Family Rejection and LGBTQ+ Asian Americans' Psychological Distress and Disordered Eating: The Role of Conflicts in Allegiances and Familial Shame

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Acknowledgments: This material is based upon work supported by the National Science Foundation Graduate Research Fellowship Program under Grant No. DGE 1840340. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the National Science Foundation. This material is also based upon work supported by the University of Maryland through the College of Behavioral and Social Sciences Summer Scholars Program and the Department of Psychology Dr. Dennis F. Marion Undergraduate Mental Health Research Award.

Word Counts: Abstract (212), Text (6339)

Keywords: Family rejection, Family shame, LGBTQ+, Asian American, Intersectionality

Abstract

Objectives: LGBTQ+ Asian Americans experience unique psychological health concerns at the intersection of multiple forms of marginalization. White supremacist, cisheteronormative, and colonial ideals and their structural and interpersonal manifestations may encourage family rejection of LGBTQ+ identities within Asian American family units. Family shame, conflicts in allegiances, and internalized anti-LGBTQ+ stigma were hypothesized as mediators in the association between family rejection and psychological distress and disordered eating.

Method: The current study examined family rejection and its impacts on psychological distress and disordered eating in a sample of LGBTQ+ Asian American adults (N = 155; M_{Age} = 24.26; 30.3% Gender Diverse) using a cross-sectional survey design and path analysis.

Results: There was a significant serial mediation such that family rejection was positively associated with conflicts in allegiances, which was positively associated with familial shame, which was positively associated with psychological distress (B = .12, p = .01). The same serial mediation was nonsignificant for disordered eating (B = .04, p = .26).

Conclusions: Results indicate the importance of considering conflicts in allegiances, family shame, and the interpersonal dynamics of LGBTQ+ Asian Americans in understanding experiences of psychological distress and disordered eating. Implications are drawn for further research, clinical work, and broader efforts addressing the larger sociocultural environment that encourages familial rejection of LGBTQ+ identity.

Public Significance Statement: LGBTQ+ Asian Americans have unique social experiences at the intersection of racism and homophobia/transphobia, particularly within family units, that contribute to mental health concerns. Family rejection of LGBTQ+ identity is associated with mental health distress. Feeling conflict between one's LGBTQ+ and Asian American identities as well as feeling family-related shame may explain these mental health vulnerabilities. Mental health interventions that recognize the complex experiences of LGBTQ+ Asian Americans are urgently needed alongside efforts to address racism and homophobia/transphobia more broadly to create a world where LGBTQ+ Asian Americans and their families can thrive authentically.

Family Rejection and LGBTQ+ Asian Americans' Psychological Distress and Disordered Eating: The Role of Conflicts in Allegiances and Family Shame

Asian Americans have consistently been present in the fight for LGBTQ+ equity, however their perspectives have long been erased and obscured in history (Sueyoshi, 2016). Only recently has attention been given to the impacts of ongoing racist and homophobic/transphobic oppression on LGBTQ+ Asian Americans. Choi and colleagues (2021) found that over 600,000 LGBTQ+ Asian Americans live in the United States and that they experience mental health concerns, healthcare barriers, poverty, food insecurity, housing instability, and unemployment at higher rates than non-LGBTQ+ Asian Americans. Depression, for instance, was three times more prevalent among LGBTQ+ Asian Americans than non-LGBTQ+ Asian Americans (21% versus 7%; Choi et al., 2021). Emerging literature also points to how white-centered body ideals may particularly harm Asian American body image and contribute to disordered eating within the community (Keum et al., 2018; Le et al., 2020, 2021), with further implications for LGBTQ+ Asian American body image (Le & Pease, 2022). Understanding the factors that influence mental health for LGBTQ+ Asian Americans is critical to advance long-overdue pursuits toward intersectional health equity.

LGBTQ+ Asian American Familial Experiences

Family rejection is a strong predictor of mental health concerns among LGBTQ+ people (Newcomb et al., 2019; Sheets & Mohr, 2009; Ryan et al., 2009, 2010), yet past research has focused mainly on white LGBTQ+ populations. While Ching and colleagues (2018) allude to the importance of exploring family influences in Asian American sexual and gender minority samples, little empirical research has examined LGBTQ+ Asian American young adults and their familial relationships as they pertain to mental health outcomes. This is especially concerning

given the intersectional challenges faced by LGBTQ+ Asian Americans in the United States, namely structural and interpersonal racism and homophobia/transphobia (Becerra et al., 2021; Choi & Israel, 2016) and the related importance of social supports such as family in navigating these systemic issues across the life-course. While some parents show support for and practice acceptance of their Asian American LGBTQ+ children (Choi & Israel, 2016), research suggests that other parents express more negative reactions to their children's sexual minority identities (Nadal & Corpus, 2013), highlighting the necessity of research examining the association between family rejection and mental health.

Although those familial contexts may include experiences of homophobia/transphobia, we must be explicit that homophobia and transphobia are not inherent to Asian American culture(s), but rather a product of more nuanced structural oppressive forces such as colonial and cisheteronormative ideals (Laurent, 2005). For example, parents of LGBTQ+ Asian Americans may feel pressured to encourage their children to conform to cisnormative and heteronormative expectations, because they believe that doing so will help prevent their children from experiencing heterosexist discrimination on top of already potentially having to contend with racial discrimination in a predominately white context (Choi & Israel, 2016; Ma & Lan, 2022). Further, LGBTQ+ Asian Americans may lack support structures that affirm both intersecting identities, feeling excluded from predominantly heterosexual, cisgender Asian American spaces due to anti-LGBTQ+ attitudes and excluded from predominantly white LGBTQ+ spaces due to anti-Asian attitudes (Le et al., 2022a; Pease et al., 2022). With these complex intersections, the need for further thoughtful exploration of how family contexts influence mental health is critical.

