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BEYOND THE NEGATIVE LENS: A STRENGTH-BASED APPROACH TO UNDERSTANDING SEXUAL MINORITY WOMEN'S HEALTH

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BEYOND THE NEGATIVE LENS: A STRENGTH-BASED APPROACH TO
UNDERSTANDING SEXUAL MINORITY WOMEN'S HEALTH

BY

ANGELA DAROSH

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF

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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2020

ABSTRACT

Introduction: It is well-documented that, compared to their heterosexual counterparts, sexual minority women (SMW) are at an increased risk for a variety of negative mental health outcomes, including depression, nonsuicidal self-injury (NSSI), suicidal ideation, and suicide attempts. According to the minority stress model, lesbian, gay, and bisexual individuals are at an increased risk for adverse health outcomes because they experience excess stress as a result of belonging to a stigmatized group. In particular, sexual minority stress may be mediated by LGB-specific stressors including discrimination and victimization as a result of one's sexual orientation, internalized homophobia, and concealment. The majority of studies examining mental health outcomes among SMW have utilized a negative lens, focusing on risk rather than protective factors in the population. Accordingly, the proposed study aimed to replicate and extend prior research on SMW by providing a comprehensive examination of how minority stressors impact NSSI and suicidality. Moreover, the current study investigated potential protective factors in the context of this model, including family processes (i.e., family support and number of family supports), peer processes (i.e., peer support and number of peer supports), and individual processes (i.e., resilience and adaptive coping). **Methods:** Participants were 271 self-identified, sexual minority women aged 18 and older, from the general population. The majority of participants identified as lesbian ($n = 143$), White (83.4%; $n = 226$), and had a mean age of 29 ($SD = 7.64$). Participants were recruited using various LGB electronic mailing lists and LGB-focused social media platforms. Study participants anonymously completed several measures related to minority stressors,

social supports, resiliency and coping style, and mental health symptoms. **Results:** Structural equation modeling (SEM) was used to examine if the proposed protective factors of family, peer, and individual processes mediated the relationship between minority stressors (i.e., internalized homophobia, discrimination, victimization, and concealment) and suicidality/NSSI. Preliminary results did not find NSSI to be significantly related to the latent mediational factors (i.e., family, peer, and individual processes), and therefore subsequent structural equation models for NSSI were not conducted. Structural equation model results for suicidality revealed individual processes significantly mediated the relationship between internalized homophobia and suicidality. **Conclusions:** Overall findings of the present study highlight the unique role of risk and protective factors related to suicidality in SMW. The current study underscores the critical need for continued research focused on identifying the underlying mechanisms contributing to higher rates of suicidality among SMW, specifically the unique contributions of risk factors such as internalized homophobia, as well as the role of individual processes as a protective factor against suicidality. Future research should be conducted with the goal of designing more culturally sensitive suicide risk assessments and tailoring individual treatment to address risk and protective factors specific to SMW and suicidality.

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Chapter 1.

INTRODUCTION

Statement of the Problem

It is well-documented that, compared to their heterosexual counterparts, sexual minority women (SMW; e.g., lesbian and bisexual women) are at an increased risk for a variety of negative mental health outcomes, including depression, nonsuicidal self-injury (NSSI; i.e., the intentional harming of one's own body tissue in the absence of suicidal intent), suicidal ideation, and suicide attempts (Bradford, Ryan, & Rothblum, 1994; Gruskin et al., 2001; House, Van Horn, Coppeans, & Stepleman, 2011; King et al., 2008). SMW are approximately 2 to 3 times more likely than heterosexual women to attempt suicide, even after critical suicide risk factors are taken into account (i.e., hopelessness, depression, alcohol abuse, recent suicide attempt by close family member or friend; Haas et al., 2011; King et al., 2008; Russell & Joyner, 2001). Converging evidence also suggests that SMW experience higher rates of suicidal ideation and NSSI (robust predictors of attempted suicide; Andover, Morris, Wren, & Bruzzese, 2012; Klonsky, May, & Glenn, 2013; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Whitlock et al., 2012) compared to women who self-identify as exclusively heterosexual (King et al., 2008). Moreover, the relationship between female sexual orientation, NSSI, and suicidality has been replicated in diverse samples, with a similar pattern of results across SMW varied in age, gender expression, and race/ethnicity.

Review of the Literature

Minority Stress and Mechanisms of Risk

While we know that there is a relationship between sexual orientation, NSSI, and suicidality, the nature of that relationship remains unclear. The question becomes then- what are the mechanisms that increase the likelihood these behaviors among SMW? One theory that has been proposed as a means to understand the negative health outcomes of sexual minority populations is the minority stress model (Meyer, 2003). According to the minority stress model, lesbian, gay, and bisexual (LGB) individuals are at an increased risk for adverse health outcomes because they experience excess stress as a result of belonging to a stigmatized group. In particular, Meyer (2003) suggested that sexual minority stress may be mediated by LGB-specific stressors including discrimination and victimization as a result of one's sexual orientation, internalized homophobia (i.e., an intrapsychic process characterized by the internalization of heterosexist social attitudes; Frost & Meyer, 2009), and concealment (i.e., the process of hiding one's sexuality from others). Numerous studies have established that minority stress is a pervasive part of the lives of SMW, and that such stress has harmful mental health implications (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Batejan, Jarvi, & Swenson, 2014; Lehavot & Simoni, 2011). For example, research suggests that higher levels of internalized homophobia in SMW are associated with increased depression and substance use (Lehavot & Simoni, 2011; Williamson, 2000). Similarly, discrimination and victimization experiences have been shown to be predictive of depression, substance use, NSSI, and suicidal ideation among SMW (Kelleher, 2009; Lehavot & Simoni, 2011). In 2009, Hatzenbuehler

extended minority stress theory by outlining the specific processes by which stigma-related stress may adversely affect mental health. His framework suggests that sexual minority stress facilitates elevations in emotion dysregulation, social/interpersonal problems, and cognitive processes (e.g., low self-esteem, low self-worth, hopelessness), which in turn confer risk for psychopathology. Indeed, multiple studies have found that SMW experience higher rates of these general psychosocial processes than heterosexual women (Bradford, Ryan, & Rothblum, 1994; Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; Mays & Cochran, 2001; Meyer, 2003).

The theoretical advancements of Meyer (2003) and Hatzenbuehler (2009) have guided research for the past decade and provided invaluable insights into mental health disparities in LGB populations. However, they have also contributed to the overwhelming tendency for research to frame the experiences of LGB individuals in terms of vulnerability and victimhood (Bryan & Mayock, 2016). The majority of studies examining mental health outcomes among SMW have utilized this negative lens, focusing on risk rather than protective factors in the population. Increased attention to protective factors (i.e., the characteristics, conditions, and behaviors that improve positive health outcomes or reduce the effects of stressful life events/other risk factors; Saewyc et al., 2009) is essential in order to advance our understanding of SMW's mental health.

Protective Factors

As previously stated, current research on protective factors that reduce or eliminate negative health outcomes among sexual minorities is limited at best. One of the most commonly measured protective factors in the literature is parental acceptance

of one's sexual minority status. Several studies have found that higher levels of parental acceptance of an individual's sexual orientation are associated with lower levels of depression, substance use, suicidal ideation, and suicide attempts across sexual minority adolescents and young adults (Padilla, Crisp, & Rew, 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Parental acceptance has also been shown to moderate the relationship between certain minority stressors and depressive symptoms. In a sample of SMW, higher levels of internalized homophobia were associated with greater depressive symptoms for women who endorsed low levels of parental acceptance (Feinstein, Wadsworth, Davila, & Goldfried, 2014). The broader construct of family support has also been shown to function as a protective factor in some cases. Dickenson and Huebner (2015) found that greater family support moderated the relationship between frequency of same-sex sexual contact and depressive symptoms among adolescent girls. Another study of LGB adolescents found that family support was independently associated with decreased odds of NSSI and suicidality (Reisner, Biello, Perry, Gamarel, & Mimiaga, 2014). Other studies, however, have not found a statistically significant effect of this general family support construct (Feinstein et al., 2014). Though considerably less studied, family connectedness (i.e., the ability to communicate, support, and enhance relationships among family members) has also been found to be protective against suicidal ideation; Eisenberg and Resnick (2006) found that LGB individuals who endorsed higher rates of family connectedness had half the odds of suicidal ideation than individuals with lower rates of family connectedness (Eisenberg & Resnick, 2006).

In addition to familial variables, researchers have investigated the potential buffering effect of other types of social support (i.e., friend/peer support) on negative health outcomes among sexual minorities. In a sample of SMW, social support, LGB social support (i.e., social support from individuals who identify as LGB), and satisfaction with social support were all negatively associated with internalized homophobia (Szymanski, Chung, & Balsam, 2001). Social support as well as the size of an individual's social network have also been linked to decreased odds of depression among SMW (Fredriksen-Goldsen et al., 2013; Tabaaac, Perrin, & Trujillo, 2015). Conversely, Woodford, Kulick, and Atteberry (2015) did not find a relationship between social support and depression among sexual minority college students. However, their findings did indicate that social support moderated the relationship between heterosexist harassment and risk for alcohol abuse. Overall, research examining the potential protective impact of family and peer processes is fairly limited. Not only are there few studies in this research domain, but research findings are often contradictory. This is partially due to the fact that studies have assessed family and peer variables in different ways, as well as the fact that these variables are typically studied in isolation from one another. The latter limitation will be addressed by the current study, through a collective assessment of multiple family and peer process variables.

