ABSTRACT

Title of Thesis: RACE AND IMMIGRATION STATUS AS MODERATORS OF THE RELATIONSHIP BETWEEN FAMILY ACCEPTANCE/FAMILY REJECTION AND DEPRESSIVE SYMPTOMS FOR LGBTQ+ YOUTH

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Research consistently demonstrates that LGBTQ+ youth, when compared to non-LGBTQ+ youth, are at significantly greater risk for depression, anxiety, substance use, and suicidality as a result of stressors related to belonging to a minority group (Russell & Fish, 2016). Family acceptance is an important protective factor against these negative mental health outcomes, and family rejection has been demonstrated as an important risk factor. Research on LGBTQ+ youth has been criticized for regarding all LGBTQ+ youth as the same and not accounting for the intersection and interaction with other identities such as race or immigrant status. The research questions posed by this study are 1) to what extent do race and immigrant status, separately and combined, moderate the established relationship between family acceptance and depressive symptoms?, and 2) to what extent do race and immigrant status, separately and combined, moderate the established relationship between family rejection and depressive symptoms? Results of the present study show that race significantly moderated the relationship between family acceptance and depression for LGBTQ+ youth, but did not moderate the relationship between family rejection and depression. Immigrant status moderated neither relationship. Three-way interactions with race and immigrant status moderated both the association among family acceptance, family rejection, and depression. Clinical implications and implications for future research are discussed.

RACE AND IMMIGRATION STATUS AS MODERATORS OF THE RELATIONSHIP BETWEEN FAMILY ACCEPTANCE/FAMILY REJECTION AND DEPRESSIVE SYMPTOMS FOR LGBTQ+ YOUTH

By

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Statement of the Problem

Literature on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth has documented the mental health disparities between this population and their cisgender and heterosexual peers. The term "mental health" refers to a wide variety of symptomologies which can demonstrate the state of a person's mental and emotional well-being. One of the major constructs used in literature on LGBTQ+ mental health is depressive symptoms (Ryan, Huebner, Diaz, & Sancchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Research consistently demonstrates that LGBTQ+ youth are at significantly greater risk for depression symptoms (as well as other commonly comorbid mental health symptoms such as, anxiety, substance use, and suicidality) (Russell & Fish, 2016). Furthermore, the research suggests that these disparities result from stressors experienced by LGBTQ+ youth given their membership to the LGBTQ+ community. These include, lack of social/institutional support, discrimination, and family rejection, among others (Russell & Fish, 2016). Although there are many factors that contribute to health disparities, the most empirically supported protective factor for LGBTQ+ youth mental health is family acceptance.

Decades of research on LGBTQ+ mental health has supported family acceptance and family rejection as strong predictors of depressive symptoms (Ryan et al., 2009; Ryan et al., 2010). It is important to note here that although family acceptance and rejection may seem like different sides of the same continuum, researchers in this area have increasingly regarded them as independent variables (Ryan et al., 2010). For example, although family members may not reject an LGBTQ+ family member, they also may not be accepting. Or further, family members may be accepting in some situations but rejecting in others, or it may be that within the family the LGBTQ+ person experiences acceptance from some members and rejection from others. For

all of these reasons, the literature has moved toward operationalizing and measuring acceptance and rejection as distinct constructs.

The variables of family acceptance and family rejection may be particularly impactful on the mental health of LGBTQ+ youth because youth are more likely than adults to be reliant upon family for emotional, financial, and practical needs. Research on the LGBTQ+ community has demonstrated that family rejection significantly increases the risk of depressive symptoms, and family acceptance can serve to protect against that risk (Ryan et al., 2009; Ryan et al., 2010). Beyond this, not much is known about what factors impact or moderate the relationship between family acceptance, family rejection, and depressive symptoms for LGBTQ+ youth.

Similar to the research on LGBTQ+ adults, the youth literature has been criticized for taking a unidimensional approach and treating all LGBTQ+ youth as the same (Russell & Fish, 2016). Namely, the majority of research on both LGBTQ+ adults and youth has not investigated the experiences of these individuals from an intersectional lens. Recent literature has suggested that inadequate attention has been paid to how LGBTQ+ identities intersect and interact with other social identities such as race/ethnicity, socioeconomic status, gender, and culture. Based on what research has shown about various minority groups as they stand alone, investigators have theorized about how different intersectional identities would affect health outcomes.

One of the major theories that aims to explain how the experience of belonging to multiple minority groups might impact various health outcomes, including depressive symptoms, is minority stress theory. Minority stress theory posits that individuals belonging to minority groups face a multitude of stress factors directly related to their minority group membership that contribute to overall poorer mental health than their majority group counterparts. Furthermore, the theory suggests that for multiple minority individuals (e.g. a person who is both a racial

minority and a sexual minority), the negative effects of stressors associated with each group would add on to one another, resulting in poorer mental health outcomes than single minority individuals (e.g. a person who only belongs to one minority group).

Research on adults has begun to focus on LGBTQ+ people of color in response to the call to better understand the experience of mental health issues, such as depressive symptoms, for LGBTQ+ people by looking at multiple minority groups within the community. Unfortunately, this group has received limited attention in the youth population. The limited existing research has mainly investigated within race differences between sexual minority and non-sexual minority youth (Consolacion, Russell, & Sue, 2004). Less prominent in the is investigations of sexual minority youth are studies that also consider comparisons between racial/ethnic groups.

The results of these limited studies investigating racial/ethnic differences in depressive symptoms for LGBTQ+ youth are conflicting. One study found that LGBTQ+ Latino males reported more depressive symptoms than LGBTQ+ White males, although LGBTQ+ Latina females reported fewer depressive symptoms than their White counterparts (Ryan, Huebner, Diaz, & Sanchez; 2009). Another study found that Black male sexual minority youth reported fewer depressive symptoms than White male sexual minority youth (Burns, Ryan, Garofalo, Newcomb, & Mustanski; 2015). Other studies have found no significant differences in depressive symptoms by race in a sexual minority youth sample (Mustanski, Garofalo, & Emerson; 2010). The limited amount of existing literature on this topic and the inconsistent findings both demonstrate the need for further research in this area.

In an attempt to better understand these conflicting findings, two approaches are possible. One approach would be to explicitly focus on racial differences when testing risk factors for LGBTQ+ youth; specifically family acceptance and family rejection. Family is an important

aspect of identity formation, and research on LGBTQ+ adults suggests that there may be racial differences in how LGBTQ+ individuals interact with their families of origin. For example, some studies suggest that people of color are less likely than their White counterparts to be open about their sexual orientation due to cultural factors, familial factors, and race-based gender norms (Grov, Bimbi, Nanin, & Parsons, 2006; Pastrana, 2015). The few studies which have combined a focus on family acceptance and race for LGBTQ+ youth have resulted in conflicting findings. One study found that Latino LGBTQ+ youth of color were more likely to experience family rejection than their White counterparts (Ryan, Huebner, Diaz, & Sanchez; 2009). In contrast, a review of the literature on LGBTQ+ youth of color noted conflicting results as to whether there are racial differences in how LGBTQ+ youth relate to their families (Toomey, Hunyh, Jones, Lee, & Revels-Macalinao, 2017). Inconsistent findings in this area support the need of further study.

A second avenue to increase diversity in the LGBTQ+ youth literature may be deeper investigation into other identities and group memberships. This point is particularly relevant for LGBTQ+ youth, who are in the process of forming and strengthening their identities. Gender, sexuality, and race are all important aspects of an individual's identity, but there are other salient aspects of a person's identity which intersect and can impact the established relationship between family acceptance and depressive symptoms in LGBTQ+ youth.

One group within the LGBTQ+ community which has not yet received adequate research attention is immigrants. Although there is some research on the experiences of adult LGBTQ+ individuals who immigrate to the United States, less is known about LGBTQ+ youth who immigrate to the United States and how that aspect of their identity affects their level of family acceptance, family rejection, and their wellbeing. Research on adults has demonstrated that

LGBTQ+ immigrants face unique challenges related to the intersection of these identities that are associated with poorer health outcomes (Morales, Corbin-Gutierrez, & Wang, 2013; Phillip & Williams, 2013). The lack of research on young LGBTQ+ immigrants and the findings from the limited research among adults call for more investigation into how intersecting identities of LGBTQ+ youth create unique experiences that impact depressive symptoms. Additionally, immigration experiences have a unique and profound impact on family relationships, which suggests that immigration status may affect the relationship between family acceptance and/or family rejection and depressive symptoms for LGBTQ+ youth who immigrate to the U.S. (Kertzner, Meyer, Frost, & Stirratt, 2009; Ryan et al., 2010).

The present study aims to increase understanding of the experiences of multiple minority individuals by exploring how race and immigrant status moderate the relationship between family acceptance/family rejection and depressive symptoms in a sample of LGBTQ+ youth. The goals of this study include 1) using an intersectional lens to add nuance to what is already known about the relationship between family acceptance/family rejection and depressive symptoms, 2) adding to and clarifying the ambiguous findings about racial differences in depressive symptoms within the LGBTQ+ community, and 3) increasing the limited academic knowledge about the experiences of young LGBTQ+ immigrants.

Literature Review

LGBTQ+ Adults and Youth

Public and scientific interest and awareness of LGBTQ+ individuals have increased in the last few decades (Russel & Fish, 2016). One of, if not the most, significant revelation that has emerged from the research on this population is the notable health disparities that exist between LGBTQ+ individuals and their heterosexual and cisgender counterparts (Russel & Fish, 2016). Research comparing the mental health of LGBTQ+ adults and heterosexual and cisgender adults has consistently found that LGBTQ+ adults are at a higher risk for depression, mood disorders, anxiety disorders, posttraumatic stress disorder, suicidal ideation, suicide attempts, and comorbidity of multiple psychiatric diagnoses (Bostwick, Boyd, Hughes, & McCabe, 2010; Burgard, Cochran, & Mays, 2005; Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Cochran, Sullivan, & Mays, 2003; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2009). Though the present study focuses specifically on depressive symptoms, it is important to acknowledge research on other areas of LGBTQ+ mental health because it demonstrates the depth of the impact that belonging to a marginalized group can have on one's well-being.

The past 10-20 years has seen an increase in public acceptance and approval of LGBTQ+ individuals, particularly sexual minorities, in the United States (Gallup, 2018). In May of 2001, 40% of individuals surveyed by Gallup (2018) said they regarded same-sex relationships as morally acceptable and 53% of those surveyed regarded them as morally wrong. By May of 2018 those numbers had shifted such that 67% of those surveyed said they thought same-sex relationships were morally acceptable and 30% of those surveyed said they thought same-sex relationships were morally wrong (Gallup, 2018). It is important to note that in both the adult and

youth LGBTQ+ literature some of the research includes both sexual minorities and transgender individuals in their samples, although a significant portion of studies focus solely on sexual minority individuals and does not include data on transgender individuals (Bockting, Miner, Swineburne Romine, Hamilton, & Coleman, 2013; Simons, Schrager, Clark, Belzer, & Olson, 2013). Research on transgender individuals has gained more attention recently, but there has not been nearly as much written about this subpopulation relative to sexual minorities. This is important to keep in mind as the literature on this subject is reviewed.