Family Rejection and Mental Health

Given the aforementioned pressure parents of LGBTQ+ Asian Americans may feel to ensure children conform to oppressive structures to allow them to live easier lives (Ma & Lan, 2022) combined with colonial impositions of homophobic/transphobic ideologies (Laurent, 2005), we might then see those structural issues manifest in familial rejection of their children's LGBTQ+ identities. Experiencing family rejection has been associated with a plethora of negative mental health outcomes for LGBTQ+ people (Russell, 2019; Ryan et al., 2009; Salerno et al., 2022), which makes sense given the critical role that family connections play developmentally. Family rejection, reflecting a failure to meet familial, cultural, and/or religious expectations (i.e., filial piety), may also lead to LGBTQ+ Asian Americans internalizing feelings of shame (Hu & Wang, 2013; Huang et al., 2016). Moreover, family dynamics can play a role in reinforcing strict body ideals or, through family acceptance, can allow for positive body image to form, suggesting that family rejection may also be a risk factor for disordered eating among LGBTQ+ people (Parker & Harriger, 2020).

One study indicated that anti-LGBTQ+ discrimination is positively associated with disordered eating through lowered familial support (Mason et al., 2017) and another noted how familial weight-based victimization was positively associated with various elements of disordered eating (Himmelstein et al., 2019). In the general population, family rejection has also been positively associated with emotional eating (Erriu et al., 2020; Vandewalle et al., 2017). Combined, these studies point to how identity-related stressors from family units can exacerbate vulnerability to disordered eating. However, no research has examined how the unique interpersonal and intersectional experiences of LGBTQ+ Asian Americans impact these potential vulnerabilities and, more specifically, the internal psychological constructs by which family rejection may be internalized and contribute to mental health disparities.

Conflicts in Allegiances

Conflicts in allegiances refers to the feeling that one's identities are incompatible or that expectations relating to different parts of one's identities are in conflict with one another; for LGBTQ+ people of color, this is often described as not being accepted fully in spaces for LGBTQ+ people nor spaces for people of color due to racism from the LGBTQ+ community and homophobia/transphobia from one's racial identity community (Sarno et al., 2015). In U.S. American LGBTQ+ communities, because whiteness is the norm, white ideals dictate inclusion in LGBTQ+ spaces and support systems (Harper et al., 2004; Logie & Rwigema, 2014).. This racism, manifested in the inability of people of color to meet such white-centered ideals, contributes to mental health concerns (Han, 2008) as well as body image and disordered eating concerns for LGBTQ+ people of color (Bhambhani et al., 2019; Brennan et al., 2013; Drummond, 2005). Relatedly, anti-LGBTQ+ stigma from one's ethnic community has been documented as a salient form of intersectional stigma for LGBTQ+ people of color that impacts mental health and is uniquely challenging to manage (Choi et al., 2011; Han et al., 2014). Family rejection can exacerbate conflicts in allegiances and undermine a critical source of support for LGBTQ+ Asian Americans (Ching et al., 2018; Huang et al., 2016). Specifically, for LGBTQ+ Asian Americans who experience greater family rejection, they may feel more disconnected from their Asian American identity and thus experience greater conflicts in allegiances, unable to fully embrace either their LGBTQ+ or Asian American identity. As they experience this feeling of identity incompatibility, they may experience further negative impacts on their familial dynamics and feel like they do not fit into the family unit or meet the expectations of their family.

While conflicts in allegiances has been associated with depression and negative affect (Santos & VanDaalen, 2016; Jackson et al., 2020), no empirical study to our knowledge has either focused on LGBTQ+ Asian Americans or examined the link between conflicts in allegiances and disordered eating. Ching and colleagues (2018) conceptualized conflicts in allegiances as an important mediator in facilitating mental health disparities for LGBTQ+ Asian Americans, facilitating the link between discrimination and structural/cultural factors and mental health. They theorize that conflicts in allegiances is part of larger structural and cultural factors that may contribute to internalized stigma, suggesting more complicated indirect associations between familial rejection and mental health through conflicts in allegiances and internalized anti-LGBTQ+ stigma (Ching et al., 2018). Given the unique familial and cultural experiences of LGBTQ+ Asian Americans, addressing the dearth of research examining conflicts of allegiances at this particular intersection is necessary for better supporting this community through research and practice.

Family Shame

Family shame, defined as negative feelings associated with perceived failure to meet the expectations of one's family, is one factor that may underlie the association between family shame and mental health symptoms (Wang et al., 2018; Wong et al., 2014). This construct is particularly relevant in the context of Asian American communities due to collectivist and family-oriented values often reflected in the experiences of Asian Americans (Carrera & Wei, 2017; Kim et al., 2001). Shame more broadly has been strongly associated with depressive symptoms among predominantly heterosexual Asian American adults (Kim et al., 2011). Wang and colleagues (2018) found that feeling a discrepancy between family expectations and the individual's ability to meet familial standards was associated with greater family shame which,

in turn, was associated with greater psychological distress and lower life satisfaction for Asian Americans.

Familial rejection of LGBTQ+ identity and feeling that one's LGBTQ+ and Asian American identities are incompatible can reflect such a discrepancy between family expectations and an LGBTQ+ Asian American's identity (Ching et al., 2018), highlighting the importance of shame as a relational factor valuable in explaining mental health. Positioning family shame as a form of internal stigma for LGBTQ+ Asian Americans, we might expect the added stress from this type of shame to impact emotional regulatory processes that facilitate vulnerability to both psychological distress and disordered eating (Parker & Harriger, 2020). To our knowledge, no study has examined family shame within LGBTQ+ Asian American communities specifically, leaving a notable gap in the literature around how family-related experiences and culture impact LGBTQ+ Asian Americans at the intersection of their identities.

