INTERSECTING IDENTITIES AND CONFLICT AS MODERATORS OF THE RELATIONSHIP BETWEEN DISCRIMINATION AND MENTAL HEALTH IN EMERGING ADULTHOOD

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Individuals with a minority sexual identity, such as lesbians, gay men, and bisexuals (LGB) face increased risk for stigmatization surrounding their sexual identities and subsequent psychological distress. Sexual minorities of color (SMOC) face the same difficulties faced by White sexual minorities, often compounded with stigma and discrimination linked to their racial/ethnic identities. However, because SMOC remain underrepresented in research on LGB issues, empirically-driven knowledge about these groups is lacking, even among outcomes where noted disparities exist, such as depression. Emerging adulthood may be a particularly important period for understanding effects of intersectional identities and discrimination among SMOC, who often navigate identity-related milestones and experiences independently for the first time within this developmental period. This study examined the relationships between discrimination based upon racial/ethnic and sexual intersecting identities and depression symptoms among emerging adults, as well as ways that group identity factors (ethnic identity, sexual identity, conflicts in identity allegiances) moderated this relationship. Findings indicated that experience of intersectional discrimination was strongly, positively related to depression symptoms. Ethnic identity negatively related to depression independently, but not in the regression model accounting for other variables. Identity factors were not found to statistically significantly moderate the relationship between discrimination and depression symptoms. Discussion centers on potential mechanisms involved in the relationship between intersectional discrimination and depression, and future avenues to expand work with SMOC.

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CHAPTER 1

INTRODUCTION

Despite substantial shifts in the modern social landscape, a large body of research indicates that, when compared to heterosexuals, individuals with a marginalized sexual identity are at increased risk for psychological distress and behavioral difficulties (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Meyer, 2010). While an increasing body of work has examined sexual minority stress and its implications for mental health (Mays & Cochran, 2001; King et al., 2003; Meyer, 2003; Rosario, Scrimshaw, Hunter, & Gwadz, 2002), much of this work is limited in its ability to address minority stress in relation to intersections of racial/ethnic and sexual identities. This is disheartening as the literature severely underrepresents sexual minority Persons of Color despite the very real weight of minority stress on mental health (Huang et al., 2010).

In a content analysis of literature discussing Sexual Minorities of Color (SMOC), Huang and colleagues (2010) found that, while growing, research that considers racial/ethnic and sexual identities together is limited. Studies examining links between sexual orientation and mental health largely represent experiences of White individuals (Mays & Cochran, 2001; Meyer, 1995). Studies of sexual minority stress that may have included Persons of Color often failed to report participants' racial/ethnic identities altogether (King et al., 2008; Marshal et al., 2011). Likewise, studies that examine issues of racial/ethnic group identity and mental health frequently rely on predominantly heterosexual samples (Nadal et al, 2014), or fail to report sexual orientation of participants (Huynh et al., 2014; Pieterse & Carter, 2007). In short, it is difficult to determine the extent to which the experiences of SMOC are represented in studies informing theory concerning identity and mental health.

In the absence of nationally representative census or epidemiological data surrounding minority sexual orientations and gender identities, it has been difficult to determine demography breakdown by both race/ethnicity and sexual orientation until fairly recently. Recent work, such as the GenForward survey, suggest that there are notable differences in how individuals of different racial/ethnic groups label their sexual identities and perceive needs of the LGBT* community at large (Cohen, Fowler, Medenica, & Rogowski, 2018). Although this body of work is still relatively sparse, evidence suggests that simply examining facets of racial/ethnic and sexual identities independently does not sufficiently contextualize the experiences of SMOC (DeBlaere, Brewster, Sarkees, & Moradi, 2010; Huang et al., 2010). Rather, much work suggests that the experiences of SMOC may best be understood by critically analyzing contributions of racial/ethnic and sexual identities simultaneously, examining concepts unique to the intersection of these identities (Bowleg, 2013; Logie & Rwigema, 2014).

In a 2011 article discussing the creation of the LGBT People of Color Microaggressions Scale, Balsam, Molina, Beadnell, Simoni, and Walters report that SMOC participants, while not altogether homogenous, reported distinct similarities when questioned regarding the intersections of their racial/ethnic and sexual identities. In addition to challenges linked to specific identity circumstances (e.g., "feeling unable to return to your home country because you are LGBT"), common themes emerged across three domains: heterosexism within racial/ethnic communities, racism within LGBT spaces, and difficulty finding a partner or finding community. Balsam et al.'s (2011) findings suggest that in an LGBT culture that focuses the experiences of White gay men and lesbians, the experience of racism within LGBT spaces, paired with heterosexism within family spaces, may be a unifying thread in the experiences of SMOC across racial/ethnic

* Use of acronyms LGBT, LGBTQ, LGB, etc., throughout this paper reflect how groups are referred to within works being cited.

backgrounds. Such a unifying thread may parallel ways that heterosexist stigma is often a common theme in the varied experiences of sexual minorities across a variety of sexual identities (Meyer, 2003).

Theoretical Perspectives on Intersecting Identities

Much of the work conceptualizing racial/ethnic and sexual identity intersections highlights the mechanisms by which these identities are distinct from one another, and how these differences frame experiences of SMOC. Solomon (2014) describes these identities as being horizontal or vertical, in relation to the family context. Horizontal identities (e.g., sexual minority identification) are perceived in their deviation from a baseline culture, and lack (or infrequency) of heritability. Indeed, since many sexual minorities are born to heterosexual parents, construction and development of a sense of sexual identity often must occur outside of the family unit; as such, this development may be delayed until an individual is able to do so independently (Solomon, 2014). Solomon argues that vertical identities (e.g., racial/ethnic identity), are inherited, passed down from parents to children, and reinforced through both genetics and sociocultural norms. Subsequently, these identities may clash, as desire to form a stronger sexual identity may come into conflict with threats of exclusion from family and/or racial/ethnic communities. As such, horizontal and vertical indicators of identity must be considered together, as each informs an individual's experience, much like coordinates on a map.

These identities may also be operationalized as a product of their concealability, with racial/ethnic identities conceived of as visible, and sexual minority identities considered concealable. While individuals might avoid discrimination based upon sexuality by concealing these identities, it is much less probable that they can avoid discrimination based upon their perceived racial/ethnic backgrounds (Choi, Han, Paul & Ayala, 2011).

In his classic work on stigma, Goffman (1963) theorized that individuals with a concealable stigmatized identity may face a range of negative consequences if/when that identity is revealed. That possibility may heighten motivations to conceal. Once a concealable stigmatized identity is revealed within a social interaction, Goffman (1963) argued, an individual may subsequently feel pressure to mitigate subsequent negative impressions surrounding their identity. Feelings of stigmatization may prompt individuals to engage in a variety of protective behaviors, ranging from avoidance of the non-stigmatized majority to attempts to pass as members of the majority (Scrambler, 1989). Many SMOC may face pressure to maintain a "closeted" lifestyle (Drescher, 2004. Moradi et al., 2010; Morris, Waldo, & Rothblum, 2001), maintaining extreme discretion in disclosure of their sexual identities to avoid victimization, This concealment can interrupt the lives and well-being of the stigmatized with heightened anxiety, stress, and feeling socially distant from friends and family (Meyer, 2003; Scrambler, 1989; Scrambler & Hopkins, 1986).