As Russel and Fish (2016) point out in their article reviewing the literature on LGBT youth mental health, social and cultural shifts over the past few decades has been accompanied by trends of LGBTQ+ individuals "coming out" (i.e. disclosing their LGBTQ+ identities to others) at increasingly younger ages. Data samples collected in the 2000s suggest that the average age of "coming out" was around 14 years old, although a study from the 1990s put the average age at 16, and a study from the 1970s stated that the average age was 20 (D'Augelli, Grossman, Starks, & Sinclair, 2010; Rosario, Meyer-Bahlburg, Hunter, Exner, Gwadz, & Keller, 1996; Troiden, 1979). Russell and Fish (2016) point out that the average age at which LGBTQ+ youth now come out is during adolescence, a developmental stage during or immediately after which many mental disorders have a typical onset, and suicide is the second leading cause of death for individuals ages 10-24 nationwide (CDC, 2016). Also, during adolescence, LGBTQ+ youth are more likely than adults to face peer victimization, which has significant negative effects on mental health (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Russell, Toomey, Ryan, & Diaz, 2014). Therefore, mental health is of particular concern in terms of research and intervention for LGBTQ+ youth.

As researchers have investigated the mental health of LGBTQ+ young people, they have found that many of the mental health disparities evident among LGBTQ+ adults are also present among LGBTQ+ youth. Research consistently reports that LGBTQ+ youth experience higher levels of emotional distress, symptoms of mood and anxiety disorders, self-harm, and suicidality (Fergusson, Horwood, Ridder, & Beautrais, 2005; Marshal et al., 2011). A meta-analytic review of the disparities in suicidality and depression symptoms between sexual minority and heterosexual youth reported that sexual minority youth were almost 3 times more likely to experience suicidality, with the difference between the two groups increasing as the severity of the suicidality increased (Marshal et al., 2011). As a result of these disparities, research on LGBTQ+ youth has had a significant focus on risk factors for negative mental health outcomes, such as depressive symptoms. The literature has shown that a lack of social support in important institutions (e.g. school, faith community), living in a community with higher rates of anti-LGBTQ+ sentiments, biased-based victimization, peer rejection, and family rejection are the most empirically supported risk factors for negative mental health outcomes among LGBTQ+ youth (Russel & Fish, 2016). Protective factors have gotten significantly less research attention than risk factors, but the ones that have been identified are affirming and protective school environments, support from community, support from peers/friends, and support from family (Eisenberg & Resnick, 2006).

Impact of Family. Research has consistently found that family rejection is a major risk factor for and family acceptance is a major protective factor against depressive symptoms for LGBTQ+ individuals (Bockting et al., 2013; Bouris et al., 2010; McConnel, Birkett, & Mustanski, 2015; Ryan et al., 2009; Ryan et al. 2010; Simons et al., 2013; Rothman, Sullivan, Keyes, & Boehmer, 2012). Although this is true both of LGBTQ+ adults and youth, family

acceptance and family rejection are particularly important to the youth population because they are more likely to rely on parents for various forms of support given their age. Sadly, many sexual minority youth report low levels of support from parents regarding their identity, and transgender youth tend to report even lower levels of support than sexual minority youth (Ryan et al., 2010).

Low parental support or family rejection has a consistently observable effect on the wellbeing of LGBTQ+ youth. Ryan et al. (2009) conducted a study in which the researchers asked LGBTQ+ young adults to report on family acceptance and rejection reactions that they received while they were adolescents and analyzed the relationship between those experiences and their depressive symptoms at the time of the study. Researches gave each participant a family rejection score based on their responses to closed-ended questions about the presence and frequency of rejecting caregiver behaviors (ex: "Between ages 13–19, how often did your parents/caregivers blame you for any anti-gay mistreatment that you experienced?") (Ryan et al., 2009). Family rejection scores ranging from 0-11 were classified as low, 11-25 were classified as moderate, and 25.6-51 were classified as high (Ryan et al., 2009).

They reported that, when compared to peers who reported no or low levels of family rejection, participants who reported higher levels of family rejection during adolescence were 3.4 times more likely to use illegal drugs, 3.4 times more likely to engage in in unprotected sex, 5.9 times more likely to report high levels of depression, and 8.4 times more likely to report attempted suicide (Ryan et al., 2009). Other studies have also associated family rejection with suicidal ideation, anxiety, depression, and sexual risk-taking in exclusively sexual minority, exclusively transgender, and combined LGBTQ+ samples (Budge, Adelson, & Howard, 2014; Grossman & D'Augelli, 2007; Yadegarfard, Meinhold-Bergmann, & Ho, 2014). Not only does

family rejection itself negatively impact LGBTQ+ youth mental health, research has also shown that youth who fear negative reactions from their families report higher levels of depression and anxiety symptoms (D'Augelli, 2002).

An important correlate of family rejection is family acceptance. Which, although less heavily researched than family rejection, also have an impact on the mental health of LGBTQ+ youth. Using the same dataset from their 2009 article, Ryan et al. (2010) examined the relationship between family acceptance behaviors occurring in adolescence and the depressive symptoms of their LGBTQ+ young adult participants at the time of the study. Similar to the operationalization of the family rejection variable, each participant was given a score (ranging from 0-55) based on their responses to questions about the frequency of accepting caregiver behaviors (ex: "How often did any of your parents /caregivers bring you to an LGBT youth organization or event?" "How often did any of your parents /caregivers appreciate your clothing or hairstyle, even though it might not have been typical for your gender?") (Ryan et al., 2010).

The family acceptance scores were also sorted into three categories: low (0-15), medium (15-30), or high (31-55) (Ryan et al., 2010). The study found that 18.5% of participants who reported high levels of family acceptance reported experiencing suicidal thoughts in the past 6 months, while suicidal thoughts were reported by 38.3% of participants who reported low family acceptance (Ryan et al., 2010). They also found that 30.9% of participants who reported high levels of family acceptance stated that they had attempted suicide at some point, while 56.8% of participants who reported low family acceptance said they had attempted suicide at some point in their lifetime (Ryan et al., 2010). Other studies have associated family acceptance with lower levels of depression and risk-taking behaviors among LGBTQ+ youth (Bockting et al., 2013; Simons et al., 2013). These findings suggest that family acceptance and family rejection make a

big difference to the depressive symptoms of LGBTQ+ youth. Importantly, these effect are not limited to adolescence, but also going forward across the life course.

Historically, research on family acceptance and/or family rejection has regarded the two as part of the same construct (Fuller, 2017; Perrin, Cohen, Gold, Ryan, Savin-Williams, & Schorzman, 2004; Ryan et al., 2010). Assessment tools, such as the Parental Acceptance-Rejection Questionairre (PARQ) have been developed that reflect an understanding of family acceptance and family rejection as opposite ends of the same spectrum (Rohner & Ali, 2016). Utilizing the single construct operationalization of family acceptance and family rejection, researchers have sought to compare outcomes from LGBTQ+ individuals from families labelled as accepting and families labelled as rejecting (Fuller, 2017). However, recently researchers have been calling for the examination of family acceptance and family rejection as two separate constructs (Pollitt, Fish, & Watson, 2019; Ryan et al., 2010). Those that advocate for conceptualizing them as separate constructs argue that accepting and rejecting behaviors can co-occur as families react to their child's LGBTQ+ identity, meaning that a child could be simultaneously impacted by family acceptance behaviors and family rejection behaviors (Perrin et al., 2004; Ryan et al., 2010). Theoretically, investigating family acceptance and family rejection as separate constructs would allow researchers to add depth and nuance to the academic understanding of how family-child dynamics impact LGBTQ+ youth.

Notably, a study examining different kinds of social support that are protective factors for LGBTQ+ youth reported that the form of support that was *most beneficial* to their mental health was parental (Snapp, Watson, Russel, Diaz, & Ryan, 2015). However, there remains the questions of what effect other risk and protective factors may have on the relationship between family acceptance/family rejection and LGBTQ+ youth depressive symptoms. Parra, Bell,

Benibqui, Helm, & Hastings (2018) conducted a study with a sample of LGB emerging adults which examined the effect of peer support on the link between family rejection and psychosocial adjustment. Their results showed that peer social support moderated the link between negative family attitudes and anxiety and also moderated the link between family victimization and depression (Parra et al., 2018). Their findings suggests that having a supportive peer group might protect LGBTQ+ young people who experienced rejection from their family of origin against negative mental health outcomes. In contrast, another study which examined different types of social support and their associations with the depressive symptoms of a sample of LGBTQ+ youth found that participants who reported low levels of family support and high levels of friend and significant-other support still reported more depressive symptoms outcomes than participants who reported high family support (McConnell, Birkett, & Mustanski, 2015). Also, the results of the study stated that participants who reported low levels of family support and high levels of friend and significant-other support did not report significantly different depressive symptoms than participants who reported having no forms of social support. Notably, that study was unique in that it had a majority African-American sample. The majority of the research on the relationship between family acceptance, family rejection and LGBTQ+ youth depressive symptoms has been done with majority White or exclusively White samples. These conflicting results suggests that further research on the relationship between family acceptance, family rejection, and LGBTQ+ youth depressive symptoms is warranted, particularly research which has the ability to speak to racial differences within that community and the experiences of multiple minority individuals.

Multiple Minority Status

Minority stress theory has been the major framework used as the foundation for understanding the disparities between LGBTQ+ individuals and their heterosexual and cisgender counterparts (Russel & Fish, 2016). The theory suggests that LGBTQ+ individuals are at a higher risk for depressive symptoms due to distinct, chronic stressors that are directly related to their LGBTQ+ identity (Meyer, 2003). These minority stressors, according to the theory, generally involve structural and institutionalized discrimination, direct interpersonal experiences of victimization concern about the possibility of discrimination and victimization, and the internalization of negative attitudes toward one's self. The aforementioned health disparities between LGBTQ+ youth and their heterosexual and cisgender counterparts lend support to the minority stress model, as does research that suggests experiences of prejudice-based discrimination, rejection, and victimization negatively impacts the depressive symptoms of LGBTQ+ youth (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Parra et al., 2018).

However, research with both the adult and youth LGBTQ+ populations have been criticized for treating all LGBTQ+ individuals as the same and not conducting enough research with the intention of investigating the experiences of individuals who belong to multiple minority groups. Research on LGBTQ+ people is critiqued as being limited in its exploration of racial/ethnic differences in LGBTQ+ mental health, though the adult literature on adults is more prevalent than the literature on youth (Toomey, Huynh, Jones, Lee, & Revels-Macalinao, 2017). In fact, van Eeden-Moorefield, Few-Demo, Benson, Bible, and Shannon (2018) recently conducted a content analysis of LGBT research published in top family journals from 2000-2015 and found that the vast majority of samples were either entirely or primarily White. Authors of another study examining mental health disorders, psychological distress, and suicidality in a sample of LGBTQ+ youth that was not majority White actively acknowledged the rarity of their

racially diverse sample (Mustanski, Garofalo, Robert, & Emerson, 2010). In recent years, there has been a call to use a more intersectional lens in the research on the LGBTQ+ community so as to capture the diversity of experience within the community, particularly the experience of multiple minority individuals (Consolacion, Russell, & Sue, 2004; Craig, Austin, Alessi, McInroy, & Keane, 2017).