While studies on distal protective factors such as family and peer processes are sparse, even less research has focused on the impact of individual processes (e.g., resilience & coping styles) on mental health outcomes among sexual minorities. Existing research on resilience among SMW is typically theoretical in nature; studies

have rarely investigated resilience as a measurable, standalone construct in the population. As such, several recent studies have called for the advancement of knowledge about LGB resilience (Hill & Gunderson, 2015; Kwon, 2013). In terms of coping styles, adaptive coping has been identified as a partial mediator between internalized homophobia and psychological distress among SMW (Szymanski & Owens, 2008). Maladaptive coping strategies (e.g., self-blame and venting) have also been linked to suicidal ideation and suicide attempts in a sample of SMW (Tabaac, Perrin, & Trujillo, 2015). The current study will extend prior research on SMW by examining resilience and adaptive coping style in addition to distal protective factors (i.e., family and peer processes).

Present Study

To date, the majority of research examining these mental health outcomes among SMW has utilized a negative lens; that is, researchers have predominantly focused on risk rather than protective factors. The primary goal of the proposed study is to explore the potential benefits and breadth of knowledge yet to be gained by shifting to a more strength-based approach in this research domain. Specifically, the proposed study aimed to replicate and extend prior research on SMW by providing a comprehensive examination of how minority stressors (i.e., internalized homophobia, discrimination, victimization, and concealment) impact NSSI and suicidality. Moreover, the current study investigated potential protective factors in the context of this model, including family (e.g., familial support), peer (e.g., peer support), and individual (e.g., resilience) processes. Based on the previously described literature and

research questions of interest, this study was designed to evaluate the following hypotheses (see Figures 1-3 for proposed hypothesized models):

Hypothesis 1. It was predicted that family processes (i.e., family support, number of family supports) would mediate associations between minority stressors and mental health outcomes.

Hypothesis 2. It was predicted that peer processes (i.e., peer support, number of peer supports) would mediate associations between minority stressors and mental health outcomes.

Hypothesis 3. It was predicted that individual processes (i.e., resilience, adaptive coping style) would mediate associations between minority stressors and mental health outcomes.

Figure 1

Proposed Direct Effects Model

Figure 2

Proposed Mediation Model

Figure 3

Proposed Full Model

CHAPTER 2.

METHODOLOGY

Participants

Participants were sexual minority women ($N = 271$), aged 18 and older, from the general population. Women were categorized as sexual minority women on the basis of self-identification (i.e., individuals who report their sexual orientation as anything other than *heterosexual/straight*).

In total, the current study's survey was accessed 404 times. One response was removed because the individual declined to consent to participate in the study, and 110 responses were removed because the individuals did not complete any survey items beyond the consent form or eligibility questions. Given the focus of the current study, participants were removed from the final sample if they identified their biologic sex at birth as male ($n = 7$), or if they identified their sexual orientation as “heterosexual/straight” ($n = 16$).

Measures

Demographics. A demographic questionnaire was used to assess participants' age, gender identity, race, ethnicity, relationship status, gender identity of current partner (if applicable), level of education, and income (see Appendix A).

Sexual orientation. Self-identification of sexual orientation was assessed by asking participants to indicate the category which best describes their sexual orientation: *lesbian*, *bisexual*, *heterosexual/straight*, *pansexual*, *queer*, *questioning*, or *not listed*. If participants selected the *other* option, they were asked to specify their

sexual orientation. Participants also described their sexual orientation in terms of identity, behavior, and attraction using visual analogue scales (see Appendix B).

Internalized homophobia. Internalized homophobia was measured using the Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2001; see Appendix C). The LIHS consists of 52 items which can be broken down into five subscales, with each subscale representing a different component of internalized homophobia: (a) connection with the lesbian community, (b) public identification as a lesbian, (c) personal feelings about being a lesbian, (d) moral and religious attitudes towards lesbians, and (e) attitudes toward other lesbians. Items on the LIHS are answered using a 7-point Likert scale (1 = *strongly agree* to 7 = *strongly disagree*), with lower scores indicating higher levels of internalized homophobia. The LIHS total score has been found to have high internal consistency ($\alpha = .94$), and LIHS subscales have been found to have adequate internal consistency (Szymanski & Chung, 2001). In the current study, internal consistency for the LIHS total score was high ($\alpha = .92$).

Harassment, rejection, and discrimination. The Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2006; see Appendix D) was used to assess past year prevalence of discrimination based on sexual orientation. The HHRDS has 14 items which are rated on a 6-point Likert scale (0 = *never* to 5 = *almost all of the time*). Subscales of the inventory include: (a) harassment and rejection, (b) workplace and school discrimination, and (c) other discrimination. Internal consistency of the overall scale has been reported to be high ($\alpha = .90$; Lehavot & Simoni, 2011), with subscales also demonstrating moderate to high internal

consistency. The HHRDS total score had good internal consistency in the current study ($\alpha = .86$).

Victimization. Lifetime frequency of victimization experiences was assessed through an adapted version of D'Augelli's (2006) victimization measure (see Appendix E). The original scale consisted of six items addressing physical, sexual, and verbal victimization experiences, with items scored on a 4-point Likert scale (0 = *never* to 3 = *3 or more times*). In a previous study of SMW, Lehavot and Simoni (2011) added an additional item to this scale: *being chased, followed, or stalked*. The internal consistency of this scale was acceptable ($\alpha = .78$). The current study added the item: *threatened with revealing your sexual orientation to others*. The internal consistency for the 8-item victimization scale included in the current study was good ($\alpha = .80$).

Concealment. The Outness Inventory (OI; Mohr & Fassinger, 2000) measured the extent to which participants are open about their sexual orientation to various individuals (see Appendix F). The OI is comprised of 11 items which assess participants' degree of outness to their: mother, father, siblings, extended family members, new and old heterosexual friends, work peers and supervisors, members and leaders of religious community, and strangers/new acquaintances. Items are scored on a 7-point Likert scale (1 = *definitely does not know about your sexual orientation status* to 7 = *definitely know(s) about your sexual orientation status, and it is openly talked about*. In accordance with Wilkerson, Noor, Galos, and Rosser (2015), the following response item was added to the original scale: *not applicable to your situation; there is no such person or group of people in your life*. In a sample of sexual

minority adults, the OI has yielded high internal consistency ($\alpha = .94$; Wilkerson et al., 2015). In the current study, internal consistency for the OI was acceptable ($\alpha = .78$).

Family Processes. Two indicators were used to assess family processes.

Number of family supports. Participants were asked to identify the number of family members from whom they receive emotional help and support. *Family support.* The Multidimensional Scale of Perceived Social Support- Family Subscale is a measure of family support (MSPSS- Family; Zimet, Dahlem, Zimet, & Farley, 1988; see Appendix G). The Family subscale is comprised of four items scored on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*), with higher scores indicating greater family support. In previous study of sexual minority adults, the MSPSS-Family had a Cronbach's alpha of .94 (Feinstein et al., 2014). The MSPSS-Family demonstrated high internal consistency in the current study ($\alpha = .92$).

Peer Processes. Two indicators were used to assess peer processes. *Number of peer supports.* Participants were asked to identify the number of peers from whom they receive emotional help and support. *Peer support.* The Multidimensional Scale of Perceived Social Support- Friend Subscale was used to assess peer support (MSPSS-Friend; Zimet et al., 1988; see Appendix H). Four items comprise the friend subscale, with items scored on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Higher total subscale scores indicate greater peer support. Good internal consistency has been found for the MSPSS- Friend ($\alpha = .85$; Zimet et al., 1988). In the current study, internal consistency for the MSPSS- Friend subscale was high ($\alpha = .93$).

Individual Processes. The individual processes latent variable included measures of resilience and coping style. *Resilience.* The Brief Resilience Scale (BRS;

Smith et al., 2008) assessed participants' capacity to navigate difficult life events (see Appendix I). The BRS includes a total of six items scored on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Higher scale scores indicate greater resiliency. Overall, the BRS has demonstrated high internal consistency across diverse samples ($\alpha = .88$ to $.91$; Szymanski & Feltman, 2014; Breslow et al., 2015).

Cronbach's alpha was $.92$ in the current study, indicating high internal consistency.

Coping styles. Participants' level of adaptive coping was assessed with the Brief COPE (Carver, 1997; see Appendix J). The measure is comprised of 28 items, with 16 items representing adaptive coping strategies, and 12 items representing maladaptive coping strategies. Items are rated on a 4-point Likert scale (0 = *I haven't been doing this at all* to 3 = *I've been doing this a lot*). In a sample of SMW, Cronbach's alphas for the adaptive coping composite was $.81$ (Lehavot, 2012). Internal consistency for adaptive coping in the current study was acceptable ($\alpha = .73$).

