Disagree Strongly Disagree Neither agree nor Disagree Agree Agree Strongly

4. I feel that being gay/lesbian/bisexual is a personal shortcoming for me. _____N/A

0----------1----------2----------3----------4

Disagree Strongly Disagree Neither agree nor Disagree Agree Agree Strongly

5. I would like to get professional help in order to change my sexual orientation from gay/lesbian/bisexual to straight. _____N/A

0----------1----------2----------3----------4

Disagree Strongly | Disagree | Neither agree nor Disagree | Agree | Agree Strongly

6. I have tried to become more sexually attracted to the opposite sex. _____N/A

0----------1----------2----------3----------4

Disagree Strongly | Disagree | Neither agree nor Disagree | Agree | Agree Strongly

7. I often feel it best to avoid personal or social involvement with other gay/lesbian/bisexual people. _____N/A

0----------1----------2----------3----------4

Disagree Strongly | Disagree | Neither agree nor Disagree | Agree | Agree Strongly

8. I feel alienated from myself because of being gay/lesbian/bisexual. _____N/A

0----------1----------2----------3----------4

Disagree Strongly | Disagree | Neither agree nor Disagree | Agree | Agree Strongly

9. I wish that I could develop more erotic feelings about the opposite sex. _____N/A

0----------1----------2----------3----------4

Disagree Strongly | Disagree | Neither agree nor Disagree | Agree | Agree Strongly

Your Beliefs

*Circle the **number** that best describes you. Please answer the questions honestly and to the best of your ability*

1. My ideas about my own gender identity and/or presentation have never changed as I have become older.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

2. I have definite views regarding the best gender identity and/or presentation for me.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

3. I have undergone several experiences that made me change my views about my gender identity and/or presentation.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

4. My ideas about my gender identity and/or presentation will never change.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

5. My beliefs about my sexual orientation are firmly held.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

6. I have questioned which sexual orientation is right for me.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

7. I am not sure about which sexual orientation is best for me.

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

8. I have engaged in several discussions concerning my sexual orientation

Strongly Disagree 0----------1----------2----------3----------4----------5 Strongly Agree

Gender

Circle or mark the answer that best describes you. Please answer the questions honestly and to the best of your ability

1. Please **circle the number** that best represents how you view **yourself** (Your own gender expression)

0----------1----------2----------3----------4----------5----------6

Very Feminine Very Masculine

2. Please **circle the number** that best represents how you think **others** view you (Your gender presentation)

0----------1----------2----------3----------4----------5----------6

Very Feminine Very Masculine

3. Between the ages of 6 and 12, did you prefer

____to play with boys ____to play with girls ____didn't' make any difference ____not to play with other children

____don't remember

4. Between the ages of 6 and 14 which did you like more, romantic stories or adventure stories?

____liked romantic stories more ____liked adventure stories more ____it did not make any difference

5. Between the ages of 6 and 12, when you read a story, did you imagine that you were

____the male in the story (cowboy, detective, soldier, explorer, etc.).

____the female in the story (princess, the girl being saved, mother, etc.).

____the male sometimes and the female other times

____neither the male nor the female

____did not read stories

Reasons for Use of Services

1. Are you currently in counseling or therapy? ____ yes ____ no ____ don't know

2. Do you feel these services are helping to resolve the issues? ____ yes ____ no ____ don't know

3. Have you ever been in counseling or therapy? ____ yes ____ no ____ don't know

4. Did you feel these services helped to resolve the issues? ____ yes ____ no ____ don't know

5. Approximately when was your last therapy visit? _____

6. Approximately how many total months did you see a therapist? _____

7. Please talk about why you went to therapy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

___Not Applicable

From the following options, please rank the top <u>5 reasons</u> why you attended therapy. ***1 (most important) to 5 (least important)***