When applied to multiple minority individuals, minority stress theory posits that belonging to multiple minority groups would result in greater exposure to minority stressors, which would have an additive effect that leads to even more significant impact on depressive symptoms than the impact experiences by single minority LGBTQ+ individuals. This is sometimes referred to as the additive stress model (Kertzner, et al., 2009). However, this application of minority stress theory to multiple minority individuals has been critiqued with the suggestion that multiple minority individuals may develop mechanisms of coping with minority stress that allow them to actually be more resilient in terms of its impact on their depressive symptoms (Consolacion et al., 2004; Craig et al., 2017; Kertzner et al., 2009; Toomey et al., 2017). The research that has been done in response to the call for a more intersectional lens has had conflicting results, some of which have supported minority stress theory, some of which have not.

Intersectionality theory is another theoretical framework that is central to the discussion of the experiences of multiple minority individuals. Intersectionality theory, a term coined by Kimberlé Crenshaw, emerged from Black feminist writing about the intersections of race, gender, and class (Bowleg, 2012). The framework posits that the intersection of multiple social categories (e.g. race, gender, sexual orientation, socioeconomic status, disability, etc.) experienced at the individual, or micro, level reflect multiple systems of privilege and oppression

at the macro, social-structural level (Bowleg, 2012; Toomey, Maura, Flores, & Karla, 2018). Within this framework, understanding the unique identify formed by the interactions of a person's multiple social identities is essential to understanding larger health disparities between social groups. The additive model of minority stress theory does not fit into the intersectionality framework. Intersectionality theory asserts that social categories are not independent of one another and therefore adding one identity to another cannot adequately describe unequal health outcomes (Bowleg, 2012) associated with the unique identity that is formed when these identities are juxtaposed. For example, the experience of being a woman plus the experience of being a Black person, does not equal the experience of being a Black woman because that unique social location involves ways of interacting with the world that are not experienced by other women or other Black people.

In her article outlining the importance of intersectionality theory to public health research, Lisa Bowleg (2012) states that the framework does not have the traditional core elements or variables which can be operationalized and empirically tested. Bowleg (2012) suggests that rather than testing the theory itself, research should be intersectionality-informed. Intersectionality theory calls for a more complex and multifaceted understanding of how unique identities associated with belonging to multiple minority groups can impact health disparities. The theory asserts that since research on health disparities and multiple minority individuals grapples with complex multidimensional issues, it necessitates novel and complex approaches to research that acknowledge that social identities do not exist independently from one another, prioritizes people from historically marginalized communities, and considers how multiple social identities at the micro level interact with larger societal structures (Bowleg, 2012). The present study humbly attempts to investigate the experiences of multiple minority individuals in a novel

and complex way by looking at potential disparities in depressive symptoms within one historically disadvantaged community using the social categories of race and immigrant status as possible moderators of the relationships among family acceptance, family rejection, and depressive symptoms.

Racial Differences in the LGBTQ+ Community. As researchers have begun to adopt a more intersectional lens, studies have been done investigating racial differences in depressive symptoms within the LGBTQ+ community. The studies on this subject conducted with adult samples have rendered conflicting results. Some have found that LGBTQ+ people of color experience more depressive symptoms than their White counterparts, others have found the opposite, and there are also studies that have found no significant racial differences in depressive symptoms within an LGBTQ+ sample (Burns et al., 2015; Meyer, Dietrich, & Schwartz, 2008; Mustanski et al., 2010; Ryan et al., 2009). Results in the adult studies testing racial differences in LGBTQ+ depressive symptoms differed depending on which particular racial minority group was being examined. Kertzner et al. (2009) published a study in which they examined depressive symptoms differences in a racially diverse sample of 369 LGB adults. The results of their study found no poorer well-being nor more depression symptoms in the racial minority participants as a whole when compared to their White participants (Kertzner et al., 2009). When they separated the LGBTQ+ people of color in their study out by specific racial group, they found that the depressive symptoms of the African American subsample were congruent with general-population studies that have found African Americans do not experience increased depressive symptoms, despite experiencing greater exposure to discrimination and prejudice (Kertzner et al., 2009). However, they also found that their Latino participants reported lower well-being and more depression symptoms than the White participants (Kertzner et al., 2009). The authors

appropriately point out in their discussion that their findings suggest that research investigating other factors that might influence the depressive symptoms of different racial groups in the LGBTQ+ community, such as immigration status and family acceptance, is warranted (Kertzner et al., 2009).

Although more limited the inconsistent finding in studies of adult LGBTQ+ people are largely mirrored in studies among LGBTQ youth. Consolacion et al. (2004) conducted a study investigating the mental health experiences of multiple minority status youth. Researchers found that sexual minority youth did not consistently demonstrate compromised mental health across racial/ethnic groups (Consolacion et al., 2004). African American and White LGBTQ+ youth reported more suicidal thoughts than non-LGBTQ+ counterparts of the same race, but Hispanic/Latino and Asian/Pacific Islander LGBTQ+ youth did not (Consolacion et al., 2004). Toomey et al. (2017) conducted a content analysis and critical review of the literature on sexual minority youth of color, which included 125 reports. They included studies whose samples included sexual minority people of color who were 25 years old or younger, as well as doctoral dissertations that were not published in peer reviewed journals (Coffey, 2008; Glazier, 2009; Arias, 1998; Toomey et al., 2017). The inclusion of unpublished dissertations and older samples speak to the limited availability of research on sexual minority youth of color, particularly that which includes individuals under 18. Toomey et al. (2017) found 42 reports total that collected any data whatsoever on mental health of sexual minority youth of color, even if that was not the focus of the study. These studies reported mixed results demonstrating three separate trends in the data.

Some data have reported that LGBTQ+ youth of color experience less negative mental health symptoms than White counterparts. However, the studies that reported these findings had

the least consistent results of the three patterns that emerged. For example, Burns, Ryan, Garofalo, Newcomb, and Mustanski (2015) conducted a study investigating the incidence of mental health disorders in 449 urban sexual minority men ages 16-20. Burns et al. (2015) found that White participants were at higher risk for Major Depressive Disorder and suicidal ideation than Black participants. However, their results also showed that participants who identified as a race other than Black, White, or Latino were at increased risk for suicide attempts compared to White participants (Burns et al., 2015). Another study investigating group differences among sexual minority youth found that within a group of youth who identified their sexuality as questioning, youth of color reported less depressed/suicidal thoughts than their White counterparts (Poteat, Aragon, Espelage, & Koenig,, 2009). The same study also found that in a group of youth who identified as either gay, lesbian, or bisexual, racial minority youth reported more depressed/suicidal thoughts than White youth of the same racial/ethnic identities (Poteat et al., 2009).

Another pattern reported in the literature suggests that LGBTQ+ youth of color experience more depressive symptoms compared to their White counterparts. One study, utilizing data from 2,408 participants in the Youth Risk Behavior survey, which aimed to investigate the risk behaviors of sexual minority youth, reported as part of their findings that Hispanic youth were at more risk for suicidal ideation and attempts than youth from other racial groups (Glazier, 2009). Another study in which 72 young men who have sex with men were interviewed about their needs regarding HIV prevention reported that their participants who were from racial and ethnic minorities were more likely to experience a pervasive sense of hopelessness than White participants (Seal, Kelly, Bloom, Stevenson, Coley, Broyles, 2000). Another study, which analyzed data from over 11,000 respondents to the 2009 New York City

Youth Risk Behavior Survey, reported that Hispanic sexual minority youth were significantly more likely to report a suicide attempt than non-Hispanic sexual minority youth (non-Hispanic races included White, Black, Asian/Pacific Islander, and other) (LeVasseur, Kelvin, & Grosskopf, 2013).

The third pattern found in the literature reports no significant depressive symptoms differences between races in samples of LGBTQ+ youth. One study which compared depressive symptomology of over 1,000 LGBTQ+ and non-LGBTQ+ youth ages 13-19, had a particularly racially diverse sample with more than double the number of Hispanic and Black participants than White participants (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). The study reported finding no statistically significant differences in depressive symptoms by race (Almeida et al., 2009). Another study on depressive symptoms and substance use disparities among urban adolescent lesbian and bisexual girls also reported no statistically significant differences in depressive symptomology by race (Marshal, Dermody, Shultz, Sucato, Stepp, Chung, & Hipwell, 2013). It is important to note that for the majority of the literature on the mental health of LGBTQ+ youth of color reviewed by Toomey et al. (2013), the purpose of the research was not explicitly to investigate the impact of multiple minority status on these individuals. The limited amount of literature on this topic and the inconsistent findings both demonstrate that further research into how intersecting identities impact LGBTQ+ youth depressive symptoms is warranted.

A small subset of the literature on LGBTQ+ youth of color has examined whether racial differences exist in how LGBTQ+ individuals relate to their families about their LGBTQ+ identities; again, with mixed findings. Although one study with LGBTQ+ youth of color found they were less likely to disclose their sexual orientation to their parents than White counterparts,

other studies with LGBTQ+ youth have not found racial differences in level of disclosure (Mustanski et al., 2011; Toomey et al., 2017). Moving beyond disclosure to parental support specifically, one study investigated whether parental support moderated the effect of victimization on suicidality, and found that it only did so for White LGBTQ+ youth, but not for LGBTQ+ youth of color (Poteat, Mereish, DiGiovanni, & Koenig, 2011). In contrast, other studies have suggested that parental support reduces the risk of depressive symptoms for LGBTQ+ youth regardless of race (Homma & Saewyc, 2007; Newcomb, Heinz, & Mustanski, 2012).

The conflictual results about this topic suggest that there is nuance to the interaction between family acceptance, family rejection, depressive symptoms, and race within the LGBTQ+ youth population that research has not yet come to understand. However, race is not the only aspect of identity that has the potential to intersect with LGBTQ+ youth identities and impact their mental health.

LGBTQ+ Immigrants. LGBTQ+ immigrants are a group which has not yet received significant attention in the literature on LGBTQ+ mental health, much less within the context of a youth population. Research on adult LGBTQ+ immigrants to the US has reported that they face unique minority stressors which negatively impact their mental health (Morales, Corbin-Gutierrez, & Wang, 2013; Phillip & Williams, 2013). However, a thorough review of the literature finds only three studies that include data on immigrant LGBTQ+ youth. One study which was investigating LGBTQ+ youth school victimization and their psychosocial adjustment happened to include immigration status in the demographic variables they collected (Toomey, Ryan, Diaz, Card, & Russell, 2013). The study found that immigrant LGBTQ+ youth reported higher levels of depression than non-immigrant LGBTQ+ youth (Toomey et al., 2013). Ryan et

al.'s (2010) study about how family acceptance in adolescence impacts the health of LGBT young adults had immigrants making up 19% of their study sample, and they found that non-immigrants reported significantly higher rates of family acceptance compared to immigrants. This is an important finding in light of the fact that research has suggested family acceptance one of the most influential factors impacting LGBTQ+ youth depressive symptoms. Kertzner et al. (2009) suggested that since they did not find evidence of the depressive symptoms of young LGBTQ+ Latinos being impacted by peer support, two factors that would be appropriate to investigate would be immigration status and level of family acceptance to gain understanding of how they influence the depressive symptoms of LGBTQ+ Latinos.

Purpose

The purpose of this study is to add to the growing body of research on LGBTQ+ youth mental health by exploring the extent to which race and immigration status moderate the relationship between family acceptance/family rejection and depressive symptoms. More specifically, this study is designed to 1) use an intersectional lens to add nuance to what is already known about the relationship between family acceptance/family rejection and depressive symptoms, 2) add to and clarifying the ambiguous findings about racial differences in depressive symptoms within the LGBTQ+ community, and 3) increase the limited academic knowledge about the experiences of young LGBTQ+ immigrants.