Suicidality. Four indicators were used to assess suicidality: perceived burdensomeness, thwarted belongingness, acquired capability for suicide, and suicidal behaviors. *Perceived burdensomeness and thwarted belongingness.* The Interpersonal Needs Questionnaire (INQ; Van Orden, Cukrowicz, Witte, & Joiner, 2012) was used to measure constructs outlined in the Interpersonal Model of Suicide (see Appendix J). The INQ is a 15-item measure: six items assess perceived burdensomeness and nine items assess thwarted belongingness. Items are scored on a 7-point Likert scale (0 = *not at all true for me* to 6 = *very true for me*). The INQ has been found to have good internal consistency in a sample of sexual minority adults ($\alpha = .70$ for perceived burdensomeness; $\alpha = .82$ for thwarted belongingness). In the current study, internal

consistency was high for both perceived burdensomeness ($\alpha = .93$) and thwarted belongingness ($\alpha = .92$). *Acquired capability*. The Acquired Capability for Suicide Scale- Fearlessness About Death (ACSS-FAD; Van Orden, Witte, Gordon, Bender, & Joiner, 2014) is a 7-item scale that measures both fearlessness (e.g., *Things that scare most people do not scare me*) and increased physiological pain tolerance (e.g., *The pain involved in dying frightens me*; see Appendix K). Items are rated on a 4-point Likert scale (0 = *not at all like me* to 3 = *very much like me*) with higher scores indicating a higher acquired capability. Internal consistency of the ACSS-FAD has been found to be adequate across samples ($\alpha = .77$ to $.83$). Cronbach's alpha was $.87$ in the current study, indicating good internal consistency. *Suicide Behaviors Questionnaire-Revised* (SBQ-R; Osman et al., 2001). The SBQ-R is a 4-item self-report measure assessing the frequency of lifetime suicide ideation, suicide attempts, threats of suicide, and self-reported suicide likelihood (see Appendix L). Items are summed to create a total score ranging from 3 to 18, with a cutoff score of ≥ 7 used to identify adults in the general population who are at significant risk for suicidal behavior (sensitivity= 93%; specificity= 95%). Internal consistency has been found to be acceptable ($\alpha = .88$) in a clinical sample, as well as ($\alpha = .87$) in a non-clinical sample (Osman, et al., 2001). In the current study, the SBQ-R demonstrated good internal consistency ($\alpha = .79$).

Depressed mood. The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) is a nine-item self-report measure assessing depression symptoms over the past two weeks (see Appendix M). Scores can range from 0 to 27, with higher scores indicating greater depression symptom severity. Participants rated each item using a 4-

point Likert-type scale (0 = *not at all* to 3 = *nearly every day*). The PHQ-9 has demonstrated excellent internal consistency across multiple samples ($\alpha = .86$ to $.89$; Kroenke et al., 2001). For the purposes of the current study, the PHQ-9 served as an indicator of convergent validity for suicidality and NSSI. Cronbach's alpha for the PHQ-9 was $.89$ in the current study, indicating high internal consistency.

Nonsuicidal self-injury. The Inventory of Statements About Self-injury (ISAS; Klonsky & Olino, 2008) assesses lifetime frequency of 12 NSSI behaviors: banging/hitting self, biting, burning, carving, cutting, wound picking, needle-sticking, pinching, hair pulling, rubbing skin against rough surfaces, severe scratching, and swallowing chemicals (see Appendix N). Participants were asked to estimate the number of times in their life that they intentionally performed each behavior. Consistent with past research, the current study dichotomized this variable (i.e., *history positive for NSSI* or *no history of NSSI*) given that total lifetime estimates of NSSI typically vary widely. Those endorsing any history of NSSI behaviors were asked to complete the second section of the ISAS, which assesses 13 potential functions of NSSI: affect-regulation, anti-dissociation, anti-suicide, autonomy, interpersonal boundaries, interpersonal influence, marking distress, peer-bonding, self-care, self-punishment, revenge, sensation seeking, and toughness. Participants rate each function as (0) *not relevant*, (1) *somewhat relevant*, or (3) *very relevant* to their experience of NSSI. The measure also assesses descriptive/contextual information, including age of onset, the experience of pain during NSSI, whether NSSI is performed alone or around others, time between the urge to self-injure and the act, and whether the individual wants to stop self-injuring (if current NSSI). The ISAS has

demonstrated good reliability and validity across samples of adolescents and adults (Klonsky and Olino, 2008).

Procedure

Since traditional sampling methods are a challenge when attempting to study hidden populations such as sexual minorities (Aaron et al., 2001), electronic mailing lists, websites, and social media platforms served as the primary means of data collection. Research has shown that internet findings are comparable to those gathered by more traditional methods (Gosling, Vazire, Srivastava, & John, 2004). A link to the online survey was sent via e-mail through various LGB electronic mailing lists and posted on various LGB focused websites/social media pages. The complete list of electronic mailing lists and websites were submitted to the University of Rhode Island Institutional Review Board for the Protection of Human Subjects (IRB) for approval prior to recruitment. The current study also made use of snowball sampling, as participants were encouraged to forward the link to the study to other individuals who identify as SMW. To help ensure anonymity, all participants chose to opt-in to the study by waiving signed consent. In addition, IP address harvesting was disabled. As incentive, participants were informed that a one-dollar donation would be made to a LGB youth charity for each completed survey immediately after the completion of data collection. Participants had the option to provide an email address to be entered into a raffle to win one of four twenty-five-dollar gift-cards (email addresses were saved in a separate encrypted and password-protected file); gift-cards were distributed as soon as data collection ended.

Data Analysis

Data were entered and preliminary analyses conducted using SPSS version 26 in order to examine assumptions (e.g., normality, linearity, homogeneity of regression, homoscedasticity, and multicollinearity/singularity) and missing data patterns as outlined by Tabachnick and Fidell (2007). Descriptive information and intercorrelations were obtained to examine associations among the primary study variables. Missing data were evaluated for missing completely at random (MCAR) using Little's test (Little, 1986). A nonsignificant Little's test indicates that the missingness of one variable does not depend on the values of other variables in the analysis. Structural equation modeling (SEM) was used to evaluate both the measurement model and the structural model. SEM is a causal modeling technique used for analyzing structural models which contain latent variables (Pearl, 2001). A preliminary measurement model was completed to evaluate the factor structure of the latent outcome variable (suicidality) and the three latent mediational variables (family processes, peer processes, and individual processes; see Appendix O for a list of measures by construct). Indicators that were not adequate to the measurement of their respective construct were deleted before proceeding to the structural modeling stage. Next, a series of structural models were evaluated to measure the extent of the relationship among latent constructs as well as other measured variables. Given the complexity of the proposed model, each latent mediational variable was examined individually for both of the outcome variables (NSSI and suicidality) before being added to principal models.

Study hypotheses were tested using R version 4.0.2 (R Core Team, 2020) and the package lavaan (Rosseel, 2012). Full information maximum likelihood (FIML) was used to address missing data. FIML has been shown to be a superior estimation technique across various design conditions, with less bias and more efficiency than other estimation methods (Enders, 2010). Three models were tested (full, mediation, direct effects; see Figures 1-3), as testing multiple models can increase confidence in model fit and improve power (Bullock, Harlow, & Mulaik, 1994). Each model was assessed independently and the adequacy of models were evaluated by examining several fit indices: the comparative fit index (CFI; Bentler, 1990), the root mean square error of approximation (RMSEA; Steiger, 1990), and the standardized root mean square residual (SRMR; Hu & Bentler, 1999). The CFI, an incremental fit index, assesses fit relative to a null model, by comparing the χ^2 value of the hypothesized model to an appropriately specified null model; a suggested guideline for determining goodness of fit is a CFI value $> .95$ (Hu & Bentler, 1999). The RMSEA assesses closeness of fit with preferred values $< .05$, and values between $.05$ -. $.08$ considered a moderate fit, and values between $.08$ - $.10$ considered mediocre fit (Hu & Bentler, 1999). The SRMR is the standardized difference between the observed correlation and the predicted correlation with a value $< .08$ generally considered good fit (Hu & Bentler, 1999). These parameters were used to evaluate the goodness of fit of the measurement and structural models. Models were then compared with a chi-square difference test and with the delta-CFI test to identify the best fitting model.

Chapter 3.

RESULTS

Basic Demographics

Participants in the final sample included 271 individuals who identified as sexual minority women. Of these participants, 143 identified as lesbian, 72 as bisexual, 12 as pansexual, 23 as queer, 16 as questioning, and 5 indicated their sexual orientation was not listed. Of participants who indicated their sexual orientation was not listed, the most commonly reported sexual orientation was “asexual.” In terms of gender identity, 251 participants identified as female, 10 as genderqueer, and 10 indicated that their gender identity was not listed, with “non-binary” the most commonly reported gender identity of those who selected the not listed option. All participants indicated their biologic sex at birth as female.

Participants ranged in age from 18 to 66 years ($M = 29.15$, $SD = 7.64$). In terms of race/ethnicity, participants were able to select multiple responses. The most commonly selected ethnoracial identity was White (83.4%; $n = 226$), followed by Asian (9.2%; $n = 25$), Hispanic or Latinx (5.5%; $n = 15$), Black or African American (3.3%; $n = 9$), American Indian or Alaskan Native (1.5%; $n = 4$), and Native Hawaiian or Pacific Islander (0.7%; $n = 2$). Eight participants (3.0%) indicated that their race/ethnicity was not listed and one participant (0.4%) selected the prefer not to answer option.