Work in this area suggests that the ability to conceal a stigmatized identity may hold unique implications for psychological well-being (Potoczniak, Aldea, & Deblaere, 2007). The unique realities of social inequality and identity for those with both concealable and non-concealable stigmatized identities have often left researchers at a loss for how to adequately measure the impact of intersecting identities. For instance, while some may conceptualize identity intersections as additive forces in the lives of individuals with multiple minority statuses, this approach is met with harsh feedback from critics (Collins, 1995; Weber & Parra-Medina, 2003). Weber and Parra-Medina (2003) describe the conundrum associated with asking a person who may be oppressed on multiple fronts (for instance, a Latina woman from a low SES

background) to identify a single root of that oppression, for which responses can range from messy to uninformative.

Highlighting the ways that multiple reinforcing structures of oppression must be considered together to properly analyze effects of oppression, the term 'intersectionality' emerged from sociological discussions rooted in intersections of feminist and anti-racist social movements in the 1960s-70s (hooks, 1984). Kimberlé W. Crenshaw (1989, 1991) is credited as the first to publish about intersectionality by name. Crenshaw's conceptualization initially described the ways that Black women were doubly excluded from discourse surrounding feminism in favor of White women, and within anti-racist discussions in favor of Black men. A key principle of intersectionality is that social identities are interdependent and multidimensional (Collins, 1991). That is, researchers examining issues related to one identity (e.g., race/ethnicity) cannot do so adequately without also considering other relevant identities (e.g., socioeconomic status; SES). Many of the presumed privileges and disadvantages associated with being a member of a particular racial/ethnic group may be substantially different, depending on levels of SES. Likewise, the way that those of different socioeconomic backgrounds experience life may differ drastically based upon race/ethnicity. That is, the identities of SMOC can affect both day-to-day interpersonal interactions, such as family life, as well as systemic access to resources, such as employment and housing discrimination. Intersectional marginalization often leaves many people of color (and those who occupy other marginalized identities), with trouble both seeking representation and even basic support (Malebranche, Peterson, Bryant, & Harper 2004; Mays, Cochran, & Rhue 1993; Balsam, Molina, Beadnell, Simoni, and Walters, 2011).

Intersecting Identities, Risk, and Resilience

Intersections of social identities that operate at the individual level and collectively are

expressed within a broader societal context. For instance, the multiple jeopardy advantage hypothesis (Ransford, 1980) stipulates that those who live with various social identities (e.g., race/ethnicity, sexual orientation, gender, class) occupy a unique social space. The status of this space is distinct to the intersection of the identities in question (for instance, race/ethnicity and sexual orientation), and explains more than either of the two identities alone. Within this framework, the combination of multiple privileged identities would result in multiple advantages, while the combination of multiple disadvantaged identities would result in multiple jeopardy. Ransford's line of thinking here seems to conceptually fit most closely with modern notions of intersectionality (e.g., Khan, Ilcisin, & Saxton, 2017). Bowleg (2013) aptly describes this phenomenon, utilizing the metaphor of a cake that once mixed and baked, cannot simply be reduced to the sum of its individual components. Rather, it is these components, the processes involved in combining them, and the conditions in which they intersect, that determine the final creation Bowleg (2008).

Research examining psychological outcomes among SMOC seems entrenched in debate on the nature of intersecting identities and their association with mental health outcomes. Competing hypotheses consider identification with racial/ethnic and sexual minority statuses as a risk factor and a source of resilience (Goedel, Hickson, & Duncan, 2017; Holt et al., 2012; Lelutiu-Weinberger et al., 2013; Meyer, 2010). The resilience hypothesis suggests that, rather than a simple multiplicative increase in risk due to experience of multiple sources of discrimination, these experiences can shape how a person learns to cope with future events (Meyer, 2010). Supporting this idea, several studies emphasize that living with multiple minority statuses may hold positive implications for resilience (Bowleg et al., 2003; Moradi et al., 2010; Adams, Cahill, & Ackerlind, 2005; Wilson & Miller, 2003), buffering many negative

implications of societal stigma. Frost and Meyer (2012), for example, argue that those who hold disadvantaged minority identities may feel more connected to these identities and their cultures than more privileged peers. Meyer (2010) suggests that, for SMOC, experience successfully coping with racial/ethnic discrimination prior to being open about their sexual identities may buffer the impact of homophobic discrimination downstream.

Notably, application of the resilience hypothesis suggests that SMOC actually possess more resources than sexual minority White counterparts to deal with stressful situations. However, this hypothesis conflicts with findings typical for marginalized groups within the U.S. Scholarship that suggests a heightened risk points to the compounding of stress linked to experiences of homophobia, racism, and less access to mental health resources for SMOC in comparison to Whites. This line of thought seems consistent with the understanding of outcomes found with each of these minority statuses separately, with mixed findings found for examinations of SMOC. Schwartz and Meyer (2010) highlight potential methodological issues contributing to this gap in understanding, citing the distinctions between within-groups designs (e.g., mental health trajectories among SMOC) and between-groups designs (e.g., comparisons of heterosexual and LGB mental health outcomes). A majority of studies examining the impacts of racial/ethnic identity and sexual identity do so separately (Huang et al., 2010; Meyer, 2010), which hampers knowledge of the effects of these factors on SMOC.

Group Identity and Identity Conflict

A growing body of research examines the ways individuals' perceptions of their own identity may hold broad implications for their ability to cope with stigmatizing experiences and overall well-being (Phinney et al., 1997; Schmitt et al., 2014). Complications arise, however, when trying to weigh the impact of living with historically disadvantaged and privileged

identities together. Strength of identification may substantially frame experiences of SMOC (Bowleg et al., 2009; Goode-Cross & Good, 2009).

Identification with the gay community has had mixed implications for well-being, with evidence of both protective and risk factors across outcomes such as substance use, sexual risk behaviors, and mental health (Holt et al., 2012; Lelutiu-Weinberger et al., 2013; Szymanski, 2006). Evidence indicates, for instance, that strong commitment to one or more social identities may be a predictor of mental health outcomes (Ghavami et al., 2011). For example, aving a strong sense of identification with the LGB community is linked with reduced depression symptoms (McLaren et al., 2013). Indeed, for sexual minorities, involvement within a broader community may promote feelings of belonging and fulfillment (McMillan & Chavis, 1986), and lower feelings of anxiety and stress (Woodford et al., 2014).

Similarly, a large body of research examines the effects of having a strong racial/ethnic identity on a variety of well-being outcomes (e.g., Schmitt et al., 2014). While mixed, findings often indicate that a stronger sense of commitment to a racial/ethnic group is associated with better mental health outcomes (Rivas-Drake et al., 2014), higher self-esteem (Phinney et al., 1997), and lower anxiety and depressive symptoms (Costigan et al., 2010; Fisher et al., 2014). Notably, however, SMOC may face racial/ethnic stigmatization within sexual minority communities (Han, 2007), and contend with homophobia and biphobia within racial/ethnic communities including families (Bieschke et al., 2008). As Han (2007) describes, racist attitudes tend to persist within LGBTQ+ spaces under the guise that those who experience homophobic discrimination cannot be bigoted themselves, or that racism under the guise of sexual selectivity does not have downstream consequences.