Questions. Due to the fact that a significant portion of the research on this topic has rendered inconsistent findings, a hypothesis about the extent to which race and immigration status moderate the relationship between family acceptance/ family rejection and depressive symptoms cannot reliably be developed. Thus, in the current study I will pose research questions

as opposed to making hypotheses. The research questions being addressed in the present study are:

1. To what extent do race and immigrant status, separately and combined, moderate the established relationship between family acceptance and depressive symptoms?
2. To what extent do race and immigrant status, separately and combined, moderate the established relationship between family rejection and depressive symptoms?

Methods

Procedure

Data used in the present study are from the *2017 LGBTQ National Teen Survey*, which was a comprehensive survey designed to advance understanding of victimization, school experiences, health behaviors, and family relationships of LGBTQ+ adolescents from an intersectional perspective. Data were collected in partnership with the Human Rights Campaign (HRC), between April and December 2017. All respondents were English-speaking, lived in the United States at the time they took the survey, and identified as LGBTQ+. The age range of respondents was 13-17 years.

LGBTQ+ youth were recruited through social media sites (Twitter, Facebook, Instagram, Reddit, and Snapchat) and asked to take an anonymous, online survey. Social influencers such as Jazz Jennings and Tyler Oakley assisted by sharing the link to the survey on their social platforms. The HRC posted statuses to their social platforms inviting LGBTQ+ youth to participate and sharing the link to the survey. For example one tweet read "Help HRC and UConn researchers speak out for the next generation of LGBTQ+ teens. hrc.im/teensurvey." Additionally, HRC's partner organizations (e.g., Youth Link, Trevor Project, Advocates for Youth, Planned Parenthood, and Big Brother / Big Sisters) also helped advertise the survey to their networks via email. In exchange for taking the survey, all participants were offered six HRC wristbands that could be mailed to them if they provided and address. Additionally, youth were invited to enter a random drawing for one of 10 Amazon.com gift cards.

The survey used in this study involved many self-report questionnaires assessing the following topics: sexuality, gender, and ethnoracial identity, school experiences (e.g.,

achievement, safety, bullying), health behaviors (e.g., eating behaviors, physical activity, substance use), identity disclosure (e.g., being "out" to various contexts), family experiences (e.g., acceptance, rejection, and support), and sexuality-specific experiences (e.g., LGBTQ+ racism, microaggressions, bias-based victimization).

When respondents opened the survey website, they were asked to provide demographic information on their age, race/ethnicity, state of residence, living situation, parental/caregiver education, sexual/gender identity, religion, and disability status. The measures included in the survey were existing validated measures or adapted from existing validated measures. Measures were organized into topic area blocks (e.g., school experiences, bullying, substance use), the order of which were randomized for each respondent. All study protocols were approved by the University of Connecticut's Institutional Review Board.

Respondents

In total, of the 29,291 youth that opened the survey website, 20,306 eligible participants started the survey. Participants who completed less than 10% of the survey were excluded from data analysis (3,006 total). A post hoc analysis of responses was done to removed suspicious entries from the analysis pool, resulting in 17,112 LGBTQ+ youth included in data analysis. The final sample included youth from all 50 states. The sample was further restricted for use in this study to 8377 respondents (see Table 1 for demographic characteristics of the sample). Respondents were included only if they provided responses for all study variables including covariates.

Measures

Covariates

The covariates used in the present study were age, gender identity, sexuality, residential region of the United States, parent nativity, and highest level of caregiver education. The sexuality variable was recoded such that the four smallest response groups of straight, queer, asexual, questioning, and other were all collapsed into the other category to preserve power.

Independent Variables.

Family Acceptance. Both the family acceptance and family rejection measures were adapted from the Family Acceptance Project (Ryan et al., 2010). The family acceptance measure includes 4 questions asking participants how much they feel their family engages in accepting behaviors, which are scored on a 5-point scale (doesn't apply to me = 0, never=1, rarely=2, sometimes=3, often=4). The family acceptance prompts were as follows: How much do you feel that your family, 1) like you as you are in regard to being an LGBTQ person? 2) Say they were proud of you for being an LGBTQ person? 3) Get involved in the larger LGBTQ community? 4) Tell you that you are a role model as an LGBTQ person? A final family acceptance score was constructed, ranging from 1-4, and is the average response from all four questions.

Family Rejection. The family rejection measure is also scored on the 5-point scale, and includes 4 questions about how much participants feel their family engages in rejecting behaviors. The family rejection prompts were: How much do you feel that your family, 1) Taunt or mock you because you are an LGBTQ person? 2) Say negative comments about you being an LGBTQ person? 3) Say bad things about LGBTQ people in general? 4) Make you feel like you are bad because you are an LGBTQ person? A final family rejection score was constructed, ranging from 1-4, and is the average response from all four questions.

Dependent Variable.

Depressive Symptoms. The depressive symptoms measure used in this study is the 10 item Kutcher Adolescent Depression Scale (Brooks, 2004). The original scale includes an 11th question related to suicide which was excluded from the survey. Respondents are asked how often over the last week they "on average" or "usually" experienced 10 depression symptoms. They were asked to respond to each item on a 4-point scale (0=hardly ever, 1=much of the time, 2=most of the time, 3=all of the time). The 10 items on the scale are: 1) Low mood, sadness, feeling blah or down, depressed, just can't be bothered, 2) Irritable, losing your temper easily, feeling pissed off, losing it, 3) Sleep difficulties - different from your usual: trouble falling asleep, lying awake in bed, 4) Feeling decreased interest in: hanging out with friends; being with your best friend; being with your boyfriend/girlfriend; going out of the house; doing school work or work; doing hobbies or sports or recreation, 5) Feelings of worthlessness, hopelessness, letting people down, not being a good person, 6) Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot, 7) Trouble concentrating, can't keep your mind on schoolwork or work, daydreaming when you should be working, hard to focus when reading, getting "bored" with work or school, 8) Feeling that life is not very much fun, not feeling good when usually would feel good, not getting as much pleasure from fun things as usual, 9) Feeling worried, nervous, panicky, tense, keyed up, anxious, 10) Physical feelings of worry like: headaches, butterflies, nausea, tingling, restlessness, diarrhea, shakes or tremors. A final depression score was calculated based on the sum of all 10 responses, scores range from 0-30.

Moderator Variables.

Race/Ethnicity. Respondents were asked the question "How would you describe yourself?" and instructed to select all that applied from the following options: "White, non-

Hispanic, non-Latino," "Black or African American," "American Indian or Alaska Native," "Asian or Pacific Islander," "Latino, Hispanic, or Mexican-American,," "Other." A Biracial or Multiracial subcategory was created for individuals who selected more than one option. Also, the American Indian/Alaska Native category was collapsed into the Other category in order to preserve power.

A separate variable which coded race as binary (White or non-White) was created in order to conduct post-hoc analysis. Individuals who selected any race other White were regarded as non-White, and individuals who selected only White were regarded as White.

Immigrant Status. Respondents were asked the question "How long have you lived in the United States?" and were able to select one of the following responses: "Less than four years," "more than four years," "I have always lived in the United States." Participants who responded with either of the first two options were considered immigrants and participants who responded with the third option were considered non-immigrants.

Results

Demographics

Overall, the 8377 person sample was majority White (68.3%), followed by Biracial/Multiracial (13.5%), Hispanic/Latino (9.1%), Black (3.9%), Asian/Pacific Islander (3.2%), and Other (2.0%). The average age of the sample skewed on the older side of the 13-17 range, with a mean age of 15.6 years. In terms of gender identity, the most common response was cisgender female (42.0%), followed by transmasc/non-binary (24.6%), cisgender male (19.9%), trans-male (9.7%), transfem/non-binary (2.6%), and trans-female (1.2%). The most common sexuality identified by participants was gay or lesbian (37.7%), followed closely by bisexual (31.9%), and more distantly by pansexual (14.7%) and other identities (13.7%).

Study respondents were spread out across the United States, the most common region in this sample was the South (35.9%), followed by the Midwest (23.7%), the West (22.1%), and the Northeast (18.4%). The majority of respondents were non-immigrants, with only 6.5% of the sample who were immigrants. Likewise, the majority of study respondents reported that both of their parents were born in the United States (78.7%). A smaller percentage of the sample reported that one or more of their parents were born outside the U.S. (11.2%), followed by those who reported that neither of their parents were born in the United States (9.0%), and a very small percentage of the sample was not sure about their parents' birth locations (1.1%). Finally, the majority of the sample reported that the highest level of education for at least one of their caregivers was college graduate or more (61.5%), followed by some college (15.2%), high school or less (12.6%), and don't know/not applicable/missing (1.7%).

Table 1: Demographics of the Study Sample

Variables	Frequency	Percent of total
Race		
White	5721	68.3%
Black	324	3.9%
Asian/Pacific Islander	266	3.2%
Hispanic/Latino	764	9.1%
Biracial or Multiracial	1133	13.5%
Other	169	2.0%
Immigrant Status		
Non-Immigrant	7836	93.5%
Immigrant	541	6.5%
Age		
13	588	7.0%
14	1203	14.4%
15	1760	21.0%
16	2237	26.7%
17	2589	30.9%
Gender Identity		
Cisgender Male	1669	19.9%
Cisgender Female	3519	42.0%
Trans-Male	811	9.7%
Trans-Female	102	1.2%
Transmasc/Non-binary	2062	24.6%
Transfem/Non-binary	214	2.6%
Sexuality		
Gay or Lesbian	3159	37.7%
Bisexual	2674	31.9%
Pansexual	1229	14.7%
Other	1315	13.7%
Region of U.S.		
Northeast	1545	18.4%
Midwest	1981	23.7%
South	3003	35.9%
West	1848	22.1%
Parents Nativity		
Neither born in US	756	9.0%
Some born in US	9366	11.2%
Both born in US	6593	78.7%
Not sure	92	1.1%
Highest Caregiver Education		
High School or less	1054	12.6%
Some College	1274	15.2%
College Graduate or more	5153	61.5%
Don’t know/NA/Missing	896	1.7%
Total	8377	100%

Table 2 displays the summary data of the continuous variables used in the present study, family acceptance, family rejection, and depression. Family acceptance and family rejection scores ranged from 1-4. The mean family acceptance score was 1.72, and the mean family rejection score was 2.00. Depression scores ranged from 0-30, with a mean of 13.5.

Table 2: Youth Report of Family Acceptance, Family Rejection, and Depression Symptoms

Variables	*M*	*SD*	Range
Family Acceptance	1.72	.82	1-4
Family Rejection	2.00	.94	1-4
Depression Scale	13.50	7.56	0-30

Correlational Analysis

In order to answer the question of to what extent do race and immigration status, moderate the established relationship between family acceptance and depressive symptoms, and the relationship between family rejection and depressive symptoms, it was important to first investigate whether it was appropriate to approach family acceptance and family rejection as separate constructs. Correlational analysis was conducted with the three continuous variables used in the study (Table 3). All correlations were significant at the $p<.01$ level. There was a weak, negative correlation found between family acceptance and family rejection. Depression was also weakly, but positively correlated with family rejection. Finally, there was a weak, negative correlation between depression and family acceptance. Though the significance of the correlation between family acceptance and family rejection was strong, the strength of the correlation itself was weak according to the guide suggested by Evans (1996), which regards correlations with an absolute value between .20 and .39 as weak. Therefore, it was concluded that it was appropriate to continue analysis regarding family acceptance and family rejection as separate constructs.