Internalized Anti-LGBTQ+ Stigma

Internalized anti-LGBTQ+ stigma refers to how exposure to systemic oppression can lead to the internal acceptance of homophobic/transphobic societal messages, leading to worse self-concept relating to one's minoritized sexuality/gender identity (Shidlo, 1994; Watson et al., 2019). Ching and colleagues (2018) in their review article note how internalized anti-LGBTQ+ stigma likely serves as a mediator in the relationship between both structural and interpersonal discrimination and mental health outcomes. Further, Ching and colleagues (2018, p. 661) explicitly postulate that part of the Asian American experience of internalized anti-LGBTQ+ stigma may be connected to pressures around "fulfilling familial expectations of a heteronormative life," emphasizing the relevance of family rejection in the potential internalization of stigma among LGBTQ+ Asian Americans. Given that internalized stigma has

been associated with both psychological distress (Kaysen et al., 2014) and disordered eating (Parker & Harriger, 2020), it is possible that internalized stigma may mediate the associations between family rejection and psychological distress and disordered eating among LGBTQ+ Asian Americans.

Present Study

The present study explored the mental health impacts of family rejection for LGBTQ+ Asian Americans, existing at the intersection of anti-LGBTQ+ and anti-Asian oppression. Specifically, we examined the indirect effects of family rejection on psychological distress and disordered eating through three culturally relevant mediators: family shame, conflicts in allegiances, and internalized stigma. We hypothesized that family rejection would be indirectly and positively associated with psychological distress and disordered eating indirectly through positive associations with family shame, conflicts in allegiances, and internalized anti-LGBTQ+ stigma. Moreover, given the more complex association between conflicts in allegiances and other forms of internalized stigma theorized by Ching and colleagues (2018), we further hypothesized that family rejection would be positively associated with greater psychological distress and disordered eating indirectly through a serial mediation of conflicts in allegiances, reflecting a feeling of incompatibility between LGBTQ+ and Asian American identities, followed by family shame, reflecting a feeling that one is unable to meet familial expectations as a result of this incompatibility.

Methods

Procedures

The present study's procedures were conducted fully in English and took place remotely from July 2021 to April 2022. LGBTQ+ Asian Americans aged 18 and over were recruited

through various online channels. These channels included Asian American cultural organizations at universities across the United States as well as listservs of professional organizations that serve the Asian American community. When participants first opened the survey, they completed brief screener questions to assess their eligibility to partake in the study: identify as 18 or over, Asian American, a member of the LGBTQ+ community, and currently living in the United States. Participation was specific to those over 18 based in the U.S. to be as inclusive and generalizable as possible while acknowledging the theoretical framings and constructs of the study were developed specifically in reference to LGBTQ+ people and Asian Americans within Western contexts. After completing a virtual informed consent, participants then completed questionnaires that measured the present study's main variables of interest. The survey also contained three attention check items (e.g., "For this item, please select 'a little of the time'") and we also reviewed the heights participants inputted to assess for bot responses. When participants completed the survey, they had the opportunity to enter a raffle to win one of three $50 Visa gift cards. The results of the present study are part of a larger dataset that also examined LGBTQ+ Asian American adults' experiences of race and racism. All study procedures were approved by the Institutional Review Board of the first author's university.

Participants

The survey was accessed 933 times. 826 of those cases completed over 90% of the questionnaires. However, only 207 responses had valid height responses (e.g., entered a number less than 12 for inches), suggesting the other 619 responses were likely computerized bots which were then excluded. Lastly, 52 responses failed attention check items (e.g., "For this item, please select "Agree" to indicate you are paying attention"), resulting in a final sample size of 155 LGBTQ+ Asian American adults.

Participant ages ranged from 18-56 (M = 24.26, SD = 7.03). Demographic information including ethnicity, gender identity, sexual orientation, and education are presented in Table 1. Over 14 ethnic identities were represented in the sample, with the most common being Chinese (25 participants or 22.6% of the sample), Indian (18 or 11.6%), and Filipino (17 or 11%), with a quarter of the sample identifying as multiethnic (39 or 25.2%). Approximately three-quarters of the sample were born in the United States (114 or 73.5%), around half the sample were women (75 or 48.4%), and nearly a third identified as trans or gender diverse (47 or 30.3%).

Study Variables

Family Rejection

Family rejection was measured using the family rejection subscale of the Sexual Minority Adolescent Stress Inventory (SMASI; Schrager et al., 2018). This subscale consists of 11 items that assess the extent to which participants' family members are intolerant of LGBTQ+ identities, including those of the participant. While some items of the original measure were designed to specifically capture rejection related to sexual minority identities, we modified items to reflect LGBTQ+ identity broadly (e.g., "My family tries to make me straight" was modified to "My family tries to make me straight and/or cisgender.") Another example item includes "My parents are sad that I am LGBTQ+." Participants responded with either "*yes*" or "*no*" to whether each item occurred within the past 30 days, and "*yes*" responses were summed such that a higher number indicated greater family rejection within the past 30 days. The family rejection subscale has displayed adequate discriminant validity as well as adequate test-retest reliability after a two-week period (Schrager et al., 2018). Cronbach's alpha in the present study was .75.