Given the potential for stigmatization within shared-identity communities, balancing the

influence of these identities may prove to be a source of stress (Sarno, Mohr, Jackson, & Fassinger, 2015). Further, protective factors present for heterosexual people of color may not necessarily generalize for SMOC. In 2014 a study of LGBT Youth of Color, Kuper, Mustanski, and Coleman found that, while coping-based racial/ethnic socialization messages can serve as a source of reassurance in the face of discrimination, those with concerns of parental rejection of an LGBT identity may not necessarily reap the same benefits. Similarly, in comparison to Whites, well-being among SMOC may not be as positively affected by greater affiliation with others in the community. Yet, the influence of positive sexual identity development among SMOC may be less protective than that of racial/ethnic identity (Walker, Longmire-Avital, & Golub, 2015). Greene (1997; 2002) argues that for many people of color, while life takes influence from group history and communities, it is inextricably linked to the will of the dominant society, as a function of power and access. Greene further argues that the interaction of differently visible aspects of identity plays a substantial role in formation of a collective identity. For instance, for some SMOC, increasing exposure and commitment to racial/ethnic identity may expose individuals to anti-LGB attitudes and cultural norms, and subsequently hamper positive sexual identity development (Bieschke et al., 2008; Espin, 1993)

Originally coined by Morales (1989), conflicts-in-allegiance (CIA) theory describes a person's feelings of perceived incompatibility between racial/ethnic and sexual identities. CIA stipulates that racial/ethnic and sexual identities need to be experienced separately because feelings from participation in lifestyles associated with either identity betrays the other (Sarno, et al., 2015). Sarno and colleagues (2015) found that participants who identified strongly with both their ethnicity and their sexual orientation experienced less conflict than those who identified with one more strongly than the other. Supporting CIA is evidence that increased conflict

between racial/ethnic and sexual identities is associated with increased psychological distress (Santos & VanDaalen, 2016), though it may be a familiar feeling for many SMOC (Balsam et al., 2011; Morales, 1989).

Intersecting Discrimination and Mental Health

Experiences of discrimination and stigma surrounding identity can hold a wide array of implications for physical and mental health. Societal attitudes that disparage identity can be internalized (Crocker, 1999), lead to increased harassment and violence against those perceived as part of stigmatized minority groups (Federal Bureau of Investigation, 2016), and subsequently increase risk for mental illness (Feinstein, Goldfried, & Davila, 2012). Sexual minority Persons of Color in the U.S. navigate a cultural landscape that can be simultaneously discriminatory to multiple aspects of their identities.

Among people of color (POC), studies have found that racial discrimination has been linked to increased risk for depression (Alegría et al., 2007; Kim & Choi, 2010), worsened depression symptoms (Williams et al., 2007), and increased risk for suicide (Chu, Goldblum, Floyd, & Bongar, 2010). Experiences and perceptions of racial/ethnic discrimination have been linked to depression among Latinx and Black communities in particular (Torres, 2009; Ong, Fuller-Rowel, & Burow, 2009). Similarly, experiencing heterosexist discrimination has been linked with higher levels of depression and increased risk for suicidality among sexual minorities across a variety of contexts and geographic locations (Herek et al., 1999; King et al., 2008; Lewis, Derlega, Griffin, & Krowinski, 2003; Marshal et al., 2013), though findings are mixed when examining SMOC. In addition, the intersections of sexual/gender and racial/ethnic minority identities may lead to greater susceptibility for the downstream psychological impacts of discrimination (Cochran & Mays, 1994; Diaz et al., 2001; Wilson & Yoshikawa, 2004). Both

in comparison to White individuals and to heterosexual POC, SMOC seem to demonstrate elevated risk for heightened symptoms of depression and suicidality (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Consolacion, Russell & Sue, 2004). As Baams, Grossman, and Russell (2015) suggest, among LGB youth this increased risk for suicidality and depression may be linked to feelings of burdensomeness to people in their lives, echoing some sentiments expressed in Balsam et al.'s 2011 study (e.g., "Feeling like you are reflecting negatively on your ethnic group because you are LGBT").

In addition to facing multiple potential sources of harassment and discrimination, this discrimination may even be compounded further by the source. For instance, racism within the LGBTQ+ community may push SMOC further from would-be primary sources of support, given potential for familial rejection due to sexual orientation (Han, 2007). This within-group discrimination is also evidenced across various racial/ethnic groups, such that SMOC may experience heterosexist discrimination from within their own cultural groups and families (Malebranche, Fields, Bryant, & Harper, 2009; Siegel & Epstein, 1996, Bridges & Selvidge, 2003). This type of harassment by those considered to be part of a person's in-group and broader community contextualizes findings that SMOC are less likely to feel supported by the LGBTQ+ community than White counterparts, and even less likely to consider themselves to be a part of the community (Han, 2007).

Beyond the immediate harm caused by experiences of harassment and assault, fear of such harassment can add an additional burden of stress, further victimizing those already vulnerable to the ire of a majority society (Meyer, 2003). McCabe and colleagues (2010), for instance, found that stress linked to experiences of discrimination based upon race/ethnicity, gender, and sexuality was associated with increased risk for substance use problems. Especially

concerning was that more than two thirds of LGB participants indicated having experienced at least one instance of discrimination based upon aforementioned identity characteristics. Individuals who experienced discrimination based upon racial/ethnic, sexual, and gender identities within the past year were three times as likely to meet criteria for a substance use disorder. Further compounding the negative effects of both stigma and psychological difficulty (Hughes & Eliason, 2002), sexual minorities facing psychological difficulties are less likely to seek help for these problems (McCabe, Bostwick, West, Hughes, & Boyd, 2013). This reduction in help-seeking may be rooted in both feared and lived experiences of discrimination from helping professionals (Beehler, 2001).

Intersectional Identities in Developmental Context

The relationship between racial/ethnic and sexual identities may be particularly important to understand within the context of emerging adulthood (Arnett, 2007). Problems with social stresses and anxiety may be especially problematic in younger adults compared to older adults (Grant et al., 2005). Emerging adulthood, often conceptualized as the period between legal adulthood and an individual's late twenties, can be a period in which SMOC further integrate and contextualize their racial/ethnic and sexual identities, in a way that can be categorically dissimilar to the experiences of White sexual minorities. For instance, while sexual identity development is often prompted by an internal trigger (e.g., experiencing and identifying same-sex attraction), ethnic identity development is often triggered by experiences completely external to an individual's control (Jamil, Harper, & Fernandez, 2009). Indeed, individuals' awareness of their own ethnic identities is often prompted by experiences with racially/ethnically dissimilar people, and instances of racism, which typically results in awareness of this identity "coming online" earlier in life than sexual identity, with some exceptions (Herdt & McClintock, 2000).

As Jamil, Harper, and Fernandez (2009) further describe, sexual minority Youth of Color may utilize community and family support in contextualizing their racial/ethnic identities, while navigating sexual identity development outside of the family context (e.g., via the internet). Categorized by exposure to new stresses, roles, and responsibilities, emerging adulthood sets the stage for how individuals handle this stress later in life (Arnett, 2007), and may be especially relevant for SMOC. Many sexual minorities disclose sexual orientation to family and peers for the first time as young adults (Rosario et al., 2001), which can be an anxiety-provoking experience with potentially damaging consequences (Baiocco et al., 2014). Cultural stigma can subsequently heighten anxieties and increase risk of a negative outcome to a minority sexuality disclosure (Pearson, Thrane, & Wilkinson, 2017). Rejection from parents can severely impact both emotional and financial resources for sexual minority youths. In a 2004 study of Asians and Asian Americans, Kimmel and Huso found that many LGB young adults felt the pressure to remain closeted to preserve family expectations, negatively shaping both conceptions of identities, and future prospects. While evidence suggests that SMOC may be less likely to be out than White counterparts (Moradi et al., 2010; Morris, Waldo, & Rothblum, 2001), for many, the narrative of coming out may not fit their experiences. For instance, same-gender-loving Men of Color may live fulfilling lives, independent of the coming out conversations with family members typically deemed essential on the road to identity achievement for Whites (Hawkeswood, 1996; Johnson, 2008; Peña, 2004).