Table 3: Correlation Analysis of Continuous Variables

	Family Acceptance	Family Rejection	Depression
Family Acceptance	1		
Family Rejection	-.396**	1	
Depression	-.147**	.335**	1

Note: ** denotes correlation significant at the .01 level

Analysis of Variance

Prior to testing adjusted multivariate models and moderation effects of race and immigration status bivariate analysis was conducted to look at group differences. One-way ANOVAs were conducted to determine whether race and immigrant status groups differed in their family acceptance, family rejection, and depression scores (Table 4)**.**

Statistically significant (*p>.01*) differences between racial groups were found for all three study variables. In terms of family acceptance, Black, Asian/Pacific Islander, and Hispanic/Latino youth reported lower family acceptance than White youth. Also, Black and Asian/Pacific Islander youth reported lower family acceptance than Biracial or Multiracial youth. All five non-White groups of youth reported higher family rejection scores than White youth. Black and Asian/Pacific Islander youth reported higher family rejection than the Biracial or Multiracial youth. Depression scores for the Hispanic/Latino, Biracial or Multiracial, and Other youth were higher than White youth. The mean scores of the non-immigrant and immigrant youth did not differ from one another for any of the three study variables.

Table 4: Bivariate Analysis of Study Variables

Variables	Family Acceptance (1-4)			Family Rejection (1-4)			Depression Scale (0-30)		
	M	*SD*	F, p-value	*M*	*SD*	F, p-,value	*M*	*SD*	F, p-value
Race			14.02, *p<.01*			31.48, *p<.01*			1.01, *p<.01*
White	1.75abc	.82		1.91fghij	.91		13.16mno	7.50	
Black	1.48ad	.71		2.29fk	1.02		13.57	7.31	
Asian/Pacific Islander	1.48be	.78		2.28gl	.96		13.24	7.78	
Hispanic/Latino	1.62c	.77		2.19h	.99		14.13m	7.81	
Biracial or Multiracial	1.73de	.83		2.09ikl	.96		14.58n	7.49	
Other	1.68	.82		2.22j	1.04		15.25o	7.69	
Immigrant Status									
Non-Immigrant	1.72	.81	3.00, *p>.05*	1.99p	.94	8.15, *p<.05*	13.53	7.55	1.12, *p>.05*
Immigrant	1.66	.83		2.11p	1.00		13.17	7.67	

Note: Subscripts denote statistical differences between subgroups at *p<.05*.

Regression

Several ANCOVA models with interaction terms were used to test whether the race and immigrant status independently moderated the associations among family acceptance, family rejection, and depression. Table 5 displays the results of the first three ANCOVA models testing adjusted main effects between family acceptance, family rejection, race, and immigrant status on depression. Both family acceptance and family rejection were significantly associated with depression. Family acceptance was negatively associated with depression (b=-.34, $p<.001$), and family rejection was positively associated with depression (b=2.13, $p<.001$). The independent effect of race on depression was also significant ($F(5, 8352)=5.18$, $p<.001$). However, the independent effect of immigrant status on depression was not significant ($F(1, 8352)=.51$, $p=.49$).

Table 6 displays the results of the four regression models that include the interaction terms. Only the interaction terms (the final step of Models 4-7) are represented in the table. Model 4 tested whether race moderated the associations between family acceptance and depression. The overall interaction between family acceptance and race was statistically significant ($F(5, 8345)=2.9$, $p<.05$). Simple slopes analysis revealed that Asian, Hispanic/Latino, and Other youth did not display a significant associate between family acceptance and depressive symptoms in contrast to the significant negative association in the overall sample ($p<.001$) (Fig. 1). However, White youth was the only racial group for whom family acceptance was statistically significantly associated with depression (b=-.52, $p<.001$).

In Model 5, the interaction between family acceptance and immigrant status was tested (Table 6). Immigrant status did not significantly moderate the relationship between family

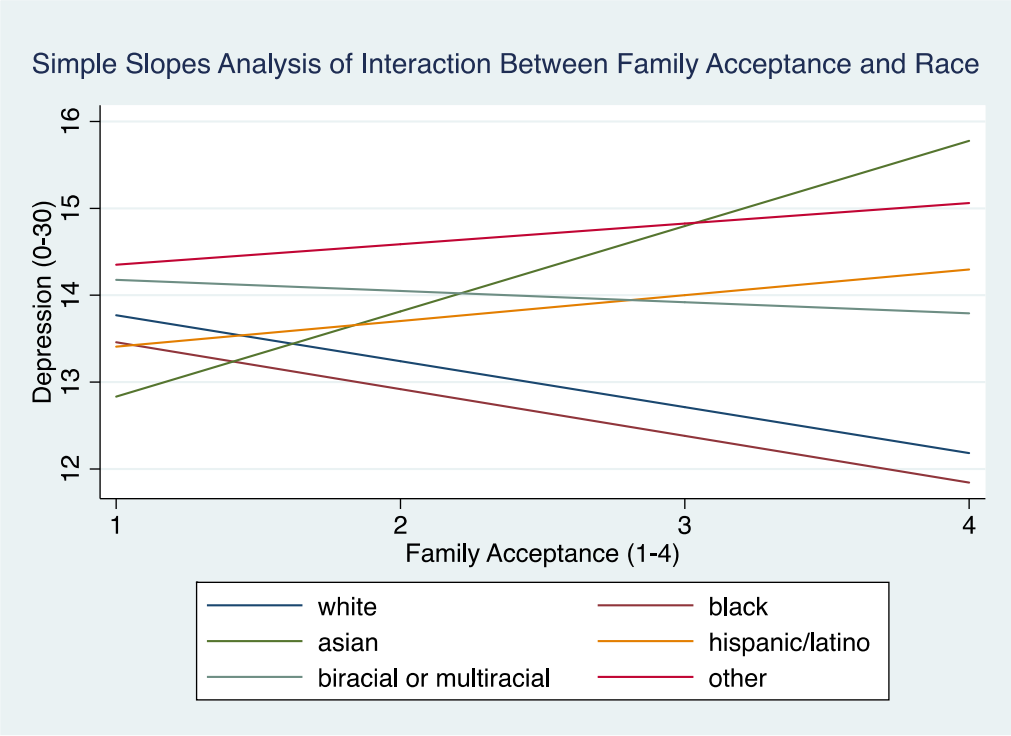

Figure 1

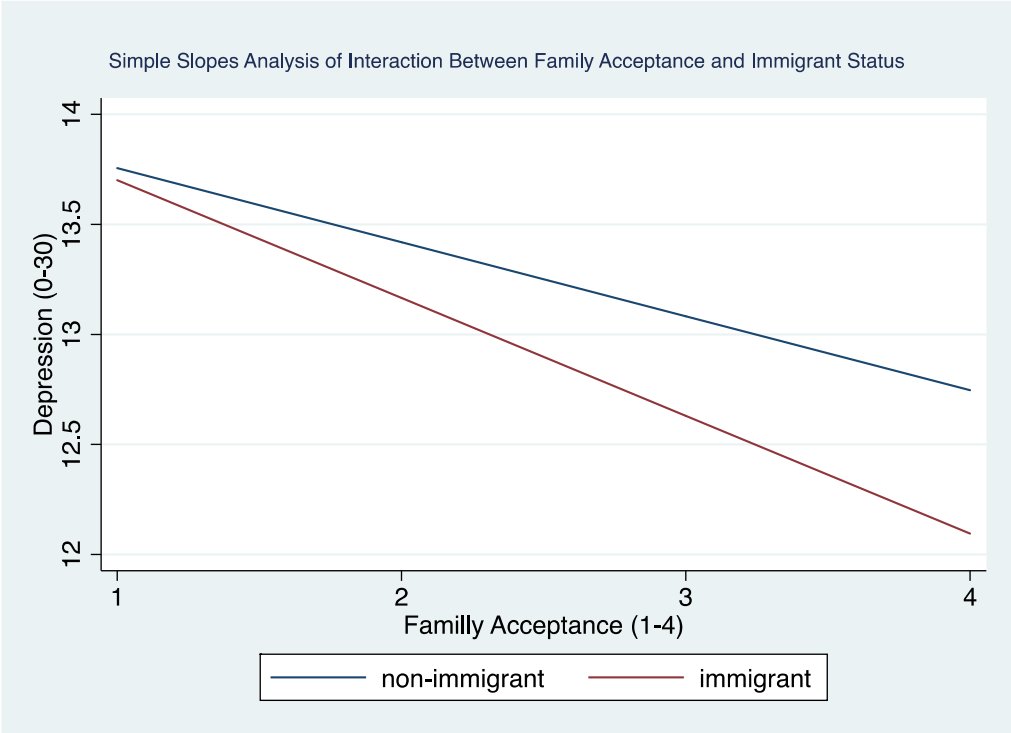

Figure 2

acceptance and depression ($F(1, 8349)=.30$, $p=.59$). Simple slopes analysis demonstrated that the negative association between family acceptance and depression was greater for immigrants than non-immigrants, though the slope between family acceptance and depression was only significant for non-immigrant youth (b=-.34, $p=.001$), and not for immigrant youth (b=-.54, $p=.131$) (Fig. 2).

Model 6 tested the interaction between family rejection and race. Race did not significantly moderate the interaction between the two variables ($F(5, 8345) = 1.25$, $p=.28$) (Table 6). Biracial/Multiracial youth were the only group to differ from White youth on the asssociation between family rejeciton and depression (b=-.45, $p<.05$). Simple slopes analysis indicated that the slope between family rejection and depression was significant for every race (all $p<.001$). Notably, however, visual inspection of slopes reveals that the slope were steepest for tOther and White youth (Fig. 3).

The final model, Model 7, tested the interaction between family rejection and immigrant status. Immigrant status did not significantly moderate the relationship between family rejection and immigrant status ($F(1, 8348) = .08$, $p=.77$). Family rejection was significantly associated with depression for both non-immigrants and immigrant youth (both $p<.001$). Despite the lack of statistically significant differences between groups, visual inspection of simples slopes analysis shows slight differences bettween the two groups at low levels of family rejection, such that immigrant report slightly lower depression scores than non-immigrants.