Family Shame

Family shame was measured utilizing the five-item family shame subscale of the Interpersonal Shame Inventory (ISI; Wong et al., 2014) for Asian Americans. This subscale examines the extent to which participants feel that they have brought disgrace and dishonor to their family. An example item includes “These days, I wish I could disappear because my deficits might cause my family to lose face.” Participants responded to each item on a 6-point Likert scale ranging from 1 (“*strongly disagree*") to 6 (“*strongly agree*”), and scores were then summed with greater composite scores indicating higher levels of family shame. The family shame subscale has shown construct validity through positive correlations with suicidal ideation and loss of face (Wong et al., 2014), and the subscale has demonstrated a Cronbach’s alpha of .96 in a sample of Asian American adults (Wang et al., 2018). Cronbach’s alpha in the present study was .97.

Conflicts in Allegiances

Conflicts in allegiances were measured using the six-item Conflicts in Allegiances scale (Sarno et al., 2015). This scale assesses the extent to which participants feel that their racial identity and their LGBTQ+ identity are incompatible. While the measure originally only asked about sexual orientation identity (e.g., identifying as lesbian, gay, or bisexual), we revised these items to refer to identifying as LGBTQ+ broadly (e.g., “I have not yet found a way to integrate being LGB with being a member of my cultural group” was modified to “I have not yet found a way to integrate being LGBTQ+ with being a member of my cultural group.”) Participants responded to each item on a 7-point Likert scale from 1 (“*strongly disagree*”) to 7 (“*strongly agree*”), and item responses were then summed such that higher scores indicate greater conflicts in allegiances. The scale has demonstrated adequate face and construct validity with a sample of 124 LGB people of color (Sarno et al., 2015) and solid reliability (i.e., Cronbach’s alpha = .80)

within a sample of lesbian, gay, and bisexual people of color (Santos & VanDaalen, 2016). Cronbach's alpha in the present study was .77.

Internalized Anti-LGBTQ+ Stigma

Internalized anti-LGBTQ+ stigma was measured utilizing four items adapted from an internalized homophobia scale (Shidlo, 1994) as done in Watson et al. (2019). These four items assessed the extent to which participants felt negatively about their LGBTQ+ identities. An example item includes "I wish I were not LGBTQ+." Items are scored on a 4-point Likert scale from 0 ("*strongly disagree*") to 3 ("*strongly agree*"). Item responses are summed, with higher scores indicating greater internalized stigma. The scale demonstrated adequate reliability in a racially diverse sample of sexual and gender minority adolescents (Cronbach's alpha = .91; Watson et al., 2019) as well as in a sample of Latinx LGBTQ+ adults (Cronbach's alpha = .75; Yamasaki & Le, 2022). Cronbach's alpha in the current study was .76.

Psychological Distress

Psychological distress was assessed using the six-item Kessler Psychological Distress Scale (K6; Kessler et al., 2003). The K6 measures the presence of nonspecific psychological distress over the past 30 days. The six questions examine how often participants feel: worthless, restless, nervous, hopeless, restless, and that everything was an effort. Participants respond to each item on a 5-point Likert scale from 0 ("*none of the time*") to 4 ("*all of the time*"). Responses to each item are summed so that greater scores indicate higher psychological distress. The scale has shown convergent validity through a positive correlation with serious mental illness (Kessler et al., 2003). The K6 has demonstrated adequate internal consistency among a large sample of Asian American adults (Cronbach's alpha = .93; Le et al., 2022b). Cronbach's alpha for the present study sample was .87.

Disordered Eating

Disordered eating symptomatology was assessed utilizing the 12-item Eating Disorder Examination Questionnaire - Short Form (EDEQ-S; Gideon et al., 2016). The EDEQ-S examines disordered eating behaviors and attitudes within the past week. An example item includes "Have you gone for long periods of time (e.g., 8 or more waking hours) without eating anything at all in order to influence your shape or weight?" Participants respond on a 4-point Likert scale ranging from 0 ("*0 days*") to 3 ("*6-7 days*"). Item responses are summed to create a composite score, with higher scores indicating greater disordered eating. This measure has displayed adequate convergent validity through positive correlations with other disordered eating measures (Gideon et al., 2016) and has displayed strong internal consistency in a sample of transgender and gender diverse adults (Cronbach's alpha = .86; Duffy et al., 2021). Cronbach's alpha in the current study was .88.

Data Analytic Plan

Analyses were conducted using SPSS version 28 and alpha values $p < .05$ were deemed statistically significant. Data were inspected for normality by examining skewness and kurtosis, as well as multicollinearity and multivariate outliers. Bivariate correlations were run to assess the degree of association between the primary variables of interest. As done in past research with LGBTQ+ Asian Americans, demographic variables correlated significantly with either outcome variable were included as covariates in the analyses that involved that specific outcome variable (Le et al., 2022a).

To test our primary research questions about the indirect effects of family rejection on psychological distress and disordered eating through conflicts in allegiances, family shame, and internalized stigma, we executed a path analysis model via Mplus (Muthén & Muthén, 1998-

2017). In addition, we examined nested and non-nested alternative models. Specifically, for non-nested models, we examined 1) whether family rejection is associated with greater conflicts in allegiances, and in turn, family shame and internalized stigma, and consequently psychological distress and disordered eating and 2) whether family rejection is associated with greater family shame and internalized stigma and in turn, greater conflicts in allegiances, and consequently greater psychological distress and disordered eating. We also tested nested models for both of these models to examine whether constraining direct paths to zero would result in better model fitWe used the maximum likelihood estimation with robust standard errors (MLR) estimation in Mplus. For the path analysis, we used model fit recommendations of Comparative Fit Index (CFI) equal or greater than .95, standardized root-mean-square Residual (SRMR) equal or less than .08, and root mean square error of approximation (RMSEA) equal or less than .08 (Browne & Cudeck, 1993; Kline, 2011). If model fit deemed acceptable, direct and indirect associations between variables were examined. We reported unstandardized coefficients in the path analysis model.