In a series of interviews of 100 black lesbians, Moore (2011) identifies ways that mainstream research may miscategorize or misunderstand the needs and lives of SMOC, including issues of identity and coming out. For many women interviewed, widely disseminated trajectories to understanding sexual identity achievement were not accurate, failing to consider

relevant cultural concerns of black families, as well as more systemic issues linked to status and educational goals (Diamond & Savin-Williams, 2000). For many, "coming into the life" was a more appropriate description of their journey, managing sexual identity in relation to racial/ethnic and other identities, while learning norms of other black lesbians after having attained educational and career goals. Some women interviewed chose to forego relationships and acknowledgement of sexuality earlier in life due to concerns of heterosexist stigma, which could pose yet another barrier to academic and occupational achievement. This process of learning norms and expectations within Black gay social circles, and fellowship with other black lesbians ultimately influenced both how they interpreted and disclosed their same-sex desires. This route of coming to terms with one's identity may be largely a matter of survival. These findings seem to be consistent with work that suggests that racial/ethnic identification does not directly interfere with sexual identity development, but rather may play a role in the integration of both identities.

Additionally, while rates of educational attainment are growing for many groups, the achievement gap for college-educated, lower SES Persons of Color is still lower than that of high school-educated high SES Whites, resulting in a categorically different social landscape for many SMOC (U.S. Bureau of Labor and Statistics, 2016). Given the importance of this period in the development of adult identity, understanding how the intersections of sexuality and race/ethnicity affect younger adults may help prevent problematic outcomes later in life, e.g., anxiety and depression, substance abuse, suicide, (Bostwick et al., 2010; Eisenberg & Resnick, 2006). This is especially relevant in the face of knowledge that these experiences may be exacerbated by facing off against multiple forms of discrimination and lack of access to resources (McCabe et al., 2010).

The Present Study

The especially complex nature of intersections of identity often leaves many people of color, and those who occupy multiple marginalized identities generally, with trouble both seeking representation and even basic support (Malebranche, Peterson, Bryant, & Harper 2004; Mays, Cochran, & Rhue 1993; Balsam et al., 2011). At an individual level, SMOC may feel conflict between racial/ethnic and sexual identities. Interpersonally, feared or experienced rejection of one or more identity statuses among peers and loved ones may contribute to feelings of isolation. Being perceived as a member of both racial/ethnic and sexual minority groups may flag SMOC as targets for harassment and discrimination, with tangible damages and downstream psychological consequences.

The present study seeks to examine these factors, particularly the extent to which discrimination and group identity relate to depression symptomatology among sexual minority emerging adults, and whether CIA moderates the relationships between discrimination, group identity, and depression.

Primary Hypotheses

The present study tests the following hypotheses:

1) Experience of discrimination positively correlates with depression.
2) Group identity negatively correlates with depression symptoms.
    a. Ethnic identity negatively correlates with depression.
    b. Sense of LGB identity negatively correlates with depression.
3) Conflicts-in-allegiances positively correlates with depression
4) Group Identity moderates the relationship between discrimination and depression, such that:

a. Having a stronger ethnic identity buffers the relationship between discrimination and depression;

b. Having a stronger sexual identity buffers the relationship between discrimination and depression.

Exploratory Hypotheses

5) Exploratory: Conflicts-in-allegiances (CIA) moderates the relationship between group identity and depression.

CHAPTER 2

METHOD

Participants

A power analysis using the GPower 3.1 software indicated that in order to observe a medium effect (f = .15; conservative estimate based on findings of Balsam et al., 2011) at 80 percent power, at least 167 participants were needed. To allow for group comparisons and descriptive analysis of differences based upon race/ethnicity, gender, and sexual orientation, targeted recruitment efforts focused on oversampling underrepresented SMOC within the LGBTQ community.

The current study included 313 individuals ages 18-29 (M = 21.69, SD = 3.39) who identified as sexual minorities of color, and completed at least one full study measure. Data were drawn from an initial sample of online participants (N = 1433), of whom 49 participants indicated that they had carelessly clicked through the data and suggested that it not be used. Next, sample participants who did not meet inclusion criteria (at least one non-White racial/ethnic identity, minority sexual identity, reported an age between 18 and 29) were excluded from further analysis (n = 1041). Fifty-three participants failed to complete the majority of study measures, leaving a final sample of 313 participants who completed at least one full study measure. Due to randomization of measure order, data completeness for remaining participants who completed a portion of the study measures varies, with no patterns of missingess found using Little's MCAR test. Data for those participants were included in each analysis for which that measure or variable is not required, resulting in an effective sample size of 88 for primary analyses, and 114 for exploratory analyses.

Descriptive statistics for study variables are shown in Tables 1-2. The sample was

predominantly cisgender (87.8%), female (62.8%), bisexual (35.8%), and had completed at least some level of postsecondary education (76.0%). Most participants were University of North Texas students (56.8%), with 83.3% of those individuals completing the study as part of the SONA participant pool. The remainder who completed the study were recruited from social media (2.0% from Reddit, 24.3% from Facebook, and 0.7% from other social media), from Physical Flyers (2.1%), and via word-of-mouth or another source (2.7%). The remainder of the sample (13.4%) failed to report a recruitment source.

Measures

Sexual Orientation

Participant sexual orientation was measured with a face-valid item ("How would you classify your sexual orientation?") to assess sexual orientation. Categorical responses for sexual identity included: gay/lesbian/homosexual, bisexual, pansexual, heterosexual, asexual, not sure/questioning, and other. Responses listed in "other" were examined to determine the extent to which these fit well with other categories. Participants were allowed to select each sexual identity with which they identified, which resulted in some participants selecting more than one sexual identity (frequently, these consisted of combinations of "pansexual" and "queer" with other sexualities, and were coded as "more than one sexual identity").

Racial/Ethnic Background

Participant racial/ethnic background was measured using a face-valid item, "Which of the following best describes your race or ethnicity? (please select all that apply)." Participants were provided the following options: Asian or Asian American, Latino/a American/ Hispanic, Pacific Islander, African, African American or Black, Native American, Alaska Native, European, White, or Caucasian, and an open-ended response for other racial/ethnic groups not listed. Those

who indicated multiple racial/ethnic groups were categorized as “Multiracial or More than one race or ethnicity.”

Intersectional Discrimination

Instances of discrimination based upon both racial/ethnic and sexual identities was measured using the distress subscale of the LGBT People of Color Microaggressions Scale (LGBT-PCMS; Balsam et al., 2011). The 18-item scale captures frequency and distress related to three aspects of intersectional discrimination, including heterosexism within POC communities (“Not being accepted by other people of your race/ethnicity because you are LGBT”), Racism within LGBT communities (“Being told that ‘race isn’t important’ by White LGBT people”), and LGBT relationship racism (“Reading personal ads that say ‘White people only’”). Participants were asked whether scale items occurred and the extent to which the events bothered them on a 5-point Likert-type scale, ranging from 0 (Did not happen/not applicable to me) to 4 (It happened, and it bothered me extremely). The subscale demonstrates construct and discriminant validity and excellent internal consistency (Cronbach’s $\alpha = .92$; Balsam et al., 2011).