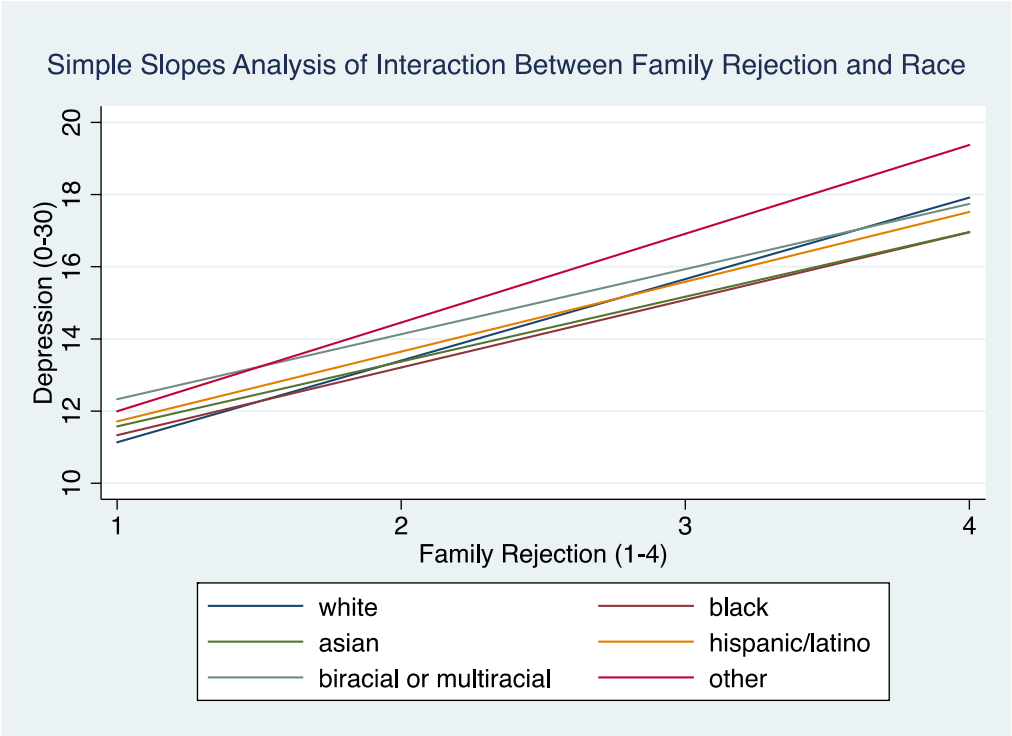

Figure 3

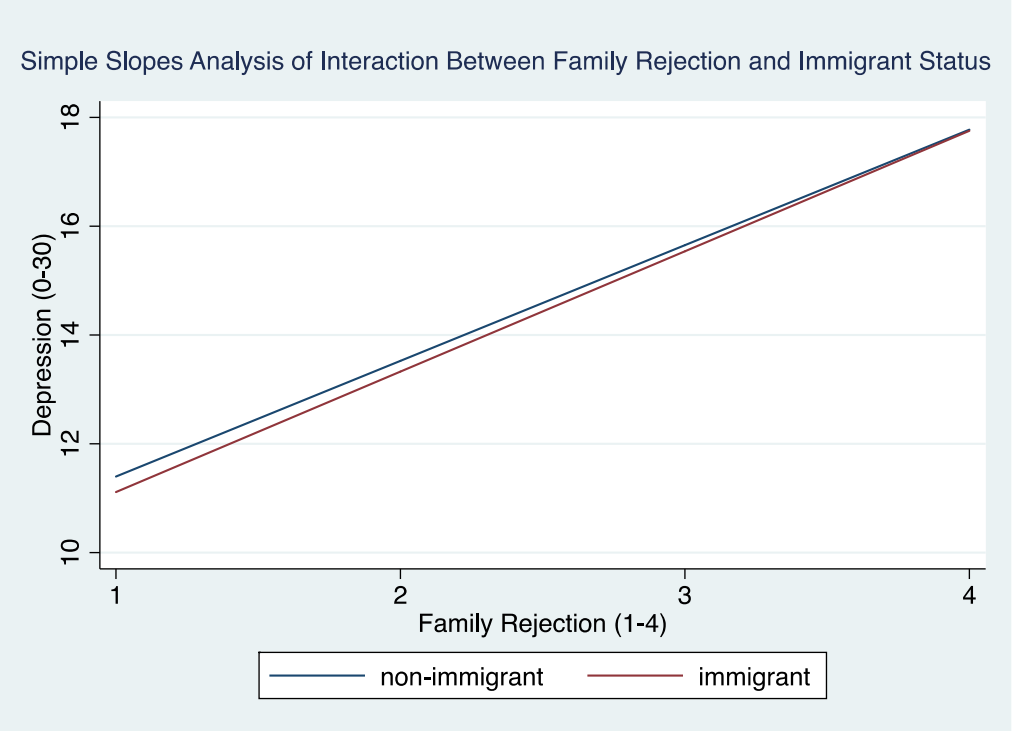

Figure 4

Table 5: Summary of Regression Analysis without Interaction Terms

	Model 1				Model 2				Model 3			
Variable	b	SE	β	p-value	b	SE	β	p-value	b	SE	β	p-value
Sexuality												
Gay/Lesbian												
Bisexual	.61	.20	.04	.002	.60	.19	.04	0.002	0.46	0.19	0.03	0.014
Pansexual	1.03	.26	.05	.000	.98	.26	.05	0.000	0.79	0.25	0.04	0.001
Other	.18	.25	.01	.478	.18	.25	.01	0.482	0.03	0.24	0.00	0.899
Age	-.18	.06	-.03	.004	-.18	.06	-.03	0.005	-0.24	0.06	-0.04	0.000
Gender Identity												
Cisgender Male												
Cisgender Female	2.49	.22	.16	.000	2.50	.22	.16	0.000	2.19	0.21	0.14	0.000
Trans-Male	6.57	.33	.26	.000	6.60	.33	.26	0.000	5.70	0.31	0.22	0.000
Trans-Female	3.28	.73	.05	.000	3.33	.73	.05	0.000	3.17	0.70	0.05	0.000
Transmasc/Non-binary	5.66	.26	.32	.000	5.66	.26	.32	0.000	4.96	0.25	0.28	0.000
Transfem/Non-binary	3.41	.52	.07	.000	3.38	.52	.07	0.000	3.14	0.50	0.07	0.000
Location												
Northeast												
Midwest	.56	.24	.03	.021	.56	.24	.03	0.020	0.27	0.23	0.02	0.242
South	.88	.22	.06	.000	.85	.22	.05	0.000	0.37	0.21	0.02	0.083
West	.57	.25	.03	.020	.51	.25	.03	0.038	0.33	0.24	0.02	0.164
Parent Nativity												
Neither born in US												
Some	-.56	.35	-.02	.109	-.62	.37	-.03	0.096	0.23	0.36	0.01	0.529
Both	-.75	.28	-.04	.007	-.53	.34	-.03	0.115	0.25	0.32	0.01	0.445

Not sure	.46	.79	.01	.563	.53	.80	.01	0.503	0.91	0.76	0.01	0.234
Caregiver Highest Education												
HS or less												
Some college	-.79	.30	-.04	.008	-.79	.30	-.04	0.008	-0.61	0.28	-0.03	0.031
College or more	-2.48	.24	-.16	.000	-2.38	.25	-.15	0.000	-1.79	0.24	-0.11	0.000
DK/NA/miss	-.75	.33	-.03	.022	-.74	.33	-.03	0.023	-0.43	0.31	-0.02	0.169
Race												
White												
Black					.53	.41	.01	0.196	-0.25	0.39	-0.01	0.519
Asian					.50	.49	.01	0.301	-0.08	0.47	0.00	0.872
Hispanic/Latino					.50	.31	.02	0.108	0.24	0.30	0.01	0.419
Biracial or Multiracial					1.02	.24	.05	0.000	0.72	0.23	0.03	0.002
Other					1.65	.56	.03	0.003	1.15	0.53	0.02	0.032
Immigrant Status												
Non-immigrant												
Immigrant					-.24	.34	-.01	0.476	-0.19	0.33	-0.01	0.564
Family Acceptance									-0.35	0.10	-0.04	0.000
Family Rejection									2.13	0.09	0.27	0.000
Constant	14.57	1.08		.000	14.09	1.11	.	0.000	11.18	1.10	.	0.000

Note: Race had a statistically significant, independent effect on family acceptance (F=4.89, p<.01), family rejection (F=14.79, p<.01), and depression (F= 5.18, p<.01). Immigrant status did not have a statistically significant, independent effect on family acceptance (F=2.58, p=.11), family rejection (F=.13, p=.72), and depression (F= .51, p=.49).

Table 6: Summary of Regression Analysis with Interaction Models

	Model 4: Family Acceptance x Race				Model 5: Family Rejection x Race				Model 6: Family Acceptance x Immigrant Status				Model 7: Family Rejection x Immigrant Status			
Variable	b	SE	β	p-value	b	SE	β	p-value	b	SE	β	p-value	b	SE	β	p-value
Interactions with Race																
White																
Black	-0.01	0.54	0.00	0.986	-0.38	0.38	-0.02	0.315								
Asian	1.51	0.55	0.06	0.006	-0.46	0.45	-0.03	0.300								
Hispanic/Latino	0.83	0.34	0.06	0.015	-0.33	0.27	-0.03	0.222								
Biracial or Multiracial	0.40	0.27	0.04	0.131	-0.46	0.23	-0.05	0.049								
Other	0.77	0.65	0.03	0.237	0.20	0.51	0.01	0.696								
Interactions with Immigrant Status																
Non-immigrant																
Immigrant									-0.20	0.36	-0.01	0.585	0.09	0.30	0.01	0.771

Three-Way Interaction

Although power precludes the ability to do a three-way interaction using family acceptance, race, and immigrant status or family rejection, race, and immigrant status, an exploratory post-hoc analysis was conducted in which the racial minority groups were collapsed into a singular non-White group in order to conduct three-way interaction tests. This approach is supported by earlier analysis that showed statistically equivalent associated between family acceptance and depression, as well as family rejection and depression, among all racial minority youth.

Results from the ANCOVA showed that the three-way interaction between family acceptance, race, and immigrant status was significant overall ($F(3, 8351) = 5.29$, $p<.001$). Simple slopes analysis illustrated that in this model, family acceptance was significantly associated with depression for the non-immigrant, White youth (b=-.54, $p<.001$) (Fig. 5). The slop for non-white, non-immigrant youth was not significant (b=-.22, $p=.222$).

The three-way interaction between family rejection, race, and immigrant status was also statistically significant ($F(3, 8351) = 2.79$, $p<.05$). Simple slopes analysis of the model revealed that family rejection was significantly associated with depression at the $p<.001$ level for every group (see Figure 6), but that the slopes were stronger for Whites than non-Whites, and the steepest slope was found for White immigrant youth.