Socioeconomic Factors

Participants in the current study were highly educated, with 68% of participants having completed a Bachelor’s degree ($n = 102$) or graduate degree ($n =$

82). An additional 17% of participants reported that they completed at least some college ($n = 47$). Approximately 13% of participants received their high school diploma/GED ($n = 16$) or an Associate's degree/vocational education ($n = 20$). Only two participants (0.7%) indicated that they did not complete high school, and two participants (0.7%) selected the prefer not to answer option.

Total yearly household income ranged from less than \$10,000 (4.7%; $n = 13$) to \$100,000 or more (16.2%; $n = 44$). The majority of participants in the sample reported an income of greater than \$40,000 (53.1%; $n = 144$). Thirty-three participants (12.2%) selected the prefer not to answer option. Demographic characteristics of the sample are presented in Table 1. Bivariate correlations for primary study variables are presented in Table 2.

Table 1

Participant Demographics for Study Sample (N =271)

	<i>M (SD)</i>	<i>n (%)</i>
Age	29.15 (7.64)	
18 - 25		100 (36.9%)
26 - 30		73 (26.9%)
31 - 35		54 (19.9%)
36 - 40		16 (5.9%)
41+		28 (10.4%)
Gender Identity		
Female		251 (92.6%)
Genderqueer		10 (3.7%)
Not listed		10 (3.7%)
Sexual Orientation		
Lesbian		143 (52.8%)
Bisexual		72 (26.6%)
Pansexual		12 (4.4%)
Queer		23 (8.5%)
Questioning		16 (5.9%)
Not listed		5 (1.8%)
Racial/Ethnic Background		
White		226 (83.4%)
Black/African American		9 (3.3%)
Hispanic/Latinx		15 (5.5%)
American Indian/Alaskan Native		4 (1.5%)
Asian		25 (9.2%)
Native Hawaiian/Pacific Islander		2 (0.7%)
Not listed		8 (3.0%)
Prefer not to answer		1 (0.4%)
Highest Level of Education		
Some high school		2 (0.7%)
High school diploma/GED		16 (5.9%)
Trade or technical school		6 (2.2%)
Associate's Degree		14 (5.2%)
Some college		47 (17.3%)
Bachelor's Degree		102 (37.6%)
Graduate degree (MA, MD, PhD)		82 (30.3%)
Prefer not to answer		2 (0.7%)
Yearly Household Income		
Less than \$10,000		13 (4.8%)
\$10,000 to 29,999		50 (18.5%)
\$30,000 to \$49,000		55 (20.3%)
\$50,000 to \$69,000		31 (11.4%)
\$70,000 to \$89,000		36 (13.3%)

\$90,000 to 99,000	8 (3.0%)
\$100,00 or more	44 (16.2%)
Prefer not to answer	33 (12.2%)

Table 2

Bivariate Correlations Between Primary Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Internalized homophobia	--															
2. Discrimination	.002	--														
3. Victimization	.079	.553**	--													
4. Concealment	.587**	.107	.175**	--												
5. Family support	.188**	-.357**	-.283**	.165*	--											
6. Number of family supports	.158*	-.366**	-.293**	.151*	.878**	--										
7. Peer support	.238**	-.107	-.139*	.157*	.238**	.167**	--									
8. Number of peer supports	.170*	-.116	-.097	.151*	.205**	.155*	.825**	--								
9. Resilience	.248**	.025	.032	.217**	.127*	.105	.171**	.170**	--							
10. Adaptive coping	.191**	.140*	.131*	.207**	.061	.064	.316**	.275**	.299**	--						
11. Suicidal behaviors	-.179**	.104	.140*	-.027	-.047	-.021	-.160*	-.153*	-.381**	-.082	--					
12. Acquired capability	.027	-.036	.093	-.015	.000	.079	-.008	.036	.113	-.012	.088	--				
13. Perceived burdensomeness	-.326**	.095	.146*	-.183**	-.106	-.103	-.340**	-.299**	-.431**	-.325**	.579**	.057	--			
14. Thwarted belongingness	-.421**	.071	.136*	-.353**	-.245**	-.204**	-.600**	-.489**	-.436**	-.478**	.375**	.043	.625**	--		
15. Depressed mood	-.320**	.009	.099	-.254**	-.129	-.139*	-.289**	-.247**	-.507**	-.295**	.503**	.055	.671**	.604**	--	
16. Nonsuicidal self-injury	-.091	.160*	.139*	-.090	-.107	-.131	-.077	-.043	-.228**	-.068	.380**	-.005	.272**	.240**	.242**	--
M	287.13	22.15	11.23	30.25	17.07	2.57	22.69	3.71	18.11	41.56	8.11	22.78	13.22	32.02	19.91	0.69
SD	34.89	7.69	4.12	13.09	6.91	1.64	5.06	1.40	5.80	7.83	3.78	7.47	8.91	13.29	6.71	0.46

Note: Family processes is comprised of a measure of family support and number of family supports; Peer processes is comprised of a measure of peer support and number of peer supports; Individual processes is comprised of measures of resilience and adaptive coping; Suicidality is comprised of measures of suicidal behaviors, acquired capability for suicide, perceived burdensomeness, and thwarted belongingness; M = mean; SD = standard deviation; * $p < .05$, ** $p < .001$

Suicidality

Measurement Model

A measurement model evaluating the factor structure of the latent variables (family processes, peer processes, individual processes, and suicidality) was evaluated for model fit to determine appropriateness of the latent structure. The proposed measurement model showed mediocre fit to the data, $\chi^2 = 105.036$, $p < .001$; CFI = 0.929; RMSEA[90%CI] = 0.103[0.082; 0.124]; SRMR = 0.060. Acquired capability did not significantly load onto the latent construct of suicidality ($p = .427$) and was dropped from subsequent models. All other indicators remained on their latent constructs.

Structural Model

A series of individual structural models were completed to evaluate the relation between suicidality and each of the latent mediational factors (family processes, peer processes, and individual processes) prior to being entered into the principal model. A significant relation was found between suicidality and peer processes ($b = -0.214$, $SE = 0.061$, $t = -3.500$, $p < .001$), as well as suicidality and individual processes ($b = -0.554$, $SE = 0.122$, $t = -4.529$, $p < .001$). No significant relation was found for family processes ($b = -0.197$, $SE = 0.135$, $t = -1.466$, $p = 0.143$), thus it was excluded from subsequent structural models.

A direct effects model was completed to determine the relation between suicidality and each of the predictor variables (internalized homophobia, discrimination, victimization, and concealment). The direct model demonstrated adequate model fit to the data, $\chi^2 = 26.236$, $p = .001$; CFI = 0.950; RMSEA[90%CI] =

0.092[0.056; 0.129]; SRMR = 0.049. A significant relation to suicidality was found for internalized homophobia ($b = -0.024$, $SE = 0.006$, $t = -3.879$, $p < .001$) and victimization ($b = 0.142$, $SE = 0.064$, $t = 2.200$, $p = 0.028$). No significant relation was found between suicidality and discrimination ($b = -0.012$, $SE = 0.023$, $t = -0.521$, $p = 0.603$) or concealment ($b = -0.016$, $SE = 0.020$, $t = -0.767$, $p = 0.443$). See Figure 4 for the direct effects model.

Figure 4

Direct Model Results for Suicidality

A structural path (mediation) model was completed to determine the relation between the latent outcome variable (suicidality), the predictor variables (internalized homophobia, discrimination, victimization, and concealment), and the latent mediator variables (peer processes and individual processes). The mediation model demonstrated adequate model fit ($\chi^2 = 107.125, p < .001$; CFI = 0.914; RMSEA[90%CI] = 0.095[0.076; 0.115]; SRMR = 0.063. Significant relations to peer processes were found for internalized homophobia ($b = .006, SE = 0.003, t = 2.217, p = .027$) and victimization ($b = -0.049, SE = 0.024, t = -2.059, p = .039$). Significant relations to individual processes were found for internalized homophobia ($b = 0.027, SE = 0.008, t = 3.296, p = .001$), victimization ($b = -0.183, SE = 0.055, t = -3.312, p = .001$), and concealment ($b = 0.053, SE = 0.024, t = 2.230, p = 0.026$). A significant relation to suicidality was found for individual processes ($b = -0.533, SE = 0.188, t = -2.839, p = .005$) but not peer processes ($b = -0.0241, SE = 0.232, t = -1.039, p = .299$). No significant relations were found for peer processes and discrimination ($b = -0.003, SE = 0.013, t = -0.227, p = .821$), peer process and concealment ($b = 0.008, SE = 0.008, t = 1.035, p = .300$), or individual processes and discrimination ($b = 0.031, SE = 0.030, t = 1.033, p = .301$). See Figure 5 for the mediation model results for suicidality.