Ethnic Identity

Participants reported their ethnic identification on the 12-item Revised Multigroup Ethnic Identity Measure (MEIM-R), as revised by Phinney and Ong (2007). The composite measure captures two factors—Identity exploration and Commitment. Some example items include: “I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs” (exploration), and “I have a strong sense of belonging to my own ethnic group” (commitment). The items are rated using a 5-point Likert-type scale from 1, *strongly disagree*, to 5, *strongly agree*. The MEIM-R has demonstrated good construct validity utilized as one

"identity" factor, as well as utilizing subscales of exploration and centrality (Chakawa, Butler, & Shapiro, 2015; Phinney & Ong, 2007).

LGB Identity

Participants were administered the Lesbian, Gay, and Bisexual Group Identity Measure, an adaptation of the MEIM (Phinney, 1992) as adapted by Mohr and Fassinger (2000). The 12-item adapted MEIM (henceforth referred to as LGBIM) asks participants to indicate levels of exploration of and commitment to LGB Identity, or overall sense of group identity on a 4-point Likert-type scale. Example items include "I feel a strong attachment to the LGB community." The LGBIM has demonstrated good to excellent internal consistency (α = .88 and .92 respectively) in previous studies that have utilized the measure (Mohr & Fassinger, 2000; Santos & van Daalen, 2016).

Conflicts-in-Allegiances

Conflict between racial/ethnic and sexual identities was assessed utilizing the Conflicts in Allegiances Subscale (CIA-S) of the Culture and LGB Identity Scale (Sarno et al., 2015). The CIA-S asks participants the extent to which they perceive their cultural and sexual identities as incompatible with six items on a 7-point Likert-type scale. Example items include "I feel as if my cultural identity is at odds with my LGB identity" and "I have not yet found a way to integrate being LGB with being a member of my cultural group," with responses ranging from *disagree strongly* to *agree strongly*. The scale has demonstrated good internal consistency (α = .86) and construct validity.

Depression

Participants' mental health was measured via endorsement of depressive symptoms

within the past week, using the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). The CES-D examines multiple facets of depressive symptoms on a 4-point Likert-type scale, with anchors of 0 (*rarely or none of the time*) and 3 (*most or all of the time*). This measure is widely utilized and demonstrates convergent validity as well as good internal consistency within both sexual minority samples and general populations (Beals et al., 2009; Frost & Meyer, 2009; Radloff, 1977; Shafer, 2006)

Procedure

Institutional Review Board (IRB) approval was sought and obtained prior to participant recruitment and data collection. Participants were recruited from both college and community-at-large samples, utilizing a university participant pool, course announcements, flyers in local areas, and targeted postings online via LGBTQ+- and SMOC-oriented listserves and social media.

The university participant pool was representative of the racial/ethnic diversity of the university broadly, including among sexual minority participants (University of North Texas Teaching Commons, 2019). Student participants were offered extra credit for all research activities in which they participated. Alternatively, participants had the option to be entered into a raffle for a cash incentive ($25 Amazon Gift Card) for those who wish to forego credit or who cannot receive extra credit. Informed consent and all study data were collected via the Qualtrics online survey platform. To ease data cleaning and analysis, in addition to careless responding check questions (see Appendix G), at each page of the survey participants confirmed that any blank responses were purposeful, rather than accidental.

Analytic Approach

Data Cleaning

Careless response check questions were examined and filtered prior to data cleaning, to

ensure quality of data. Prior to analysis, participant data was examined to determine existence of outliers, normality, skewness, and kurtosis of study measures, missingness, and randomness of any missing data. Data transformation may be utilized in instances of substantial deviation from assumptions of normality, high levels of kurtosis (>10), or substantial skewness (less than -1 or greater than 1). Details on data cleaning are in the results section below.

Preliminary Analyses

Descriptive univariate analyses were conducted with subsets of the sample based upon gender, sexual orientation, race and ethnicity, to contextualize the impacts of demographic differences on outcome measures. Differences among categorical variables (gender, race/ethnicity, sexuality, recruitment source) were examined using analyses of variance (ANOVA). Bivariate relationships among continuous variables (e.g., age, measure scores) were analyzed using Pearson and polychoric correlations. Cronbach's alpha statistics were calculated to determine internal consistency of each scale utilized in the study.

Primary Analyses

A series of hierarchical regression analyses were conducted to test each hypothesis. Each regression model examined relationships between distress linked to intersectional discrimination (LGBT People of Color Microaggressions scale), identity factors (ethnic identity, sexual identity, and conflicts in allegiances) and depression symptoms (Block 1), and the extent to which group identity moderated the relationship between discrimination and depression symptoms (Block 2). The first regression model examined ethnic identity as a moderator, and a second model examined sexual identity as a moderator.

Exploratory Analyses

The exploratory 5th hypothesis was tested utilizing two regression models. Each model examined relationships between identity factors (ethnic identity, sexual identity, and conflicts in allegiances) and depression symptoms (Block 1), and whether conflicts in allegiances moderated the relationship between group identity and Depression (Block 2). The first model examined conflicts in allegiances as a moderator of the relationship between ethnic identity and depression, and the second examined the relationship between conflicts in allegiances and sexual identity.

To aid in understanding ways that differences among various identities impact the relationships between study variables, descriptive statistics for primary variables were examined, split by racial/ethnic, sexual, and gender identities.

CHAPTER 3

RESULTS

Preliminary Analyses

Descriptive Statistics

All measures demonstrated good to excellent internal consistency within the combined sample (see Tables 2 and 3 for alpha statistics and correlations, respectively). Total scores for the majority of measures (MEIM-R, LGBGIM, CIA-S, CES-D) were normally distributed, though intersectional discrimination scores (LGBT-PCMS Distress) were slightly positively skewed (.50).

Means for study variables are reported in Table 2, and Tables 4-5 (split by gender, race/ethnicity, and sexual identity). Participants who questioned their sexuality [$F(6,177) = 5.18$, $p < .001$, $\eta_p^2 = .15$], identified as female [$F(6,177) = 2.56$, $p = .021$, $\eta_p^2 = .08$], or were not out about their sexuality [$F(1,180) = 31.46$, $p < .001$, $\eta_p^2 = .15$] reported statistically significantly lower sexual identity than did their peers (gay/lesbian, out). Out [$F(1,184) = 6.65$, $p = .011$, $\eta_p^2 = .03$], multiracial, African American, and Latinx participants [$F(5,182) = 2.56$, $p = .029$, $\eta_p^2 = .07$] tended to report lower identity conflict in comparison to peers (not out, Asian American/Pacific Islander/other race or ethnicity). Participants reported divergent experiences with intersectional discrimination, such that those who identified as bisexual or questioning [$F(6,155) = 4.64$, $p < .001$, $\eta_p^2 = .15$], transgender [$F(1,160) = 19.88$, $p < .0011$, $\eta_p^2 = .11$], were not out [$F(1,158) = 19.67$, $p < .0011$, $\eta_p^2 = .11$], or were students [$F(2,159) = 5.96$, $p = .0031$, $\eta_p^2 = .07$] reported lower distress due to experiences with discrimination. Transgender participants ($n = 14$) were statistically significantly more depressed than cisgender participants ($t = 2.13$, $p = .018$, $d = .86$), though small group size limits interpretability of that finding.