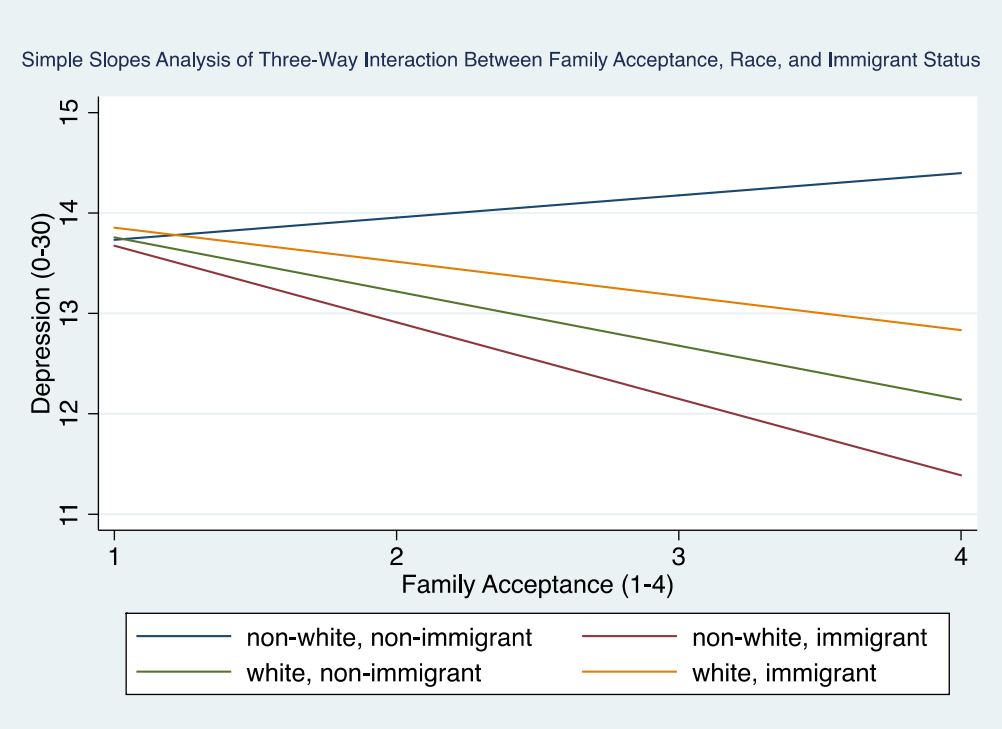

Figure 5

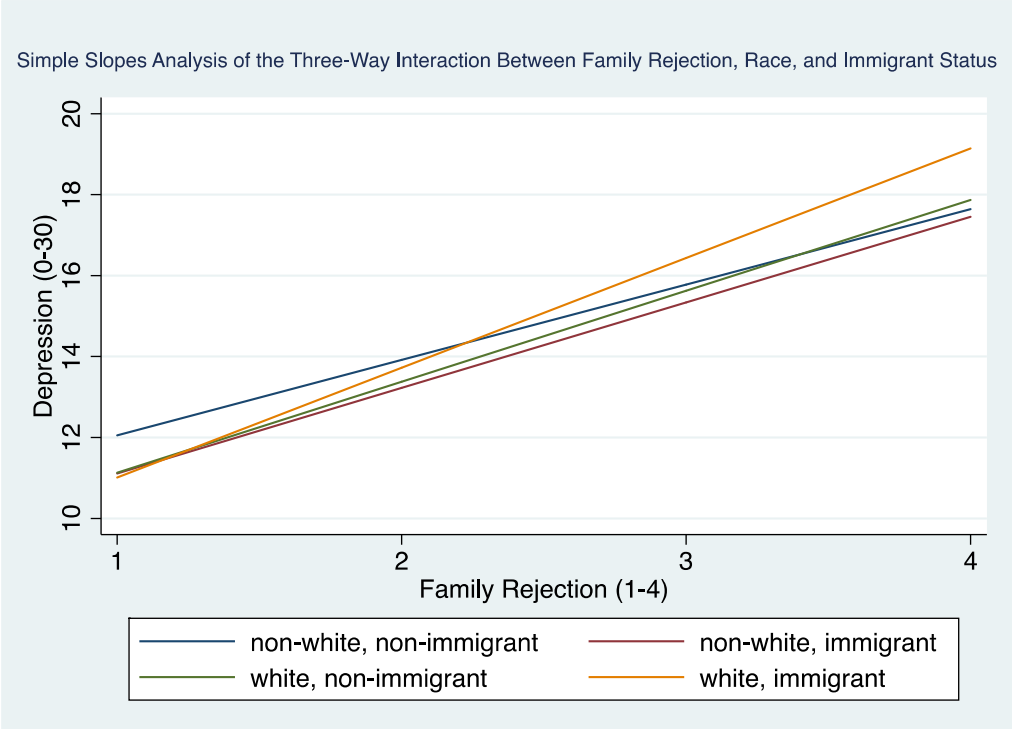

Figure 6

Discussion

The overall purpose of this study was to add to the growing body of research on LGBTQ+ youth mental health by exploring the extent to which race and immigration status moderate the relationship among family acceptance, family rejection, and depressive symptoms. More specifically, this study intended to 1) use an intersectional lens to add nuance to what is already known about the relationship between family acceptance/family rejection and depressive symptoms, 2) add to and clarify the ambiguous findings about racial differences in depressive symptoms within the LGBTQ+ community, and 3) increase the limited academic knowledge about the experiences of LGBTQ+ immigrant youth.

The research questions posed in the present study were 1) to what extent do race and immigration status, separately and combined, moderate the established relationship between family acceptance and depressive symptoms?, and 2) To what extent do race and immigration status, separately and combined, moderate the established relationship between family rejection and depressive symptoms?

Before discussing the impact of the moderator variables in the present study, it is important to note the main effects of family acceptance and family rejection on depression. The relationship between family acceptance and depression for LGBTQ+ youth reported in this study supports the findings of previous research which found that family acceptance was associated with lower levels of depression (Bockting et al., 2013; Ryan et al., 2010; Simons et al., 2013). In contrast, family rejection was revealed to be a significant predictor of depression such that higher family rejection scores were associated with higher depression scores. Importantly, this relationship was significant for all youth regardless of race and immigrant status. The positive

association between family rejection and depression is in line with findings from previous research on the impact of family rejection on the depressive symptoms of LGBTQ+ youth (Budge, Adelson, & Howard, 2014; Grossman & D'Augelli, 2007; Ryan et al., 2009; Yadegarfard, Meinhold-Bergmann, & Ho, 2014). Additionally, the present study's findings of racial differences in depressive symptoms for LGBTQ+ youth support some of the previous research, which has suggested the LGBTQ+ youth of color experience more negative mental health symptoms that White LGTBQ+ youth (Glazier, 2009; LeVasseur et al., 2013; Seal et al., 2000).

Turning now to the consideration of the moderating effects of race and immigrant status, separately and combined, race significantly moderated the relationship between family acceptance and depression, although immigrant status did not, and neither variable significantly moderated the relationship between family rejection and depression.

Looking further into the moderating effect of race on the relationship between family acceptance and depression reveals notable differences between groups. Although the interaction between family acceptance and race was significant overall, the relationship between family acceptance and depression was only statistically significant for White youth, with higher levels of family acceptance being associated with lower levels of depression. However, both Asian/Pacific Islander and Hispanic/Latino youth differed from White youth, such that for both groups, there was no significant association between family acceptance and depressive symptoms. The present study is not the only study where results suggest that the impact of family acceptance on the mental health of LGBTQ+ youth may be different for White youth and non-White youth. For example, a study conducted by Poteat, Mereish, DiGiovanni, and Koenig (2011) found that parental acceptance moderated the relationship between victimization and

suicidality for White LGBTQ+ youth, but not for LGBTQ+ youth of color. It may be that there are cultural differences between White and non-White LGBTQ+ youth that effect the significance or importance of family acceptance on a young person's life. It is possible that LGBTQ+ youth of color may be raised to be more autonomous, which makes their experience of depression less subject to change based on protective factors like family acceptance.

Cultural differences in the impact of parenting on young people is observed in research regarding parenting styles in different racial groups. Although White youth may experience negative behavioral and health outcomes related to an authoritarian parenting style, it has been observed in the literature that youth of color do not experience those same negative outcomes (Baldwin, 1990; Baumrind, 1972, 1996; Chao, 2001; Lassiter, 1987; Peters, 1988a, 1988b; Wilson, 1974). It may be that cultural expectations for parental behavior differ between races in a way that leads family acceptance to be more impactful on the mental health of White LGBTQ+ youth than LGBTQ+ youth of color. Having said that, the patterns of Asian/Pacific Islander and Hispanic/Latino youth showing no association between family acceptance and depression is certainly merits additional examination. Notably, the measure of family acceptance used in the present study specifically measures parental acceptance of their child's LGBTQ+ identity, not their acceptance of other aspects of their child. It may be that other types of family acceptance or rejection behaviors that center around something other than a child's membership to the LGBTQ+ community impact the child's mental health in ways that were not captured by the current study. Regardless of the reason for these racial differences, this moderation indicates that it is important not to regard all LGBTQ+ individuals as the same, which has been done in previous literature (Russell & Fish, 2016). There is variability in the experiences of LGBTQ+

youth that is associated with the other identities they hold, which means that these differences must be acknowledged and accounted for in research.

In contrast to the findings on the moderating effects of race on family acceptance and depression, there was no moderating effect of race in regard to family rejection and depression. This begs the question, why would race matter for family acceptance but not family rejection? Looking at the slopes, what becomes very apparent is that there were no racial differences because rejection was strongly negatively associated with depression across the board. Although it is possible that lack of power due to small group sample size may have contributed to non-significant findings between acceptance and depression for some groups, that interpretation is called into question by the starkly different findings for family rejection. Family rejection was a significant predictor of depression for all youth in the study, regardless of race or immigrant status. This suggests that although both family acceptance and family rejection are important, family rejection, overall, has a stronger, and more consistent, impact on LGBTQ+ youth depressive symptoms.

It is noteworthy that immigrant status did not moderate the relationship between family acceptance and depression, or family rejection and depression. Similar to the results of the interaction between race and family acceptance, the association between family acceptance and depression was only significant for the majority group, non-immigrants in this case. Also similar to the findings for race, it is possible that immigrant status didn't moderate the relationship between family rejection and depression because family rejection was strongly associated with depression for both groups. It was speculated that immigrant status may be an important variable because, as a minority group, LGBTQ+ immigrants face unique stressors which impact their mental health (Morales et al., 2013; Phillip & Williams, 2013). It is hard to say why immigrant

status was not found to be a significant moderator because there is very little research on this population. One possibility could be that immigrant group of youth was too small to compare to non-immigrant youth. It is possible that LGBTQ+ immigrant youth are imbedded in social networks or communities that were not tapped into by the recruitment strategies employed in the present study.

Another factor influencing these findings could be the fact that immigrant youth included people who responded that they had either lived in the US for more than four years or less than four years. The measurement did not rally capture length of time in the US, which has importantly, been found to be related to what is referred to as the "immigrant paradox." The immigrant paradox is a phenomenon demonstrated in research whereby as immigrants acculturate to the United States, over time and generations, their health outcomes become less desirable (Marks, Ejesi, & Coll, 2014). This pattern has been observed in research even when stressors that might accompany being an immigrant are accounted for (e.g. socioeconomic status and parental education) (Marks et al., 2014). In the context of this study, the paradox would suggest that immigrant youth who have been in the US for a shorter amount of time might report lower depression scores than immigrant youth who have been in the US for longer. However, a review of the literature on the immigrant paradox by Marks, Ejesi, and Coll (2014) revealed that support for the immigrant paradox varies in strength of evidence across age ranges, developmental domains, ethnic groups, and methodology. Some of the strongest evidence for the paradox comes from research on adolescent immigrant youth, which would suggest that the immigrant paradox might apply to the immigrant youth captured in the present study (Marks et al., 2014). If notable differences exist between LGBTQ+ immigrant youth who have been here for a longer amount of time and those who have been here for a shorter amount of time, they

could not be captured by the way the variable was coded in the present study. Although looking at the independent moderating effect of immigrant status might suggest it is not an important variable, the findings of the combined effect of race and immigrant status suggest that it deserves more attention.

The three-way interaction testing the moderating effects of race and immigrant status on the relationship between family acceptance and depression was significant. Analysis of the slopes revealed that family acceptance and depression were negatively associated for all groups except non-immigrant non-White LGBTQ+ youth. The meaning of this finding is not clear. What is apparent in the current sample is that non-White LGBTQ+ youth that were born in the United States are having an experience with family acceptance that is different from the experiences of other LGBTQ+ youth.