___Issues relating to family/friends
___Help with coming out/Sexual orientation identity
___Desire to talk with an advocate
___A friend recommended therapy
___Conflict between religious beliefs and sexuality
___Romantic Relationships
___Self image/Body image
___Depression
___Anxiety
___Harassment/Victimization
___Help dealing with stress
___Drugs/Substance use
___Other:_____
___Not Applicable (I did not attend therapy)

*Thinking **hypothetically**, if you were to attend therapy, how likely would the following be reasons for using mental health services? For each response gin an answer for both **yourself** and **another** LGBT young adult. (Please complete even if you have not been to therapy).*

Yourself: *How likely are these reasons you might attend therapy?*	**Others:** *How likely are these reasons another LGBT young adult might attend therapy?*
1a. Issues relating to family/friends Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	1b. Issues relating to family/friends Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
2a. Help with coming out/Sexual orientation identity: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	2b. Help with coming out/Sexual orientation identity: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
3a. A friend recommended that **I** talk to a therapist: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	3b. A friend recommended **they** talk to a therapist: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
4a. Desire to talk with an advocate : Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	4b. Desire to talk with an advocate Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
5a. Conflict between moral/religious beliefs and sexuality: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	5b. Conflict between moral/religious beliefs and sexuality: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
6a. Issues relating to romantic relationships: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	6b. Issues relating to romantic relationships: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
7a. Issues relating to self image/body image: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	7b.Issues relating to self image/body image: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
8a. Issues relating to depression: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	8a. Issues relating to depression: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
9a. Issues relating to anxiety: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	9a. Issues relating to anxiety: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
10a. Issues relating to harassment/victimization: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	10b. Issues relating to harassment/victimization: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
11a. Help dealing with stress: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	11b. Help dealing with stress: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6
12a. Issues relating to drug/substance use: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6	12b. Issues relating to drug/substance use: Not at all likely Extremely Likely 0-----1-----2-----3------4-----5-----6

Attitudes Toward Therapy

Please circle the number that best describes you. Please answer the questions honestly and to the best of your ability

1. If I believed that I was having an emotional crisis, my first inclination would be to get professional attention.

Disagree 0----------1----------2----------3 Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

Disagree 0----------1----------2----------3 Agree

3. If I were experiencing a serious emotional crisis at this point I my life, I would be confident that I could find relief in psychotherapy.

Disagree 0----------1----------2----------3 Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.

Disagree 0----------1----------2----------3 Agree

5. I would want to see a therapist if I were worried or upset for a long period of time.

Disagree 0----------1----------2----------3 Agree

6. I might want to have psychological counseling in the future.

Disagree 0----------1----------2----------3 Agree

7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.

Disagree 0----------1----------2----------3 Agree

8. Considering the time and expense involved in therapy, it would have doubtful value for a person like me.

Disagree 0----------1----------2----------3 Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

Disagree 0----------1----------2----------3 Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

Disagree 0----------1----------2----------3 Agree

Feelings About Life

This is a list of problems and complaints that people sometimes have. For each one, indicate how much that problem has bothered or distressed you during the ***past week****, including today*

1. Nervousness or shakiness inside.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___ Not Sure/Don't know

2. Suddenly scared for no reason.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___Not Sure/Don't know

3. Feeling fearful.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___Not Sure/Don't know

4. Feeling tense or keyed up.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___Not Sure/Don't know

5. Spells of terror or panic.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___Not Sure/Don't know

6. Feeling so restless you could not sit still.

___Not at all ___A little bit ___ Moderately ___ Quite a bit ___ Extremely ___Not Sure/Don't know

*Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the **past week.***

During the past week…	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I felt happy	0----------1----------2----------3			
2. I felt depressed	0----------1----------2----------3			
3. I felt lonely	0----------1----------2----------3			
4. I felt sad	0----------1----------2----------3			
5. I did not feel like eating; my appetite was poor	0----------1----------2----------3			
6. People were unfriendly	0----------1----------2----------3			
7. I felt that people disliked me	0----------1----------2----------3			
8. I enjoyed life	0----------1----------2----------3			

Harassment Experiences

Circle the number or mark the answer that best describes you. Please answer the questions honestly.