Data Screening and Preparation

All variables of interest were within the acceptable range of skewness and kurtosis. Aside from demographic data, the only data missing among variables of interest was one case (.6%) missing five of the conflicts in allegiances items and one case (.6%) missing all K6 items. Thus, the vast majority of the sample (153 or 98.7%) were not missing values for any variables of interest. Little's missing completely at random analysis was executed and a nonsignificant chi-square statistic, $\chi^2(3001) = 2970.35$, $p = .65$ was found, indicating that data were missing at random. Given the miniscule amount of missing data and that data were missing at random, we followed recommended procedures (Parent, 2013) and used pairwise deletion to account for

missing data. This method entails that available data were used for analyses and missing data were only excluded for analyses that involved those missing data points, resulting in n =146 for the psychological distress model and n = 147 for the disordered eating model. A post hoc power analysis indicated that a sample of 146 can detect significant medium effects in linear regression with 99% power.

Results

Bivariate Analyses

Table 2 portrays correlations among and descriptive statistics among the present study's main variables of interest. Gender diversity (i.e., 0 = cisgender, 1 = non-cisgender) was associated with psychological distress (r = .228, p = .004) and income was associated with both psychological distress (r = -.199, p = .014) and disordered eating (r = -.160, p = .048). Additionally, ANOVA analyses comparing East Asian, Southeast Asian, South Asian, Native Hawaiian/Pacific Islander, and Multiethnic groups indicated that there were no significant differences within our sample in psychological distress (F(4,140) = 1.42, p = .230) or disordered eating (F(4,139) = 1.25, p = .294) across ethnic groups.

Model Fit

First, we ran a model that examined whether family rejection predicted family shame, conflicts in allegiances, and internalized LGBTQ+ stigma and in turn, psychological distress and disordered eating. For all models, we controlled for gender diversity and income. Results indicated poor model fit, so we examined non-nested and nested alternative serial mediation models and compared goodness-of-fit indices. For alternative model 1, we examined whether family rejection → conflicts in allegiances → family shame and internalized stigma → psychological distress and disordered eating. The model for the pathway fit the data well, AIC =

4258.24, BIC = 4343.96, RMSEA = .04, CFI = .99, SRMR = .04. For alternative model 2, we switched the order of conflicts in allegiances with family shame and internalized stigma such that family rejection → family shame and internalized stigma → conflicts in allegiances → psychological distress and disordered eating. We found that the model fit was identical with alternative model one, AIC = 4258.24, BIC = 4343.96, RMSEA = .04, CFI = .99, SRMR = .04.

We then examined nested models where we constrained pathways to zero. For alternative model 3, we constrained all pathways to zero and only examined whether family rejection was associated with greater distress and disordered eating. The model fit was poor, AIC = 4420.04, BIC = 4470.29, RMSEA = .25, CFI = .16, SRMR = .23. Next, for alternative model 4, we constrained paths of internalized stigma and shame to zero and examined whether family rejection → conflicts in allegiances → psychological distress and disordered eating. The model fit was poor, AIC = 4402.82, BIC = 4461. 83, RMSEA = .25, CFI = .27, SRMR = .22. For alternative model 5, we constrained all pathways with conflicts in allegiances and examined family rejection → internalized stigma, family shame → psychological distress and disordered eating. The model fit was also unacceptable, AIC = 4299.01, BIC = 4369.95, RMSEA = .17, CFI = .76, SRMR = .14. After examining all models, we determined that alternative model one and alternative model two exhibited the best model fit. In addition, given that both models produced identical fit indices, we could not statistically compare which model was more favorable. However, based on previous theorizing on the link between conflicts in allegiances (as a result of structural and cultural norms) and other forms of internalized stigma (Ching et al., 2018), we retained alternative model 1 as the final model and reported the results below.

Final Model Direct and Indirect Effects

As mentioned above and illustrated in Figure 1, the final model of family rejection → conflicts in allegiances → family shame, internalized stigma → psychological distress and disordered eating while controlling for gender diversity and income resulted in good model fit. For direct effects, we found that family rejection had no significant direct effects on both psychological distress (B = -.17, p = .27) and disordered eating (B = .27, p = .45). In addition, there were no significant direct effects of conflicts in allegiances on distress (B = .01, p = .84) and disordered eating (B = .04, p = .70), as well as internalized stigma on distress (B = .26, p = .21) and disordered eating (B = .18, p = .59). However, family shame had a positive association with psychological distress (B = .32, p < .001) but not disordered eating (B = .22, p = .07). Family rejection did have a significant, positive association with conflicts in allegiances (B = 1.02, p < .001), family shame (B = 0.96, p <.001), and internalized stigma (B = .29, p < .001). In addition, conflicts in allegiances was associated with greater family shame (B = .38, p < .001) and internalized stigma (B = .15, p < .001).

In terms of indirect effects, family rejection was not associated with psychological distress through conflict of allegiances (B = .01, p = .84) or internalized stigma (B = .07, p = .23). However, family rejection was indirectly related to psychological distress through family shame (B = .30, p = .003). That is, those who reported greater family rejection were more likely to then feel interpersonal family shame, and in turn greater distress. In addition, we found evidence for serial mediation such that family rejection → conflicts in allegiances → family shame → psychological distress (B = .12, p = .01). That is, participants who reported experiencing family rejection were more likely to report incompatibility with their racial and LGBTQ+ identities and consequently, feel greater family shame and in turn more psychological distress. However, the indirect pathway of family rejection → conflicts in allegiances → internalized stigma →

psychological distresswas nonsignificant (B = .04, p = .26). Lastly, there were no significant indirect effects between family rejection, conflicts in allegiances, internalized stigma and shame, and disordered eating.