Figure 5

Structural (mediation) Model Results for Suicidality

A full model accounting for mediating paths as well as direct paths from the predictor variables (internalized homophobia, discrimination, victimization, and concealment) showed improved model fit ($\chi^2 = 113.018, p < .001$; CFI = 0.920; RMSEA[90%CI] = 0.087[0.069; 0.106]; SRMR = 0.055). Significant relations to peer processes were found for internalized homophobia ($b = .006, SE = 0.003, t = 2.330, p = .020$) and victimization ($b = -0.048, SE = 0.023, t = -2.148, p = .012$). A significant relation to individual processes was found for internalized homophobia ($b = 0.023, SE = 0.010, t = 2.234, p = .025$). A significant relation to suicidality was found for individual processes ($b = -0.476, SE = 0.165, t = -2.880, p = .004$) and the direct path from victimization ($b = 0.100, SE = 0.040, t = 2.499, p = .012$). No significant relations were found for peer processes and discrimination ($b = -0.003, SE = 0.012, t = -0.264, p = .792$), peer process and concealment ($b = 0.008, SE = 0.007, t = 1.096, p = .279$), individual processes and discrimination ($b = 0.062, SE = 0.045, t = 1.393, p = .164$), individual processes and victimization ($b = -0.014, SE = 0.087, t = -0.161, p = .872$), individual processes and concealment ($b = 0.055, SE = 0.028, t = 1.961, p = 0.050$), or suicidality and peer processes ($b = -.0244, SE = 0.187, t = -1.310, p = .190$). Additionally, direct paths to suicidality from internalized homophobia ($b = -0.004, SE = 0.005, t = -0.730, p = 0.465$), discrimination ($b = 0.014, SE = 0.21, t = 0.681, p = 0.496$), and concealment ($b = -0.002, SE = 0.013, t = -0.119, p = 0.905$) were not significant. See Figure 6 for the full model results for suicidality.

Figure 6

Full Model Results for Suicidality

To evaluate the mediating effect of peer processes and individual processes on the relations between the predictor variables (internalized homophobia, discrimination, victimization, and concealment) and suicidality, changes in the direct paths were examined. In the direct effects model, internalized homophobia and victimization were significantly associated with suicidality (see above). In the full model, the indirect path from internalized homophobia to individual processes was significant, as well as the indirect path from individual processes to suicidality. Moreover, the direct path from internalized homophobia to suicidality was no longer significant, $b = -.004$, $SE = .005$, $t = -0.730$, $p = .465$. This pattern of results indicates that individual processes successfully mediated the relationship between internalized homophobia and suicidality. Despite the significant indirect paths from victimization and concealment to individual processes in the mediation model, these paths were no longer significant in the full model.

Chi-square difference test for model comparison indicated that the mediation model was significantly better than the direct model, $\Delta\chi^2 = 277.351$, $p < .001$. When comparing the mediation model against the full model, no significant differences were found, $\Delta\chi^2 = 5.895$, $p = .659$. Given that there was no significant difference between the mediation and full models, the mediation model was determined to be the best fitting model, as it is more parsimonious than the full model. See Table 3 for model comparison.

Table 3

Model Comparison for Suicidality

Model	$\chi^2(\text{df})$	$\Delta\chi^2(\Delta\text{df})$	CFI	RMSEA	RMSEALL	RMSEAUL	SRMR	Significant Difference
Direct	384.476 (8)		0.95	0.092	[.056	0.129]	0.049	
Measurement	107.125 (31)	277.351(23)	0.91	0.095	[.076	0.115]	0.063	Yes
Full	113.02 (37)	5.895(8)	0.92	0.087	[.069	0.106]	0.055	No

Nonsuicidal Self-Injury

A series of individual structural models were completed to evaluate the relation between NSSI and each of the latent mediational factors (family processes, peer processes, and individual processes) prior to being entered into the principal model. No significant relations were found between NSSI and family processes ($b = 0.033$, $SE = 0.022$, $t = 1.501$, $p = .133$), peer processes ($b = 0.007$, $SE = 0.007$, $t = 0.953$, $p = .341$) or individual processes ($b = 0.018$, $SE = 0.018$, $t = .994$, $p = .320$). Given that NSSI was not significantly related to any of the latent mediational factors, subsequent structural equation models were not conducted.

A logistic regression model was conducted to evaluate the relations between the predictor variables (internalized homophobia, discrimination, victimization, and concealment) and NSSI. The full model containing all predictors was not statistically significant, $\chi^2 = 7.194$, $p = .126$, indicating that the model was not able to distinguish between individuals who reported and did not report a history of NSSI.

Chapter 4.

DISCUSSION

The current study examined the role of family, peer, and individual processes in explaining the relationship between minority stressors (i.e., internalized homophobia, discrimination, victimization, and concealment) and mental health outcomes (i.e., suicidality and NSSI). The present study makes a substantial contribution to a growing body of research examining suicidality in LGB individuals by specifically focusing on SMW. This study sought to explore the benefits of moving beyond predominantly risk-focused methods by adopting a strength-based approach, highlighting the potential role of protective factors. Further, this study extends previous work by examining several minority stressors and multiple protective processes (i.e., family, peer, and individual) in a single, comprehensive model. The primary aims of this study also served a broader purpose, which was to create an opportunity to reflect on important clinical implications related to the continued development in the assessment and treatment of suicidality in SMW.

Consistent with past research, results of the direct model confirmed that internalized homophobia and victimization significantly predicted suicidality, such that higher levels of internalized homophobia predicted suicidality and a greater number of lifetime victimization experiences predicted suicidality. Contrary to previous literature, there was not a significant relationship between discrimination and concealment and suicidality; however, internalized homophobia was strongly correlated to concealment, and victimization was strongly correlated with discrimination. These results suggest that the relationship between minority stressors

and mental health outcomes are complicated, and that minority stress variables should be considered together.

Although the present study anticipated family processes to mediate the relationship between minority stressors and suicidality, results did not support this hypothesis. Upon examination using individual structural models, family processes was not significantly related to suicidality, thus it was excluded from the subsequent structural models (the mediation and full models). Some research has shown family support to be a protective factor against depression and suicidal behaviors, whereas other studies have not found a significant relationship. In addition to contradictory findings, this body of research has focused primarily on LGB individuals more broadly, with samples of male and female participants combined. One primary aim of this study was to examine this relationship specifically for SMW; however, results indicate family processes may not play as large a role for SMW compared to other processes. Primarily, individual structural model results found peer processes significantly predicted suicidality, where higher levels of peer support were related to lower levels of suicidality. This is consistent with cultural values within sexual minority groups where individuals are often rejected by their biological/nuclear families. As a result, sexual minority individuals place value in creating a chosen family of their peers in which they turn to for social support. This cultural value may explain why peer processes was related suicidality and family processes was not.

Results from the mediation and full models indicated that individual processes was the only significant mediator in the model for suicidality. Specifically, individual processes mediated the relationship between internalized homophobia and suicidality.

Contrary to study hypotheses, peer support was not a significant mediator of the relationship between internalized homophobia and suicidality. This pattern of results suggests that mechanisms such as resilience and adaptive coping may be particularly relevant when it comes to mitigating the impact of internalized homophobia on suicidality, over and above more distal factors such as peer support. The mediation and full models also indicated that neither peer process nor individual processes mediated the relationship between victimization experiences and suicidality. This could be due to a number of factors not collected in our data, such as time since victimization or severity of victimization. Future research should investigate the intricacies of these relationships.

Contrary to study hypotheses, NSSI was not significantly related to the predictor variables or the latent mediational factors. Review of the bivariate correlations between these variables as presented in Table 2 reveals that the correlations between NSSI, internalized homophobia, and concealment were not significant. Although the correlation coefficients between NSSI, discrimination, and victimization were significant, this was at the $p < .05$ level instead of the higher significance threshold of $p < .001$. Further, NSSI was not significantly related to the proposed latent mediation variables (family, peer, and individual processes). Altogether, these results suggest that NSSI and the variables of interest were not significantly related in the current sample. It is possible that a larger sample may have yielded significant results.

Study Limitations and Future Directions

Although the present study adds to the body of literature examining protective factors mediating the relationship between suicidality in SMW, study limitations need to be taken into account. While significant efforts were made to obtain a sufficient sample size, it is possible that additional participants would have improved power and resulted in significant results for other analyses, such as the model examining NSSI. Future research would benefit from employing sampling techniques that may increase study participation. A second limitation is related to the cross-sectional nature of the data from the current study, which precludes the ability to make causal inferences about the relationship among variables in the model. Future research should utilize longitudinal study designs so that temporal relationships between minority stressors, protective factors, and health outcomes can be examined in this population.

The method of data collection (i.e., the internet) may also limit generalizability of the current study. By recruiting some participants using the internet, research findings may not be generalizable to SMW who may not have access to use such devices. This method of data collection, however, is often necessary to successfully recruit a hidden population such as sexual minorities (Aaron et al., 2001).

Disseminating the survey through various LGB organizations, electronic mailing lists, and websites/social media pages may also limit generalizability. Essentially, SMW who access the LGB community may differ in their experience of minority stressors compared to SMW who do not access this content. For example, SMW who go to LGB-focused websites or social media pages may have lower levels of internalized homophobia and concealment given their openness to LGB-related content.