Participants did not differ statistically significantly on other study measures (Depression, Ethnic Identity).

Primary Analyses – Intersectional Discrimination, Group Identity, and Depression

Intersectional Discrimination, Ethnic Identity, and Depression

The first regression model examined relationships between frequency of intersectional discrimination (LGBT People of Color Microaggressions scale), identity factors (ethnic identity, sexual identity, and conflicts in allegiances) and depression symptoms, and the extent to which ethnic identity moderated the relationship between discrimination and depression symptoms.

Findings supported the first hypothesis, such that within the model (Adj. R^2= .34, p <.001), intersectional discrimination statistically significantly, positively related to depression symptoms, (β = .54, p <.001). Hypothesis 2 was partially supported, with ethnic identity statistically significantly, negatively relating to depression symptoms (β_{ethID} = -.20, p =.024; β_{sexID} = -.02, p =.880). Neither Hypotheses 3 nor 4 were supported (ΔR^2= .00, Δp =.614.), such that neither conflicts in allegiances (β = .14, p =.118), nor the interaction terms of conflicts in allegiances and ethnic identity (β = -.04, p =.614) were statistically significantly predictive of depression symptoms.

Intersectional Discrimination, Sexual Identity, and Depression

The second model examined relationships between frequency of intersectional discrimination, identity factors, and depression symptoms, and examined whether sexual identity moderated the relationship between discrimination and depression symptoms.

Similar to findings in the first model, findings supported the first hypothesis, such that within the model (Adj. R^2= .34, p <.001), intersectional discrimination statistically significantly, positively related to depression symptoms, (β = .54, p <.001). Hypothesis 2 was partially

supported, with ethnic identity statistically significantly, negatively relating to depression symptoms (β_{ethID} = -.19, p =.034; β_{sexID} = -.02, p =.880). Neither Hypotheses 3 nor 4 were supported (ΔR^2= .00, Δp =.650), such that neither conflicts in allegiances (β = .14, p =.118), nor the interaction terms of conflicts in allegiances and sexual identity (β_{sexID} = -.04, p =.650) were statistically significantly predictive of depression symptoms.

Exploratory Analyses – Group Identity, Conflicts in Allegiances, and Depression

As an exploratory examination of the relationships between group identity factors and depression symptoms, another regression model examined the extent to which conflicts in allegiances moderated the relationship between ethnic identity, sexual identity, and depression. Ethnic identity, sexual identity, and identity were each entered into the first block of the model, while interaction terms between conflicts in allegiances and group identity (ethnic identity and sexual identity respectively) was entered into the second block of each model. As a reminder, it was hypothesized that conflicts in allegiances moderates the negative relationship between strength of group identity and depression symptoms, such that depression symptoms would negatively relate to group identity only conflicts in allegiances is low.

Ethnic Identity, Identity Conflict, and Depression

Findings from the first model failed to support hypothesis 5. Specifically, the first block including conflicts-in-allegiances (β = .29, p =.002), group identity (β_{ethID} = -.13, p =.168; β_{sexID} = .19, p =.048), and depression was statistically significant (F(3,110) = 4.67, Adjusted R^2= .09, p = .004). The moderation term including ethnic identity (ΔR^2_{ethID} = .00, β = .02, p = .854) was not a statistically significant predictor of depression symptoms. In sum, conflicts-in-allegiances, sexual identity, and their interaction were statistically significantly related to depression symptoms. Specifically, individuals with low conflict, and with higher ethnic identity experienced fewer

depression symptoms, and the relationship between ethnic identity and depression was consistent across varying levels of conflicts in allegiances (See Figure 1).

Sexual Identity, Identity Conflict, and Depression

Findings from the second model did support hypothesis 5. The first block, including conflicts-in-allegiances ($\beta = -.29$, $p = .002$), group identity ($\beta_{ethID} = -.13$, $p = .168$; $\beta_{sexID} = .19$, $p = .048$), and depression was statistically significant ($F(3,110) = 4.67$, Adjusted $R^2 = .09$, $p = .004$). The moderation term including sexual identity ($\Delta R^2_{sexID} = .05$, $\beta = .14$, $p = .018$) was a statistically significantly predictive of depression symptoms. In sum, conflicts-in-allegiances, sexual identity, and their interaction were statistically significantly related to depression symptoms. Specifically, individuals with low conflict experienced fewer depression symptoms with higher sexual identity, while individuals with high conflict reported greater depression symptoms with high sexual identity (See Figure 2).

CHAPTER 4

DISCUSSION

The present study examined relationships between experiences of intersectional discrimination, group identity (sexuality, race/ethnicity, conflicts in allegiances [CIA]), and depression symptoms. Findings indicated that experiences of discrimination were correlated with symptoms of depression both independently and in a regression model accounting for other variables. Ethnic identity was statistically significantly related to depression symptoms independently, but not within the regression model, perhaps suggesting some suppression from other variables within the regression model. Strength of sexual identity was not statistically significantly related to depression. Neither strength of sexual identity nor ethnic identity moderated relationships between intersectional discrimination and depression. Likewise, CIA was not found to moderate relationships between group identity and depression symptoms. In sum, the present findings present further support for the idea that the experience of marginalization linked to intersectional racial/ethnic and sexual identities holds implications for mental health, regardless of level of either group identity. This lack of a relationship contrasts somewhat with previous findings (Akibar, Niemann, Bazemore-James, Thomas, & Dovidio, 2020; Chatman, Eccles, & Malanchuk, 2005; Schmitt, Branscombe, Postmes, & Garcia, 2014), which suggest some support for the ability of group identity to buffer negative outcomes. Notably, however, much of this past work is based upon experiences of hardship based upon a single-identity (e.g., racism & racial/ethnic identity), which may point to a need to examine intersectional discrimination in the context of group identity characteristics that take this into account.

The present study provides a very important step in examining intersectional identity

factors (intersectional discrimination, identity conflict) in the context of mental health. Intersectional discrimination notably had a very large effect on depression symptoms, accounting for approximately one third of variance in depression. While future investigation is warranted to unpack this phenomenon, present study findings lend credence to the importance of understanding the ways that intersectional forms of stigmatization (e.g., microaggressions from within shared identity communities) affect well-being. Currently, existing quantitative work examining impacts of discrimination on members of marginalized communities has focused on experiences linked to one identity at a time (e.g., McCabe et al., 2010). While perhaps more parsimonious, it may leave out important information linked to intersectional contexts, or even weaken predictive power for experiences not explained by identities separately. In this study, intersectional identity factors explained a substantial proportion of variation in depression symptoms, which begs further research to understand experiences unique to the intersection of marginalized racial/ethnic and LGBTQ+ identity, particularly in health contexts. Further, the present findings add needed context to our understanding of when group identity positively or negatively predicts well-being outcomes. Currently, extant literature suggests mixed findings for the relationships between group identity and well-being outcomes with some muted, negative, and positive affects depending on situational circumstances (Akibar et al., 2020; Schmitt et al., 2014). Given that these relationships may be highly context dependent, understanding roles of other relevant identity factors (i.e., CIA) aid in understanding how SMOC specifically experience and process minority stress.