Discussion

Our results found support for a serial mediation model where family rejection is positively associated with conflicts in allegiances, which is positively associated with family shame, which is positively associated with psychological distress. However, this indirect effect was not significant for disordered eating. There was also a significant indirect effect of family rejection on psychological distress through family shame, but not through conflicts in allegiances or internalized stigma. These results indicate the considerable role family shame may play in LGBTQ+ Asian American experiences with family rejection and their role in facilitating mental health disparities. The results also expand on existing intersectional stress theories by indicating how conflicts in allegiances may relateto family shame in LGBTQ+ Asian American communities to contribute todisparities. These insights provide directions for researchers and clinicians to explore when navigating different ways systemic racism and homophobia/transphobia inform the interpersonal relational dynamics and the internal psychological dynamics of LGBTQ+ Asian Americans.

That family shame was significantly associated with psychological distress points to the particular potence of shame in facilitating mental health concerns among LGBTQ+ Asian Americans, expanding on past research to LGBTQ+ Asian Americans experiencing unique intersections of oppression (Kim et al., 2011; Wang et al., 2018; Wong et al., 2014). In addition, family rejection was directly linked with family shame, and family shame mediated the effects of family rejection and psychological distress. Past minority stress theory scholars have discussed

how mediation models connecting discrimination to internal psychological processes can indicate mechanisms by which stigma "gets under the skin" (Hatzenbuhler, 2009). This may suggest that, beyond simply feeling identity conflict or internalizing negative messages about LGBTQ+ identity, family rejection for LGBTQ+ Asian Americans may instead facilitate mental health concerns by creating an overarching feeling of shamefulness around a key (or what is meant to be a key) interpersonal dynamic and support structure. More specifically, this may look like a pressure to withdraw or hide to protect family reputation due to a perceived "defect" in one's LGBTQ+ identity. LGBTQ+ Asian Americans do not have one single experience around family and family rejection, so future research into the nuances of familial dynamics (including across ethnic groups and across sexual and gender minoritized identities) will be crucial. Additionally, while family rejection was associated with family shame, the overall indirect effect with disordered eating was nonsignificant, pointing to the need for additional research examining intersectional determinants of disordered eating (e.g., sizeism within families; Chng & Fassnacht, 2016). Still, this finding provides crucial insight into how anti-LGBTQ+ stigma within family units (contextualized by histories of colonialism and other structural manifestations of oppression; Hatzenbuehler, 2016; Laurent, 2005) impacts mental health.

The lack of significance for the mediating roles of conflicts in allegiances and internalized stigma on their own (i.e., not in serial mediation) are surprising given the theoretical rationale and past findings. By investigating conflicts in allegiances in serial mediation, we see how more complex relations beyond what is proposed by existing theory. Specifically, among LGBTQ+ Asian Americans, feeling conflict between one's race and LGBTQ+ identity may be connected to feelings of shame related to family and, depending on the extent to which family is relevant to the individual, this may create a unique experience of intersectional stress

contributing to health disparities. This provides empirical support to and expands upon Ching and colleagues' (2018) model, providing more complex pathways for understanding the ways structural and cultural factors within the larger white supremacist heteronormative context of the U.S. may be connected to mental health disparities. It is important to recognize that, although past research has looked at collectivist values within Asian American communities as they relate to family (Carrera & Wei, 2017), a myriad of factors may contribute to the salience of family in one's life. For example, family rejection may be less salient for some adults' identity experiences (e.g., at that stage in the life course, one may no longer live with or otherwise as frequently interact with family), and instead it is other racial identity communities that drive conflicts in allegiances or internalized stigma. Noting that family rejection was still significantly directly associated with conflicts in allegiances and internalized anti-LGBTQ+ stigma in the correlation analyses, these constructs cannot be disregarded in considering the intersectional impacts of family rejection on LGBTQ+ Asian Americans. Further exploration of both conflicts in allegiances and internalized stigma among LGBTQ+ Asian Americans (and subgroups) is needed to explore how dynamics beyond the family influence these important psychological dynamics.

Expanding further on internalized anti-LGBTQ+ stigma, perhaps internalized stigma is related to more global experiences of homophobia and transphobia (e.g., not necessarily from family). It could be that homophobia/transphobia from those with greater social power (e.g., white people) has more dire consequences in the lives of LGBTQ+ Asian Americans (e.g., denial of resources/employment, social support) and thus greater impact on mental health under these circumstances. While not significant in the path analysis, family rejection was still significantly correlated with internalized anti-LGBTQ+ stigma and internalized anti-LGBTQ+ stigma was

significantly correlated with both outcomes, pointing to its relevance in the intersectional experiences of LGBTQ+ Asian Americans that should not be ignored in future research.