Another limitation of the current study is that all individuals who self-identify as SMW (e.g., lesbian, bisexual, pansexual, queer, and questioning) were included in the analyses. It is possible that there are differences in health behaviors based on how an individual self-identifies. For instance, prior research has suggested that the frequency of negative health behaviors such as tobacco and marijuana use differ between lesbian and bisexual women (Mays & Cochran, 2001). In addition to a difference in health behaviors, subsets of SMW may also differ in terms of the rates with which they experience minority stressors as well as protective factors.

Similarly, most participants in the sample identified as White women, with relatively higher levels of income and education. Membership in these other cultural majority groups may protect some SMW from experiencing the additive or interactive effects of stressors inherent to existing within multiple minority groups simultaneously. The approach of intersectionality considers these interacting and connected cultural identities. Intersectionality incorporates the multiple contexts – cultural, structural, sociobiological, economic, and social – that shape individuals. For many individuals, the social groups they belong to have inherent structural inequalities, resulting in marginalized identities that experience oppression, prejudice, and discrimination (APA, 2017; Crenshaw, 1991). Conversely, cultural identities also have majority groups within social categories that will afford experiences of privilege (e.g., Whiteness, higher SES, advanced education). Intersectionality as an approach aims to capture the extensive within-in group differences in identities that can be found in both majority and minority group members, and argues the importance of considering the multiple, interacting and intersecting social and cultural identities

within a single individual. Intersectionality researchers argue that each of a person's minority identities interact in a synergistic way and therefore individuals contend with and experience discrimination and oppression as a multiply marginalized other (Crenshaw 1991; Settles 2006). Thus, future research should attempt to recruit large and diverse samples so that it is possible to examine health outcomes across sexual minority individuals who also identify with other marginalized groups (e.g., ethnic/racial minority groups).

Future research should also examine other potential risk and protective factors of negative health outcomes among SMW. The current study focused on internalized homophobia, discrimination, victimization, and concealment. There are, however, other minority stressors which may also serve as predictive of various health outcomes. For example, one such minority stressor is the expectation of rejection. In some cases, the experience of LGB-related stigma may lead to the anticipation or expectation of rejection from the dominant (i.e., heterosexist) culture (Meyer, 2003). The expectation of rejection is an understudied minority stressor which deserves further inquiry, particularly in terms of its impact on health outcomes.

Future research should utilize the current study's findings, as well as those from similar studies, to help inform health prevention and intervention efforts for SMW. Given the high frequency of negative health behaviors among SMW, it is clear that the population would benefit from the continued implementation of treatment efforts. Moreover, addressing specific dimensions of minority stressors (e.g., internalized homophobia) could facilitate the design of more effective efforts.

Potential Implications

The current study has several important clinical implications. For example, results of the study indicate that internalized homophobia and victimization experiences predict suicidality among sexual minority women. This finding may help to inform suicide risk assessment specifically in this population. Historically, suicide risk assessment and intervention efforts have followed a public health model, in which a wide net is cast in order to identify and help the largest number of people possible. As a result, there are certain common factors that are considered when conducting suicide risk assessment, including presence of suicidal ideation, plan, access to means (e.g., gun), and intent. While this is a valuable approach, a major drawback to this method is that clinicians are rarely trained to consider cultural factors beyond the scope of the traditional suicide risk assessment. In the past decade, researchers have highlighted the lack of standard inclusion of culture into suicide risk assessments (Chu, Goldblum, Floyd, & Bongar, 2010; Chu et al., 2013). The absence of attention to cultural aspects related to suicidality may increase the likelihood of suicide risk going under detected which could negatively impact clinical management and intervention.

Some researchers have begun to development culturally specific suicide risk assessment scales. For example, the Cultural Assessment of Risk for Suicide Scale (CARS Scale; Chu et al., 2013) was designed as a means to improve suicide risk assessment for sexual and ethnic minority groups. In addition to assessing for standard suicide risk factors (e.g., emotional distress and suicidal behaviors), this scale also includes domains such as family conflict and social support, sexual and ethnic

minority stress, acculturative stress, and cultural beliefs about suicide. Items within the sexual and ethnic minority stress domains capture concealment/degree of outness and other's perceptions and comfort level with an individual's sexual orientation. The measures also asks broad questions about discrimination (i.e., being treated unfairly because of their minority status) and victimization (i.e., believing the world is a dangerous place for minority groups).

Based on the findings of the current study, however, additional items related to internalized homophobia and victimization would be critical. Specifically, more targeted questions are needed to assess whether individuals have had victimization experiences and if they attribute such experiences to their sexual orientation. Similarly, study findings indicate inclusion of questions assessing internalized homophobia and self-hatred or shame related to one's sexual identity would be important in informing clinical judgement as to a sexual minority woman's level of risk.

Results of the current study may also inform treatment and intervention efforts for suicidality. Significant efforts have been made to implement evidence-based practices (EBPs) when treating mental health problems such as depression and suicidality (APA Presidential Task Force on Evidence-Based Practice, 2006). Examples of these EBPs include Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). These treatment modalities were designed to address maladaptive or unhelpful cognitions as well as difficulties with emotion regulation, and have been validated for the population at large. The therapeutic tenets and intervention techniques inherent in CBT and DBT could be used to increase protective

factors in SMW, such as enhancing individual processes aimed at increasing resiliency and adaptive coping. Similarly, CBT and DBT could explore and address thought processes and coping skills that could help alleviate the frequency and/or severity of experienced emotional distress (e.g., shame and self-hatred) related to the experience of internalized homophobia or victimization.

Given the findings related to cultural-specific factors for SMW, it is vital that treatment providers implement culturally sensitive intervention approaches. LGBT affirmative therapy is an approach applied to prevailing therapeutic modalities (e.g., CBT and DBT) to adapt related treatment interventions to the specific issues and needs of sexual minority individuals (Davies, 1996; Panchankis & Goldfried, 2004). A key principle in LGBT affirmative therapy is the critical need for the treatment provider to exemplify unconditional positive regard in working with sexual minority clients, and highlighting respect for an individual's sexual orientation, personal integrity and dignity, as well as their attitudes and beliefs (Davies, 1996). Adopting a LGBT affirmative approach to the implementation of EBPs, may facilitate a therapeutic environment that is potentially more culturally relevant and sensitive to the needs of SMW. Specifically, for SMW with higher levels of internalized stigma, it may strengthen therapeutic rapport which in turn could increase the likelihood of disclosure of difficult or uncomfortable feelings (e.g., self-hatred, shame), as well as positive and negative experiences (e.g., victimization) related to their sexual orientation. This increased disclosure and information is likely to foster a therapeutic process which naturally incorporates the unique risk and protective factors related to suicidality in SMW.

Additionally, LGBT affirmative therapists recognize that sexual minority clients present unique experiences and issues in therapy, and are able to apply a body of knowledge related to cultural awareness and sensitivity to sexual orientation within the therapeutic context to address and rectify the heteronormative assumptions of traditional EBPs (Davies & Neal, 1996). This culturally informed approach may better address the thoughts and feelings related to suicide risk factors such as internalized homophobia and victimization specific to SMW and suicidality. Specifically, therapists applying their culturally relevant body of knowledge in addressing challenging unhelpful thought patterns, and the motivation and development of emotion regulation difficulties in a more culturally sensitive manner may potentially increase treatment engagement, retention, and effectiveness when working with SMW.

CONCLUSION

Overall findings of the present study highlight the unique role of risk and protective factors related to suicidality in SMW. The current study underscores the critical need for continued research focused on identifying the underlying mechanisms contributing to increased suicidality for SMW, specifically examining the unique contributions of risk factors such as internalized homophobia, as well as the role of individual processes as a protective factor against suicidality. Future research should be conducted with the goal of designing more culturally sensitive suicide risk assessments and tailoring individual treatment to address aggravating and protective factors specific to SMW and suicidality.

APPENDIX A

Demographic Information

Biologic sex:

- Female
- Male
- Intersex
- Not sure

Gender identity:

- Female
- Male
- FTM (female to male) Transgender
- MTF (male to female) Transgender
- Genderqueer
- Not listed. Please specify: _____

Age: _____ years old

Ethnoracial identity: (select all that apply)

- American Indian or Alaskan Native
- Asian
- Black
- Hispanic or Latinx
- Native Hawaiian or Pacific Islander
- White
- Not listed. Please specify: _____
- Prefer not to answer

Relationship status:

- In a relationship
- Not in a relationship
- Prefer not to answer

Gender identity of current partner (if applicable):

- Female
- Male
- FTM (female to male) Transgender
- MTF (male to female) Transgender
- Genderqueer
- Not listed. Please specify: _____
- Prefer not to answer

Please select the highest level of education you have attained:

- Some high school
- High school diploma/GED
- Trade or technical school
- Associate's Degree
- Some college
- Bachelor's Degree
- Graduate degree (Master's Degree, MD, PhD)
- Prefer not to answer

What is your total yearly income?

- Less than \$10,000
- \$10,000 to \$19,999
- \$20,000 to \$29,999
- \$30,000 to \$39,999
- \$40,000 to \$49,999
- \$50,000 to \$59,999
- \$60,000 to \$69,999
- \$70,000 to \$79,999
- \$80,000 to \$89,999
- \$90,000 to \$99,999
- \$100,000 or more
- Prefer not to answer

Do you currently have health insurance?