How often do you hear others make negative comments based on:

1. Sexual Orientation ____ Never ____Rarely ____Sometimes ____Often
2. Gender presentation ____ Never ____Rarely ____Sometimes ____Often

During the past 12 months, how many times were you harassed for any of the following reasons?

3. Because you are gay, lesbian, or bisexual or someone thought you were

0----------1----------2----------3

0 times 1 time 2-3 times 4 or more times

4 Because you weren't "masculine enough"

0----------1----------2----------3

0 times 1 time 2-3 times 4 or more times

5. Because you weren't "feminine enough"

0----------1----------2----------3

0 times 1 time 2-3 times 4 or more times

6. Because you didn't fit in

0----------1----------2----------3

0 times 1 time 2-3 times 4 or more times

Reaction to Current Political Climate

We live in a time of important cultural and political change for LGBT individuals (both positive and negative change). For each item indicate how positively it has impacted you to be alive during this time.

Being alive during this time has helped me to...

1. ...finally grasp how homophobia impacts me personally

Not at all positive 0----------1----------2----------3----------4 Extremely positive

2. ...feel less shame as an LGB person

Not at all positive 0----------1----------2----------3----------4 Extremely positive

3. ...increase my self-understanding

Not at all positive 0----------1----------2----------3----------4 Extremely positive

4. ...look at my beliefs about self, community, politics, etc.

Not at all positive 0----------1----------2----------3----------4 Extremely positive

5. ...to come together with partner(s)/lover(s)

Not at all positive 0----------1----------2----------3----------4 Extremely positive

6. ...come out at work

Not at all positive 0----------1----------2----------3----------4 Extremely positive

7. ...come out among friends

Not at all positive 0----------1----------2----------3----------4 Extremely positive

8. ...come out to family of origin

Not at all positive 0----------1----------2----------3----------4 Extremely positive

9. ... feel stronger as an LGB person

Not at all positive 0----------1----------2----------3----------4 Extremely positive

10. ... deal with my negative feelings about being LGB

Not at all positive 0----------1----------2----------3----------4 Extremely positive

11. ... confront fears about being out as an LGB person

Not at all positive 0----------1----------2----------3----------4 Extremely positive

12. ...question own religious values/beliefs

Not at all positive 0----------1----------2----------3----------4 Extremely positive

CODING SCHEME FOR OPEN-ENDED REASONS TO USE THERAPY

APPENDIX C

Coding Scheme for Open-ended Reasons to Use Therapy

000 Participant Failed To Give at Least 4 Responses or if No Other Statement Was Given.

001 Not about Sexuality (Explicit)

010 Reparative Therapy to Fix Sexuality

020 Victimization
- 021 Sexual Abuse / Rape
- 022 Partner Abuse
- 023 Peer Victimization / Bullying
- 024 Parental Abuse
- 025 Parent Neglect/Abandonment

030 Interpersonal Relationships
- 031 Romantic
- 032 Family
- 033 Peers
- 034 Parents

040 Minority Stress

050 Coming Out
- 051 Family
- 052 Parents
- 053 Friends
- 054 Work

060 Mental Health-(Obsessive Compulsive Disorder, Severe Loneliness, Post Traumatic Stress Disorder, Low Self Esteem, Insomnia, Other Specific Disorders)
- 061 Anxiety
- 062 Stress
- 063 Depression
- 064 Substance Use/Abuse
- 065 Suicidality
- 066 Anger Management
- 067 Bipolar
- 068 Self-Mutilation
- 069 Attention Deficit Disorder

070 General Support
- 071 Recommendation from Others
- 072 For Parental Education
- 073 Death

074 Divorce
075 Recovery (From Addiction)

080 Identity
081 Personal Identity
082 Sexual Identity
083 Gender Presentation
084 Transition to New Gender
085 Religion

090 Achievement
091 School Problems

100 Somatic