Limitations

There are several limitations to this research that contextualize the results. First, this study cross-sectionally examined familial experiences in a sample of people over the age of 18 (and thus may not live with immediate family). The cross-section mediation analysis, while justified by theory, may open the possibility that the mediators examined may not truly function as mediators longitudinally (Maxwell et al., 2011), necessitating further study to clarify the ways the constructions function over time. Additionally, while age and years in the U.S. were considered as potential covariates and were not found to be associated with the outcome, generational differences around experiences with LGBTQ+ identification and experiences in the U.S. may remain, leaving important avenues for future research to understand the ever-evolving nature of sexuality and gender. Examining these constructs longitudinally and with more narrowly defined subsamples of LGBTQ+ Asian Americans may more effectively capture the dynamics emerging from this study and how the salience of familial experiences may change across the life course and across generations. Additionally, although a plethora of ethnic identities, sexual orientations, and genders was represented in the study, this does not change the fact that LGBTQ+ Asian Americans are not a monolith and that further research at specific intersections is crucial to highlight the mental health factors impacting various marginalized communities and how those factors are connected to unique histories of oppression and violence. This limitation simultaneously highlights the need for data disaggregation around ethnicity in larger datasets, including nationally representative samples and the U.S. Census, to systematically fill these gaps (AAPI Data, 2022). The convenience sampling methods may also

create bias within the results, creating a sample that may not fully represent the experiences of LGBTQ+ Asian Americans who, for example, do not speak English or do not have access to a reliable internet connection. One approach to address this limitation is to engage in and fund community-based approaches to research, improving both the sampling and research methodology and ensuring the questions addressed by research truly address health concerns facing the community (Minkler, 2005). Lastly, it is critical to acknowledge that theory and empirical work for LGBTQ+ Asians largely exists within westernized contexts. As intersectional research on LGBTQ+ Asian Americans continues to expand, the scientific community must develop frameworks for examining international experiences of sexual and gender diversity outside of Western paradigms.

Implications and Conclusion

LGBTQ+ Asian Americans have unique experiences when it comes to familial dynamics and how those dynamics influence mental health. Family shame appears to be particularly relevant in facilitating negative mental health outcomes relating to family shame. Researchers and clinicians working with LGBTQ+ Asian American communities and interested in expanding our understanding of intersectional oppression on mental health should explore family, family rejection, and potentially related experiences of shame and identity conflict in understanding mental health and disordered eating within this population. Specifically, clinicians can leverage social justice-oriented therapeutic approaches and radical healing frameworks (French et al., 2020) to process with clients the impact of conflicts in allegiances and family shame on their mental health, responding non-judgmentally and with attention to the ways power functions at this intersection of oppressions to shape LGBTQ+ Asian American experiences. This attention to power could be used to raise clients' critical consciousness, shaping how they view their

experiences of rejection, identity conflict, and shame within the context of oppression and thus help build empowerment toward radical healing and liberation. Affirming experiences being particularly critical in the face of rejection, clinicians can also provide clients with resources that may help them feel more secure, empowered, and affirmed in both their racial and LGBTQ+ identities simultaneously, such as direct connections to community members and organizations, relevant media (e.g., memoirs or novels centering people of similar identities), online groups or forums, etc. Moreover, while the current study examined this issue from a deficit perspective, emerging research highlights the importance of challenging oppression (Suyemoto, 2022), highlighting identity strengths (Akerlund & Chung, 2000; Kwon, 2013; Peel et al., 2022; Sung et al., 2015), and examining the positive and protective impacts of family connectedness (Eisenberg & Resnick, 2006) in understanding the full nuances of the experiences of marginalized communities.

Beyond addressing the individual and family-level factors explored in this study, efforts to address structural racism and homophobia/transphobia are crucial to disrupting the cycles of violence and oppression that underlie the experiences elucidated in this study. Perhaps if Asian American families felt less constricted by white supremacy and heteronormative ideals prevalent within the United States, they may be more amenable to accepting their LGBTQ+ children and family members. While this study focused on heterosexist stressors and how they manifest for LGBTQ+ Asian Americans, it is important to acknowledge that these stressors do not exist in a vacuum for LGBTQ+ Asian Americans and should be considered in the context of other oppressive forces (e.g., racism; Le et al., 2022a) that they contend with. Overall, our results speak to the need for researchers and practitioners to concurrently address the psychological harms of family rejection and the structural social issues that contribute to that rejection in the

first place, shaping a world where LGBTQ+ Asian Americans can exist fully and freely at the intersection of their identities.

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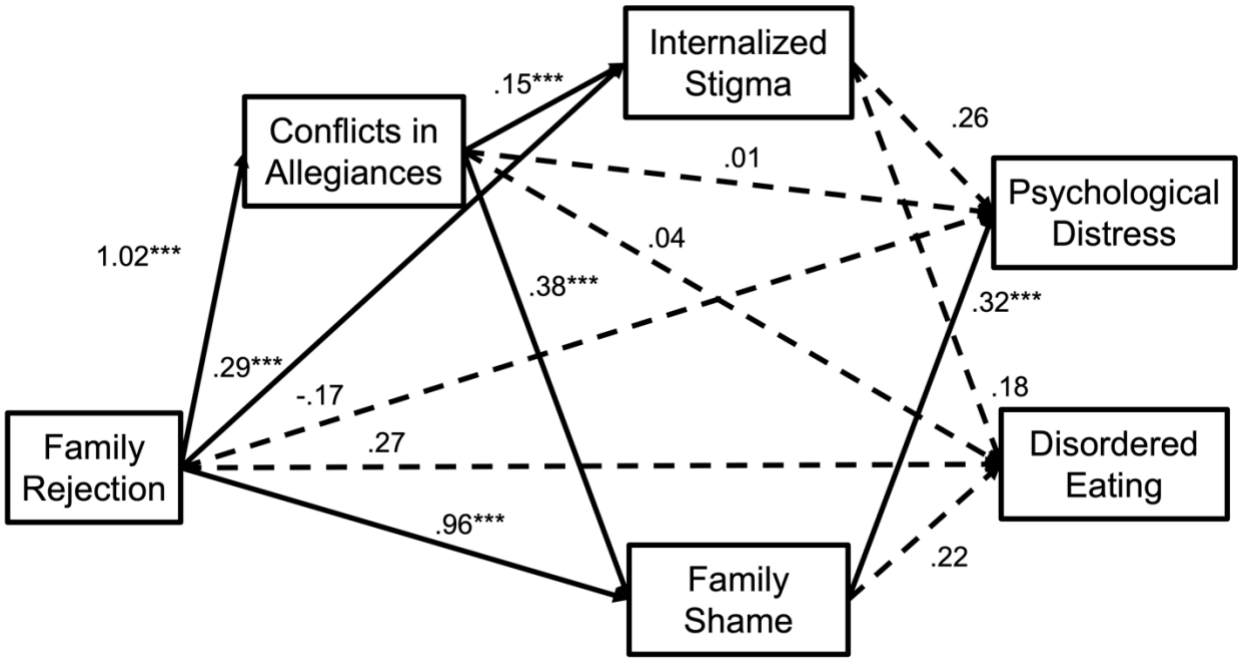
Figure 1