- Yes
- No
- Prefer not to answer

Have you ever received care for a mental health issue (e.g., depression, stress)?

- Yes
- No
- Prefer not to answer

In the past year, have you received care for a mental health issue?

- Yes
- No
- Prefer not to answer

Have you ever been hospitalized for a mental health reason?

- Yes
- No
- Prefer not to answer

In the past year, have you ever been hospitalized for a mental health reason?

- Yes
- No
- Prefer not to answer

APPENDIX B

Sexual Orientation

Please indicate which best describes your sexual orientation:

- Lesbian
- Bisexual
- Heterosexual/Straight
- Pansexual
- Queer
- Questioning
- Not listed. Please specify: _____

In your lifetime, have your sexual partners been:

- All female
- All male
- Both female and male
- Not applicable
- Prefer not to answer

Please rate your sexual orientation on a scale from exclusively heterosexual/straight to exclusively lesbian:

←-----→
Exclusively straight Exclusively lesbian

Please rate your sexual attraction to females on a scale from not at all attracted to extremely attracted:

←-----→
Not at all attracted Extremely attracted

Please rate your sexual attraction to males on a scale from not at all attracted to extremely attracted:

←-----→
Not at all attracted Extremely attracted

APPENDIX C

Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001)

Strongly agree (1) - Strongly disagree (7)

R indicates a reverse score item.

1. When interacting with members of the LGBTQ community, I often feel different and alone, like I don't fit in.
2. Attending LGBTQ events and organizations is important to me. R
3. I feel isolated and separate from other LGBTQ individuals.
4. Most of my friends are LGBTQ individuals. R
5. Social situations with other LGBTQ individuals make me feel uncomfortable.
6. Being a part of the LGBTQ community is important to me. R
7. Having LGBTQ friends is important to me. R
8. I feel comfortable joining a LGBTQ social group, sports team, or organization. R
9. I am familiar with community resources for LGBTQ individuals (i.e., bookstores, support groups, bars, etc.). R
10. I am aware of the history concerning the development of LGBTQ communities and/or the lesbian/gay rights movement. R
11. I am familiar with LGBTQ books and/or magazines. R
12. I am familiar with LGBTQ movies and/or music. R
13. I am familiar with LGBTQ music festivals and conferences. R
14. I try not to give signs that I am a LGBTQ individual. I am careful about the way I dress; the jewelry I wear; and the places, people and events I talk about.
15. I am comfortable being "out." I want others to know and see me as LGBTQ. R
16. I wouldn't mind if my boss knew that I was a LGBTQ individual. R
17. It is important for me to conceal the fact that I am a LGBTQ from my family.
18. I feel comfortable talking to me heterosexual friends about my everyday home life with my LGBTQ partner/lover or my everyday activities with my LGBTQ friends. R
19. I am not worried about anyone finding out that I am LGBTQ. R
20. I live in fear that someone will find out I am LGBTQ.
21. I feel comfortable talking about homosexuality in public. R
22. I do not feel the need to be on guard, lie, or hide my LGBTQ identity from others. R
23. If my peers knew of my LGBTQ identity, I am afraid that many would not want to be friends with me.
24. I could *not* confront a straight friend or acquaintance if she or he made a homophobic or heterosexist statement to me.
25. I feel comfortable discussing my LGBTQ identity with my family. R
26. I don't like to be seen in public with LGBTQ individuals who look "too butch" or are "too out" because others will then think I am a LGBTQ.
27. I act as if my LGBTQ lovers are merely friends.

28. When speaking of my LGBTQ lover/partner to a straight person, I often use neutral pronouns so the sex of the person is vague.
29. When speaking of my LGBTQ lover/partner to a straight person, I change pronouns so that others will think I'm involved with a man rather than a woman.
30. I hate myself for being attracted to other women.
31. I am proud to be LGBTQ. R
32. I feel bad for acting on my LGBTQ desires.
33. As a LGBTQ individual, I am loveable and deserving of respect. R
34. I feel comfortable being LGBTQ. R
35. If I could change my sexual orientation and become heterosexual, I would.
36. I don't feel disappointment in myself for being LGBTQ. R
37. Being LGBTQ makes my future look bleak and hopeless.
38. Just as in other species, female homosexuality is a natural expression of sexuality in human women. R
39. Female homosexuality is a sin.
40. Female homosexuality is an acceptable lifestyle. R
41. Children should be taught that being gay is a normal and healthy way for people to be. R
42. LGBTQ couples should be allowed to adopt children the same as heterosexual couples. R
43. Growing up in a LGBTQ family is detrimental for children.
44. LGBTQ lifestyles are viable and legitimate choices for women. R
45. I feel comfortable with the diversity of women who make up the LGBTQ community. R
46. If some LGBTQ individuals would change and be more acceptable to the larger society, LGBTQ as a group would not have to deal with so much negativity and discrimination.
47. I wish some LGBTQ individuals wouldn't "flaunt" their LGBTQ identity. They only do it for shock value and it doesn't accomplish anything positive.
48. LGBTQ individuals are too aggressive.
49. My feelings toward other LGBTQ individuals are often negative.
50. I frequently make negative comments about other LGBTQ individuals.
51. I have respect and admiration for other LGBTQ individuals. R
52. I can't stand LGBTQ individuals who are too "butch." They make LGBTQ individuals as a group look bad.

APPENDIX D

Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2006)

Directions: Please think carefully about your life as you answer the questions below. Read each question and then select the number that best describes events in the PAST YEAR, using these rules. Select 1—If the event has NEVER happened to you; Select 2—If the event happened ONCE IN A WHILE (less than 10% of the time); Select 3—If the event happened SOMETIMES (10–25% of the time); Select 4—If the event happened A LOT (26–49% of the time); Select 5—If the event happened MOST OF THE TIME (50–70% of the time); Select 6—If the event happened ALMOST ALL OF THE TIME (more than 70% of the time).

1. How many times have you been treated unfairly by teachers or professors because you are LGBTQ?
2. How many times have you been treated unfairly by your employer, boss, or supervisors because you are LGBTQ?
3. How many times have you been treated unfairly by your co-workers, fellow students, or colleagues because you are LGBTQ?
4. How many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, mechanics, and others) because you are LGBTQ?
5. How many times have you been treated unfairly by strangers because you are LGBTQ?
6. How many times have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, caseworkers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists, and others) because you are LGBTQ?
7. How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are LGBTQ?
8. How many times have you been treated unfairly by your family because you are LGBTQ?

9. How many times have you been called a HETEROSEXIST name like dyke, lezzie, or other names?
10. How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are LGBTQ?
11. How many times have you been rejected by family members because you are LGBTQ?
12. How many times have you been rejected by friends because you are LGBTQ?
13. How many times have you heard ANTI-LESBIAN/ANTI-GAY remarks from family members?
14. How many times have you been verbally insulted because you are LGBTQ?

APPENDIX E

Victimization Experiences (D'Augelli, 2006)

Directions: Please indicate the prevalence of each experience during your lifetime that you believe has occurred as a result of your sexual orientation: *Never, Once, Twice, or 3+ Times*

1. Verbal Abuse/Insults
2. Threat of Violence
3. Objects Thrown
4. Assault (being punched, kicked, slapped)
5. Threatened with Weapon
6. Sexual Assault/Rape
7. Chased, followed, or stalked
8. Threatened with revealing your sexual orientation to others

APPENDIX F

Outness Inventory (OI; Mohr & Fassinger, 2000)

Directions: Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you.

- 1 = person definitely does NOT know about your sexual orientation status
- 2 = person might know about your sexual orientation status, but it is NEVER talked about
- 3 = person probably knows about your sexual orientation status, but it is NEVER talked about
- 4 = person probably knows about your sexual orientation status, but it is RARELY talked about
- 5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
- 6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
- 7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
- 0 = not applicable to your situation; there is no such person or group of people in your life

- 1. mother
- 2. father
- 3. siblings (sisters, brothers)
- 4. extended family/relatives
- 5. my new straight friends
- 6. my work peers
- 7. my work supervisor(s)
- 8. members of my religious community (e.g., church, temple)
- 9. leaders of my religious community (e.g., church, temple)
- 10. strangers, new acquaintances
- 11. my old heterosexual friends

APPENDIX G

*Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet,
& Farley, 1988)*

Directions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

- 1 = very strongly disagree
2 = strongly disagree
3 = mildly disagree
4 = if you are neutral
5 = mildly agree
6 = strongly agree
7 = very strongly agree

1.	There is a special person who is around when I am in need.	SO
2.	There is a special person with whom I can share my joys and sorrows.	SO
3.	My family really tries to help me.	Fam
4.	I get the emotional help and support I need from my family.	Fam
5.	I have a special person who is a real source of comfort to me.	SO
6.	My friends really try to help me.	Fri
7.	I can count on my friends when things go wrong.	Fri
8.	I can talk about my problems with my family.	Fam
9.	I have friends with whom I can share my joys and sorrows.	Fri
10.	There is a special person in my life who cares about my feelings.	SO
11.	My family is willing to help me make decisions.	Fam
12.	I can talk about my problems with my friends.	Fri

Family subscale (Fam)

Friends subscale (Fri)

Significant other subscale (SO)

APPENDIX H

Brief Resilience Scale (BRS; Smith et al., 2008)

Directions: Use the following scale and circle one number for each statement to indicate how much you disagree or agree with each of the statements.