Concerns of SMOC are often left unaddressed within research, and much of this deficit may relate to the way researchers conceptualize topics of research. Contrary to commonly adopted models of sexual identity development, that focus on the experiences of white gay men

and lesbians, several studies indicate that SMOC may face a different set of goalposts associated with positive identity development and subsequent psychological well-being. Given a dearth of sexuality-oriented research across many psychological disciplines (Agars & French, 2016), it is difficult to believe that these norms will radically change very soon. With that said, the body of psychological research concerning intersectionality and mental health has grown substantially in recent years, and is likely to continue, pending trends towards more inclusivity of diverse experiences/identities, especially on larger-scale projects. Continued work that examines and remains focused on the experiences of SMOC is needed, both to examine ways that these identity-related and intersectional constructs together inform mental health, and to disentangle potential generational effects in LGBTQ+ identity and health research.

Future Directions

While this study may shed light on a shared experience among those marginalized based on their race/ethnicity and LGBTQ+ identity simultaneously, aggregation of very different racial/ethnic and sexual identity groups can prove problematic when treated as an endpoint for multiply marginalized groups. Questions concerning intersectionality may suggest meaningful inquiries regarding issues such as strength of identity, stress, and discrimination (Betancourt & Lopez, 1993; Helms et al., 2005, Weber & Parra-Medina, 2003), as opposed to solely relying on demographic information. Attention to psychological experiences unique to identity intersections (e.g., identity conflict) and how they specifically relate to identity and discrimination may move the field a step further to understanding how living with multiple minority statuses affects individuals more accurately, even from a measurement perspective. Future work will need to examine relationships among these intersectional constructs among particular racial/ethnic/sexual orientation groups, to better understand for whom and how these

relationships function, especially over time. Further work is especially needed among those most frequently underrepresented in this type of work (e.g., bi+, trans+ and nonbinary individuals), and may benefit from qualitative and mixed-methods approaches to give deeper context to experiences of LGBTQ+ people of color.

Limitations

While the present study makes important contributions to the literature surrounding mental health among SMOC, key limitations must be noted. The hypotheses in the current model were tested utilizing a cross-sectional, correlational design. As such, directionality of the present findings must be made cautiously, as causality cannot be inferred, and further, while data were missing at random, limitations linked to sample size must be noted. Likewise, while efforts were made to recruit outside of university settings, the sample overrepresents individuals with at least some college-level education, which may make inferences for those who never entered the university system less appropriate. Convenience sampling may overrepresent people from particular racial/ethnic/sexual identities and geographic areas. As historical, cultural, and social norms surrounding gender and sexual diversity continue to shift, continued research into the nuances of sociocultural understanding the nature of these identities in intersectional contexts (e.g., SES, immigration status, religion, culture).

Conclusion

The reality that living with multiple minority statuses exacerbates risk for negative outcomes for SMOC seems to be rooted in multiple layers. At an individual level, SMOC may feel conflict between racial/ethnic and sexual identities. Interpersonally, feared or experienced rejection of one or more identity statuses among peers and loved ones may contribute to feelings of isolation. Being perceived as a member of both racial/ethnic and sexual minority groups may

flag SMOC as targets for harassment and discrimination, with immediate tangible damages and downstream psychological consequences. Given this unique reality for many sexual minorities, it is important that continued research emphasizes these contexts. Shifting focus this way can begin to address the overrepresentation of the experiences of LGB Whites in sexual minority research (Clark, 2005; Grov, Bimbi, Nanin, & Parsons, 2006), as many issues facing sexual minorities especially impact people of color (Bridge et al., 2015). Placing SMOC at the center of the questions concerning them, rather than further marginalizing them, will amplify the voices of these underrepresented populations, and better inform practice and interventions geared towards these groups. Sexual minorities of color face disenfranchisement which reduces the likelihood their experiences will represented in both research and public discourse. Considering this knowledge, it is crucial to ensure that the unique experiences of multiply marginalized groups are attended to in psychological literature.

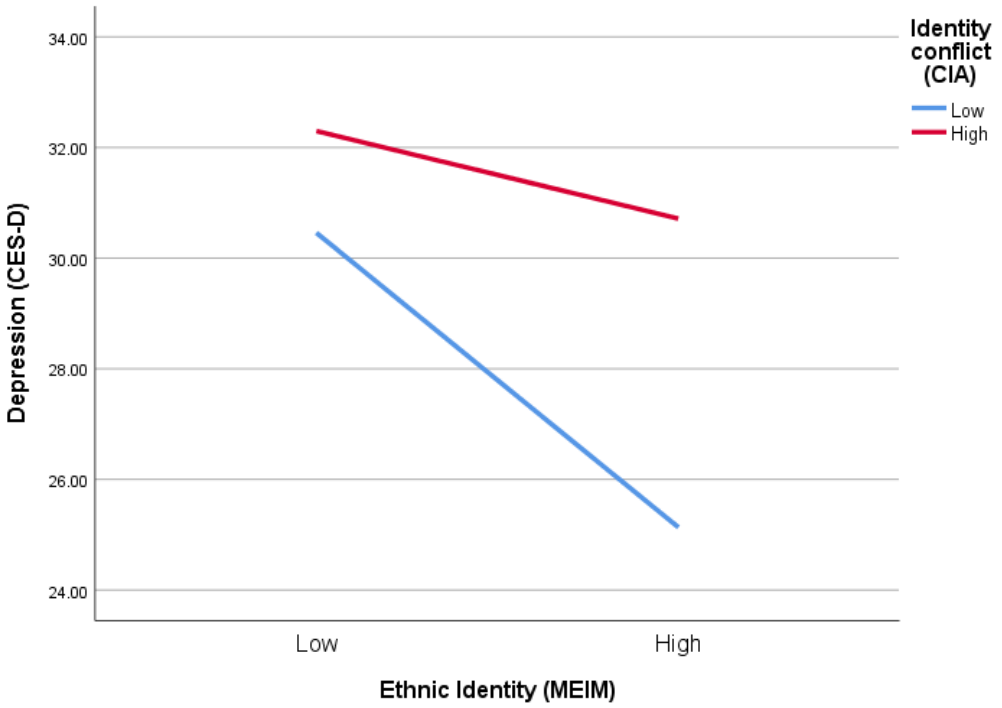

Figure 1. Ethnic identity, identity conflict, and depression symptoms.