Path Analysis Model Examining the Associations Between Family Rejection, Conflicts in Allegiances, Family Shame, and Psychological Distress and Disordered Eating



Note. Gender diversity and income were controlled for in the model; Unstandardized coefficients are reported; Bold lines indicate significant pathways; Dashed lines indicate non-significant pathways; ***p < .001

Table 1

Participant Demographics

Variable	*n*	*% of sample*
Ethnicity		
Chinese	35	22.6
Filipino	17	11
Korean	3	1.9
Vietnamese	7	4.5
Japanese	3	1.9
Native Hawaiian or Pacific Islander	2	1.3
Indian (South Asian)	18	11.6
Taiwanese	9	5.8
Thai	1	0.6
Hmong	2	1.3
Bangladeshi	3	1.9
Indonesian	1	0.6
Another Identity	15	9.7
Multiethnic	39	25.2
Born in the United States		
Yes	114	73.5
No	40	25.8
Years in the United States		
0-5	3	1.9
6-10	12	7.7
11-20	70	45.2
21+	70	45.2
Generation		
1st Generation	27	17.4
1.5 Generation (immigrated before age 12)	11	7.1
2nd Generation (at least one parent immigrated)	91	58.7
3rd+ Generation (both parents born in the United States)	18	11.6
Adoptee	8	5.1
Gender		
Woman	75	48.4
Man	41	26.5
Nonbinary	24	15.5
Gender Non-Conforming	7	4.5
Agender	2	1.3
Another Gender	6	3.9

Gender Diversity		
Transgender or Another Gender Diverse Identity	47	30.3
Cisgender	108	69.7
Sexual Orientation*		
Lesbian	20	12.9
Gay	35	22.6
Bisexual	76	49.0
Pansexual	26	16.8
Queer	54	34.8
Asexual	13	8.4
Heterosexual	6	3.9
Demisexual	2	1.3
Uncertain/Questioning	15	9.7
Income		
< $10,000	5	3.2
$10,000-14,999	1	0.6
$15,000-24,999	2	1.3
$25,000-34,999	16	10.3
$35,000-49,999	10	6.5
$50,000-74,999	17	11.0
$75,000-99,999	19	12.3
$100,000-$199,999	42	27.1
> $200,000	26	16.8
Unsure or Decline to Answer	17	11.0
Education		
Less than high school	1	0.6
High school diploma	28	18.1
Some college	54	34.8
College degree	44	28.3
Professional or graduate degree	30	19.4
Employment*		
Full-time employed	42	27.1
Part-time employed	59	38.1
Self-employed	10	6.5
Unemployed	13	8.4
Retired	1	0.6
Student	88	56.8
Disability	1	0.6
Another status	2	1.3
Marital Status		
Single	93	60

Committed Relationship	49	31.6
Married	12	7.7
Widowed	1	0.6

Note. Demographics marked with an asterisk* do not sum to 100% as participants could select more than one option.

Table 2

Correlational Analyses

Variable	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Age	24.26	7.03	-										
2. Born in U.S.	-	-	-.253**	-									
3. Years in U.S.	-	-	.159*	.258**	-								
4. Income	-	-	-.303***	.091	.036	-							
5. Education	-	-	.451***	-.218**	.320**	-.198*	-						
6. Gen Diverse	-	-	.157	.031	-.055	-.277***	-.016	-					
7. Fam Reject	1.76	2.13	-.098	.024	-.181*	-.074	-.188*	.122	-				
8. Fam Shame	12.40	7.21	.020	-.037	-.191*	-.109	-.156	.108	.383***	-			
9. CIA	25.82	7.45	-.200*	.096	-.122	.020	-.122	-.092	.289***	.441***	-		
10. Internal Stigma	3.83	2.55	-.038	.030	-.181*	-.050	-.181*	.062	.354***	.588***	.483***	-	
11. Dis Eating	9.26	7.23	.107	.015	-.088	-.160*	-.029	.157	.208*	.347***	.148	.237**	-
12. Distress	9.49	5.14	-.097	.013	.018	-.199*	-.144	.228**	.196*	.503***	.225**	.358***	.366***

Note. *$p < .05$, **$p < .01$, ***$p < .001$; Gen Diverse = Gender Diverse (1 = Non-cisgender, 0 = Cisgender); Fam Reject = Family Rejection; Fam Shame = Family Shame; CIA = Conflicts in Allegiances; Internal Stigma = Internalized Anti-LGBTQ+ Stigma; Dis Eating = Disordered Eating; Distress = Psychological Distress