- 1 = strongly disagree
- 2 = disagree
- 3 = neutral
- 4 = agree
- 5 = strongly agree

1. I tend to bounce back quickly after hard times.
2. I have a hard time making it through stressful events. R
3. It does not take me long to recover from a stressful event.
4. It is hard for me to snap back when something bad happens. R
5. I usually come through difficult times with little trouble.
6. I tend to take a long time to get over set-backs in my life. R

APPENDIX I

Brief COPE (Carver, 1997)

Directions: These items deal with ways you've been coping with the stress in your life since you found out you were going to have to have this operation. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not- just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true for you as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.

- 26. I've been blaming myself for things that happened.
- 27. I've been praying or meditating.
- 28. I've been making fun of the situation.

APPENDIX J

Interpersonal Needs Questionnaire (INQ; Van Orden et al., 2012)

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

1. These days, the people in my life would be better off if I were gone
2. These days, the people in my life would be happier without me
3. These days, I think I am a burden on society
4. These days, I think my death would be a relief to the people in my life
5. These days, I think the people in my life wish they could be rid of me
6. These days, I think I make things worse for the people in my life
7. These days, other people care about me
8. These days, I feel like I belong
9. These days, I rarely interact with people who care about me
10. These days, I am fortunate to have many caring and supportive friends
11. These days, I feel disconnected from other people
12. These days, I often feel like an outsider in social gatherings
13. These days, I feel that there are people I can turn to in times of need
14. These days, I am close to other people
15. These days, I have at least one satisfying interaction every day

Note: Items 7, 8, 10, 13, 14, and 15 are reverse coded.

APPENDIX K

Acquired Capability (ACSS-FAD)

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

1. The fact that I am going to die does not affect me.
2. The pain involved in dying frightens me.
3. I am very much afraid to die.
4. It does not make me nervous when people talk about death.
5. The prospect of my own death arouses anxiety in me.
6. I am not disturbed by death being the end of life as I know it.
7. I am not at all afraid to die.

APPENDIX L

Suicide Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001)

Directions: Answer each question as honestly as you can. Select one answer only for each question.

1. Have you ever thought about or attempted to kill yourself?

1 = Never

2 = It was just a brief passing thought

3a = I have had a plan at least once to kill myself but did not try to do it

3b = I have had a plan at least once to kill myself and really wanted to die

4a = I have attempted to kill myself, but did not want to die

4b = I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year?

1 = Never

2 = Rarely (1 time)

3 = Sometimes (2 times)

4 = Often (3-4 times)

5 = Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it?

1 = No

2a = Yes, at one time, but did not really want to die

2b = Yes, at one time, and really wanted to die

3a = Yes, more than once, but did not want to do it

3b = Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday?

0 = Never

1 = No chance at all

2 = Rather unlikely

3 = Unlikely

4 = Likely

5 = Rather likely

6 = Very likely

APPENDIX M

Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001)

- 0 = Not at all
 - 1 = Several days
 - 2 = More than half the days
 - 3 = Nearly every day
-
- 1. Little interest or pleasure in doing things
 - 2. Feeling down, depressed, or hopeless
 - 3. Trouble falling or staying asleep, or sleeping too much
 - 4. Feeling tired or having little energy
 - 5. Poor appetite or overeating
 - 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
 - 7. Trouble concentrating on things, such as reading the newspaper or watching television
 - 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
 - 9. Thoughts that you would be better off dead or of hurting yourself in some way

APPENDIX N

Inventory of Statements About Self-Injury (ISAS; Klonsky & Olino, 2008)

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

1. Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

- Cutting
- Severe Scratching
- Biting
- Banging or Hitting Self
- Burning
- Interfering w/ Wound Healing (e.g., picking scabs)
- Carving _____
- Rubbing Skin Against Rough Surface _____
- Pinching
- Sticking Self w/ Needles
- Pulling Hair _____
- Swallowing Dangerous Substances
- Other _____

Important: If you have performed one or more of the behaviors listed above, please complete the final part of this questionnaire. If you have not performed any of the behaviors listed above, you are done with this particular questionnaire and should continue to the next.

2. If you feel that you have a main form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

3. At what age did you:

First harm yourself? _____ Most recently harm yourself? _____
(approximate date – month/date/year)

4. Do you experience physical pain during self-harm?

Please circle a choice: YES, SOMETIMES, NO

5. When you self-harm, are you alone?

Please circle a choice: YES, SOMETIMES, NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?

Please circle a choice: < 1 hour, 1 - 3 hours, 3 - 6 hours, 6 - 12 hours, 12 - 24 hours, > 1 day

8. Do/did you want to stop self-harming?

Please circle a choice: YES NO

This inventory was written to help us better understand the experience of non-suicidal self-harm. Below is a list of statements that may or may not be relevant to your experience of self-harm. Please identify the statements that are most relevant for you:

- Circle 0 if the statement not relevant for you at all
- Circle 1 if the statement is somewhat relevant for you
- Circle 2 if the statement is very relevant for you

“When I self-harm, I am ...

1. ... calming myself down 0 1 2
2. ... creating a boundary between myself and others 0 1 2
3. ... punishing myself 0 1 2
4. ... giving myself a way to care for myself (by attending to the wound) 0 1 2
5. ... causing pain so I will stop feeling numb 0 1 2
6. ... avoiding the impulse to attempt suicide 0 1 2
7. ... doing something to generate excitement or exhilaration 0 1 2
8. ... bonding with peers 0 1 2
9. ... letting others know the extent of my emotional pain 0 1 2
10. ... seeing if I can stand the pain 0 1 2
11. ... creating a physical sign that I feel awful 0 1 2
12. ... getting back at someone 0 1 2
13. ... ensuring that I am self-sufficient 0 1 2
14. ... releasing emotional pressure that has built up inside of me 0 1 2
15. ... demonstrating that I am separate from other people 0 1 2
16. ... expressing anger towards myself for being worthless or stupid 0 1 2
17. ... creating a physical injury that is easier to care for than my emotional distress 0 1 2
18. ... trying to feel something (as opposed to nothing) even if it is physical pain 0 1 2
19. ... responding to suicidal thoughts without actually attempting suicide 0 1 2
20. ... entertaining myself or others by doing something extreme 0 1 2
21. ... fitting in with others 0 1 2
22. ... seeking care or help from others 0 1 2
23. ... demonstrating I am tough or strong 0 1 2
24. ... proving to myself that my emotional pain is real 0 1 2
25. ... getting revenge against others 0 1 2
26. ... demonstrating that I do not need to rely on others for help 0 1 2
27. ... reducing anxiety, frustration, anger, or other overwhelming emotions 0 1 2
28. ... establishing a barrier between myself and others 0 1 2
29. ... reacting to feeling unhappy with myself or disgusted with myself 0 1 2
30. ... allowing myself to focus on treating the injury, which can be gratifying or satisfying 0 1 2

- 31. ... making sure I am still alive when I don't feel real 0 1 2
- 32. ... putting a stop to suicidal thoughts 0 1 2
- 33. ... pushing my limits in a manner akin to skydiving or other extreme activities 0 1 2
- 34. ... creating a sign of friendship or kinship with friends or loved ones 0 1 2
- 35. ... keeping a loved one from leaving or abandoning me 0 1 2
- 36. ... proving I can take the physical pain 0 1 2
- 37. ... signifying the emotional distress I'm experiencing 0 1 2
- 38. ... trying to hurt someone close to me 0 1 2
- 39. ... establishing that I am autonomous/independent 0 1 2

(Optional) In the space below, please list any statements that you feel would be more accurate for you than the ones listed above:

(Optional) In the space below, please list any statements you feel should be added to the above list, even if they do not necessarily apply to you:

APPENDIX O

Summary of Measures

Construct/Measure	Number of Items	Cronbach's alpha (α)
<i>Internalized Homophobia</i>		
Lesbian Internalized Homophobia Scale	52	.92
<i>Discrimination</i>		
Heterosexist Harassment, Rejection, and Discrimination Scale	14	.86
<i>Victimization</i>		
Victimization Measure	8	.80
<i>Concealment</i>		
Outness Inventory	11	.78
<i>Family Processes</i>		
Multidimensional Scale of Perceived Social Support- Family Subscale	4	.92
Number of family supports	1	
<i>Peer Processes</i>		
Multidimensional Scale of Perceived Social Support- Friend Subscale	4	.93
Number of peer supports	1	
<i>Individual Processes</i>		
Brief Resilience Scale	6	.92
Brief COPE- Adaptive Coping	16	.73
<i>Depressed Mood</i>		
Patient Health Questionnaire-9	9	.89
<i>Suicidality</i>		
Interpersonal Needs Questionnaire	15	.94
Acquired Capability for Suicide Scale	7	.87
Suicide Behaviors Questionnaire-Revised	4	.79
<i>Nonsuicidal self-injury</i>		
Inventory of Statements About Self-injury	39	

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