Results of the second three-way interaction in the present study showed that the combined effect of race and immigrant status significantly moderated the relationship between family rejection and depression. Family rejection was negatively associated with depressive symptoms for all youth in the study, and analysis of the slopes suggests that White immigrants were the most negatively impacted by family rejection, while non-White non-immigrants were the least affected. Although it is difficult to speculate about the cause of this finding, it is particularly notable given that, alone, neither race nor immigrant status significantly moderated the relationship between family rejection and depression. This suggests that although the relationship between family rejection and depression is significant for all LGBTQ+ youth, intersections of identity can significantly impact the degree of that relationship.

Looking at the findings of the present study as a whole, they are particularly interesting in light of theories that have previously been used to attempt to explain the impact of being a

multiple minority individual on depressive symptoms. Minority stress theory was initially utilized to explain disparities between LGBTQ+ individuals and their cisgender and heterosexual counterparts. The original minority stress theory suggests that LGBTQ+ individuals are at a higher risk for depressive symptoms than non-LGBTQ+ individuals due to distinct, chronic stressors that are directly related to their identity as LGBTQ+ (Meyer, 2003). When researchers have applied minority stress theory to the experiences of multiple minority individuals, the theory has been used to suggest that belonging to multiple minority groups such as both a sexual minority and a racial minority would result in greater exposure to stressors, which would have an even more significant impact on depressive symptoms than the impact experienced by single minority LGBTQ+ individuals. This is sometimes referred to as the additive stress model (Kertzner, et al., 2009). Minority stress theory receives some support from the results of the present study because mean differences in depression between racial groups showed that White youth reported lower rates of depression than youth of color. However, the fact that immigrant youth did not report significantly different levels of depression than non-immigrants contrasts the additive stress model. Critics of minority stress theory have suggested that multiple minority individuals may develop mechanisms of coping with minority stress in one area of their lives that can be transferred to stress due to other minority statuses; creating some resilience to the negative impact of multiple minority stressors on their mental health (Consolacion et al., 2004; Craig et al., 2017; Kertzner et al., 2009; Toomey et al., 2017). It could be suggested that the results of the current study lend some support to the resiliency theory because racial minorities seemed to be less dependent on family acceptance for their mental health. However, this is not very strong support for the theory because nothing else in the results would lead us to support the resiliency argument. Theories have historically regarded all minority statuses as the same, a

framework which this study does not support because race was a significant moderator and immigrant status was not. This suggests that it is important to investigate the specifics of the intersecting identities of the individuals being researched in order to best understand how those identities (alone and combined) impact different outcomes, such as depressive symptoms.

The results of the present study support intersectionality theory's critique of the additive model of minority stress theory. The results suggest that belonging to multiple minority groups, in itself, does not mean that an individual will report more depressive symptoms. Race and immigrant status did not interact with the relationship between family acceptance and depressive symptoms in the same way, which suggests that the intersection of LGBTQ+ identities with racial identities and immigrant status produces unique experiences on the microlevel. This supports the validity of intersectionality theory's request for researchers to look at the experiences of multiple minority individuals in novel and complex ways that acknowledge that social identities do not exist independently from one another, prioritizes people from historically marginalized communities, and considers how multiple social identities at the micro level interact with larger societal structures (Bowleg, 2012). Additionally, minority stress theory is oriented more toward explaining the experience of multiple minority individuals in terms of the impact of risk factors on depressive symptoms. It does not adequately addresses how protective factors might reveal differences between multiple minority and single minority groups. In the present study, the relationship between family acceptance and depression (a protective factor) was significantly moderated by race, but not the relationship between family rejection and depression (a risk factor). This indicates that a full understanding of how the experience of belonging to multiple minority groups effects mental health must include an understanding not just of how these minorities are effected by the disadvantages they face, but also by the

mechanisms that can protect them from the negative impact of the outcomes for which they are at risk. It could be suggested that, as intersectionality theory is unconventional in that it does not have core aspects which can be operationalized and tested, it provides space for future research which does not solely focus on risk factors associated with belonging to multiple minority groups.

Limitations

A few limitations about sampling were identified by the original researchers using the survey (Watson, Wheldon, & Puhl, in press). The respondents for the present study were recruited through social media, which may mean that the survey only captures LGBTQ+ youth who had internet access, stable housing, and time to take the survey. This means that web-based surveys such as the one used in the present study do not reach certain members of the LGBTQ+ community such as homeless youth, meaning their voices may not be fully represented in the data. Also, the use of social media as a recruitment tool can yield disproportionately White and/or cisgender sample because mainstream LGBTQ+ organizations and culture may not provide adequate representation for people of color and/or trans and non-binary individuals.

Limitations of the present study included the small sizes of the immigrant youth group and some of the non-White racial groups. Although one of the goals of this study was to improve understanding of the experience of immigrant LGBTQ+ youth, the small number of study respondents in this group was a significant power constraint which hindered the ability to make many reliable assertions about the experiences of young LGBTQ+ immigrants. It is also notable that although Black individuals make up approximately 13.4% of the US population, they only represented 3.9% of the study sample (US Census Bureau, 2019). Therefore, the present study is

limited in its ability to generalize its results about Black youth because they may not have been adequately represented in the sample.

Another limitation of this study was that trans and non-binary youth were grouped in with cisgender sexual minority youth. Although all these youth are part of the LGBTQ+ community, we cannot be sure how the experience of trans and non-binary youth differs from that of cisgender sexual minority youth. In future research, it may be important to investigate the differences between the experience of trans and non-binary youth and their cisgender sexual minority counterparts. This is particularly significant because, as demonstrated by the breakdown of gender identities in the sample, trans and non-binary youth are a minority within the LGBTQ+ community. The present study aimed to investigate the experiences of multiple minority individuals, but did not explore all of the identities that could qualify a respondent as a multiple minority individual.

The depression measure used in this study also includes a limitation. Due to IRB requirements, a question was removed from the measure which regarded suicidal ideation. Since the suicide rate is higher than the general population for LGBTQ+ youth, suicidal ideation is an important aspect of depression and mental health in general, the impact of which this study was unable to capture.

Clinical Implications

The results of the current study have important implications for clinicians working with LGBTQ+ youth and their families. One of the major takeaways from the results is that although family acceptance and family rejection both have a significant impact on the depressive symptoms of LGBTQ+ youth, the impact of family rejection is far greater for all LGBTQ+ youth. Clinically, this would mean that it may be appropriate for individuals working with

families of LGBTQ+ youth to focus more on reducing a child's experience of family rejection than increasing their experience of family acceptance. It may be important for clinicians to educate family members about what behaviors might be interpreted as rejecting by the young LGBTQ+ family member, and how that rejection might impact the child's mental health. Although it is important for clinicians not to make assumptions about family dynamics based on race or immigrant status, it is important for clinicians to keep in mind that the process and impact of family acceptance or family rejection may be different depending on to which minority groups those clients do or do not belong. Additionally, clinicians should endeavor to understand and encourage the development of resiliency to risk factors for LGBTQ+ youth of color. This may involve a strengths-based therapeutic approach which intends to focus not on the challenges or risks a client faces, but on the use of tools they have to manage the impact of those challenges and risks on their mental health.

Implications for Future Research

The results of the present study highlight several areas for further study. The results of the current study draw attention to several subpopulations which could be targeted for further research. One of the purposes of this study was to increase the limited academic knowledge about the experiences of young LGBTQ+ immigrants. Unfortunately, power constraints due to sample size limited the ability of the present study to form conclusions about the experiences of LGBTQ+ immigrant youth. LGBTQ+ immigrants, both young and old, are a population that has not been given adequate attention in the research literature on LGBTQ+ individuals, and therefore, as a subpopulation, they are excellent candidates for future research.

Another subpopulation that represents a direction for future research are LGBTQ+ youth who identify both as trans or non-binary and as sexual minority. Research about the experiences

of these individuals could be an avenue for further study in the realm of multiple minority status. Although trans and non-binary youth are still a relative minority in the LGBTQ+ community, the number of youth identifying as something other than cisgender is significant, as evidenced by the fact that the second largest gender group in the present study was transmasc/non-binary (24.6% of the sample). The notable size of this identity group, and the fact that youth who identity as both trans or non—binary and as a sexual minority are multiple minority individuals, provides many potential avenues for further research.

The Other racial group is also worthy of discussion as a direction for future research. Despite making up only 2.0% of the overall sample, Other youth demonstrated enough consistency within it to generate statistically significant differences from other youth in family rejection and depressive symptoms. The Other youth reported significantly higher family rejection scores and depression scores than White youth. Also, out of all racial/ethnic groups, Other youth were the group whose depressive symptoms were most greatly impacted by family rejection. It is difficult to theorize about the explanation for these findings because we are unaware of who the members of Other youth are or how they identify. The one exception to this is that we know the Native American racial category was collapsed into the Other category in order to preserve power, and the Native American youth makes up approximately 3% of youth who reported "Other" as their race/ethnicity. Future research could focus on learning more about the characteristics of LGBTQ+ youth who identify with a race other than those identified in this study and whether unique patterns emerge among those groups.

Moving on to avenues for future research that are related to the main study variables, one of the major takeaways from this study is that its findings support the evaluation of family acceptance and family rejection as two unique constructs. Much of the previous research on the

impact of family acceptance and family rejection on LGBTQ+ individuals has often conceptualized them as ttwo ends of a single continuum (Fuller, 2017; Perrin et al., 2004; Ryan et al., 2010). More recently, researchers have begun to advocate for frameworks that examine the two separately (Pollitt et al., 2019; Ryan et al., 2010). The argument made in favor of regarding them separately rests on the notion that a young LGBTQ+ person could be experiencing both accepting behaviors and rejecting behaviors from family members simultaneously, therefore their mental health would be influenced by both. For instance, LGBTQ+ youth who split time between two household could experience a very different family dynamic in each home. Family members might also be accepting of one aspect of a child's LGBTQ+ identity, but rejecting of another aspect (ex: accepting same sex partnership, but rejecting non-normative gender presentation). Though the two constructs are correlated, the results of the present study suggest that family rejection has a greater impact on the depressive symptoms of LGBTQ+ youth than family acceptance. Although both constructs are important, the influence of family rejection on LGBTQ+ youth mental health may behoove researchers to focus on deepening academic understanding of family rejection. A major avenue for further study might be to recreate previous research using measures which separate family acceptance from family rejection. Another direction for future study could also be to investigate how the two constructs interact with one another as risk and protective factors against negative outcomes for LGBTQ+ youth.

Conclusion

Due to the fact that LGBTQ+ youth are at increased risk for mental health difficulties, particularly depressive symptoms, compared to the general population, it is important for researchers to understand all the factors that contribute to this population's mental health and how they interact with one another. This means that the intersections of different identities must

be acknowledged because each identity that a person holds can impact how their mental health is affected by different risk and protective factors. Multiple minority individuals present a unique challenge in research because the more specific the intersection of identities, the less potential participants there are to recruit. However, it is important for researchers to continue to study multiple minority individuals because when all individuals in a minority group are treated as the same, the experiences of multiple minority individuals can be overshadowed by the majority and lost. In order to help LGBTQ+ youth manage their mental health and lead happy and successful lives, we must be able to integrate the uniqueness of an individual's identity and circumstance with our understanding of general patterns and trends for different groups of people.

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