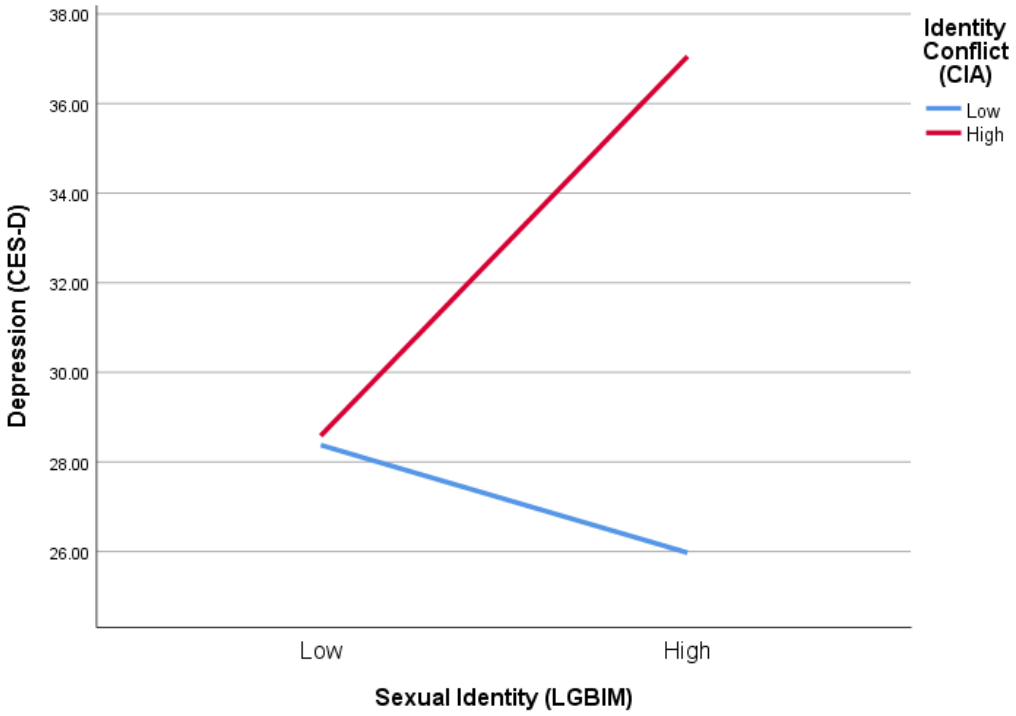

Figure 2. Sexual identity, identity conflict, and depression symptoms.

Table 1

Participant Demographics

Variable		*n*	%
Combined Parent income	Less than $30,000		22.6
	$30,000-$60,000		29.2
	$60,000-$100,000		22.7
	More than $100,000		25.5
Parent Education	Less than 12th grade	8	5.4
	HS Diploma/GED	42	28.4
	Some College	18	12.2
	Associate's Degree	15	10.1
	Bachelor's Degree	43	29.1
	Master's Degree	30	20.3
	Doctorate	7	4.7
	Other	5	3.4
Out*	Yes	88	60.3
	No	58	39.2
Religious affiliation	Christian	54	36
	Agnostic	42	28.4
	None	15	10.1
	Atheist	20	13.5
	Muslim	3	2.0
	Hindu	1	.7
	Pagan/Wiccan	10	6.8
	Buddhist	6	4.1
	Jewish	1	0.7
	Other	20	13.5

Note. *Represents proportion of participants who considered themselves to be "out" about their sexual identity

Table 2

Descriptive Statistics, Reliability Statistics

Variable	M	SD	Possible Range	Obtained Range	Cronbach's α
Age	21.69	3.39	18-29	18-29	-
Age first "out"	16.98	3.67	-	9-29	-
Religious Involvement	34.66	27.99	0-100	0-100	-
CES-D	24.35	13.37	0-60	0-56	.93
LGBT-POCMS Frequency	46.95	22.59	0-90	0-90	.95
LGBT-POCMS Distress	51.77	23.41	0-90	0-90	.94
MEIM	45.76	7.67	12-60	27-60	.89
LGBGIM	43.39	9.78	6-60	12-60	.89
CIA-S	22.46	8.07	6-42	6-42	.82

Table 3

Correlations among Continuous Study Variables

Variable	1	2	3	4	5	6	7	8	9
1. Age	-	-	-	-	-	-	-	-	-
2. Number of years "out"	.54†	-	-	-	-	-	-	-	-
3. Parent Income	.20*	.31†	-	-	-	-	-	-	-
4. Religious Involvement	.07	.21	.05	-	-	-	-	-	-
5. LGBT-POCMS Frequency	.30†	.02	.17	.15	-	-	-	-	-
6. LGBT-POCMS Distress	.24*	-.03	.13	.07	.94†	-	-	-	-
7. MEIM	.10	.10	-.01	.29†	.05	.10	-	-	-
8. LGBGIM	.13	.16	.06	-.01	.35†	.35†	.27†	-	-
9. CIA-S	-.21*	-.26*	.01	.00	.22*	.24*	-.14	.07	-
10. CES-D	.01	-.04	-.07	.06	.54†	.55†	-.12	.07	.22*

Note. *p <.05. †p < .01. ‡p < .001

Table 4

Study Means and Standard Deviations, Split by Race/Ethnicity and Sexual Orientation

	CES-D *M* (*SD*)	MEIM *M* (*SD*)	LGBGIM *M* (*SD*)	CIA *M* (*SD*)	LGBTPCMS *M* (*SD*)
Race/Ethnicity					
Asian or Asian American	28.60 (13.17)	43.30 (7.28)	40.65 (7.16)	27.28 (7.38)	51.10 (26.78)
Latinx or Hispanic	28.76 (12.51)	47.05 7.59)	45.63 (9.08)	22.58 (7.14)	51.50 (19.99)
Black, African, or African American	26.29 (10.63)	48.35 (8.05)	42.28 (10.31)	22.42 (7.30)	57.77 (26.09)
Pacific Islander	24.00 *	* *	* *	30.00 *	* *
Native American or Indigenous Culture	* *	31.00 *	* *	* *	* *
Other Racial or Ethnic Group	32 *	38.33 (1.53)	49.00 (1.41)	32.00 (5.66)	64.00 *
Multiple Racial or Ethnic Groups	37 (30.43)	43.43 (9.14)	42.34 (21.29)	21.29 (8.07)	48.00 (20.27)
Sexual Orientation					
Gay, Lesbian, or Homosexual	24.54 (10.43)	45.40 (7.69)	46.41 (8.74)	21.90 (7.88)	60.32 (21.17)
Bisexual	28.78 (11.32)	46.03 (9.13)	42.63 (8.27)	23.44 (7.03)	45.39 (19.23)
Pansexual	30.30 (14.58)	47.47 (9.64)	46.94 (10.12)	21.35 (8.31)	55.79 (23.38)
Queer	32.70 (12.09)	47.67 (7.58)	46.50 (9.07)	22.00 (9.33)	67.36 (26.29)
Asexual	41.00 (12.73)	40.60 (9.07)	36.83 (7.55)	22.50 (9.18)	47.50 (32.14)
Questioning	28.60 (16.13)	45.09 (6.56)	32.25 (13.07)	23.58 (6.88)	32.82 (15.21)
Multiple Identities Selected	29.47 (12.20)	45.07 (7.75)	43.23 (8.20)	23.07 (8.16)	55.85 (22.22)

Note. *not available due to sample size <2

Table 5

Study Means and Standard Deviations, Split by Gender

Gender	CES-D *M* (*SD*)	MEIM *M* (*SD*)	LGBGIM *M* (*SD*)	CIA *M* (*SD*)	LGBTPCMS *M* (*SD*)
Male	23.75 (11.92)	45.97 (7.61)	44.00 (10.51)	23.22 (7.28)	56.29 (23.96)
Female	28.32 (11.54)	46.26 (8.40)	41.88 (9.46)	23.01 (7.66)	46.41 (18.82)
FTM	37.00 (1.41)	55.00 *	56.00 *	19.00 *	83.00 *
Queer	35.50 (8.50)	45.75 (5.32)	55.33 (5.03)	25.25 (4.43)	102.00 *
Nonbinary/ Nonconforming	31.80 (15.61)	45.33 (10.88)	47.70 (7.29)	22.91 (7.67)	69.63 (26.23)
Other Gender Identity	37.00 *	33.00 (2.23)	42.50 (3.54)	14.67 (2.08)	95.00 *
Multiple Identities selected	38.43 (14.70)	42.08 (7.51)	48.08 (4.56)	20.31 (9.54)	68.64 (52.07)

Note. *not available due to sample size <2

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