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AN EXAMINATION OF PSYCHOLOGICAL DISTRESS IN TREATMENT-SEEKING COLLEGE STUDENTS WITH DOUBLE MINORITY STATUS

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Abstract

Evidence suggests that members of divergent cultural minority groups often experience disproportionate amounts of psychological distress as compared to the general white population. The double jeopardy hypothesis posits that as a result of occupying two marginalized statuses, the combined effects of racial/ethnic and sexual minority group memberships lead to greater negative consequences than occupying one status independently (Greene, 1994). Minority stress theory is a theoretical framework that can be used to understand the accumulative distress experienced as a double minority. However, minority stress has not been thoroughly researched with the treatment-seeking college student population. Many colleges and universities have reported significant increases in students’ utilization of counseling services (Byrd & McKinney, 2012), the severity of symptoms (Drum, Brownson, Denmark, & Smith, 2009) and the length of treatment (Tosevski, Milovancevic, & Gajic, 2010). Furthermore, the difficulty of transitioning to college and navigating the self-exploration process may evoke even more distress for questioning-identified students of color because of the complexity associated with negotiating the multiple aspects of their identity. Though, while evidence suggests that this population is at increased risk of negative psychological outcomes, there is limited to no research on this plight. Additionally, the research has not begun to examine the absence of a proximal stressor, such as social support, which might effectively buffer the psychological distress experienced by this population. The current research addressed the following research questions: (1) Do racial/ethnic minority students experience more distress than white students? (2) Do sexual minority students (LGBQ) experience more distress than heterosexual students? (3) Do those with a double minority identity
experience more distress than those with a single minority identity? (4) How does the stability of one’s sexual identity influence the amount of distress experienced? (5) Is the relationship between social support and psychological distress moderated by one’s questioning status? (6) For double minorities, is the relationship between social support and distress moderated by one’s questioning status? Results indicated that racial/ethnic minorities and sexual minorities evidenced more overall distress. Most findings evidenced small to moderate effects. Further, support for double minority stress was mixed. Double minorities did not evidence more distress than non-double minorities in most cases. Future research should develop more nuanced methodologies for examining treatment-seeking double minority college students.

*Keywords*: double minority, questioning identity, emerging adulthood, minority stress theory
# Table of Contents

List of Tables .................................................................................................................. vii
Acknowledgments ........................................................................................................... viii

**CHAPTER ONE: INTRODUCTION** .............................................................................. 1
  - Racism ....................................................................................................................... 2
  - Heterosexism ........................................................................................................... 3
  - Double Jeopardy ....................................................................................................... 4
  - Theoretical Background ......................................................................................... 5
  - College Students ................................................................................................... 6
  - Social Support ......................................................................................................... 10
  - Statement of the Problem ..................................................................................... 11
  - Purpose of Study ..................................................................................................... 13

**CHAPTER TWO: REVIEW OF THE LITERATURE** .................................................... 15
  - Part I ....................................................................................................................... 16
    - Racism .................................................................................................................. 16
    - Heterosexism ....................................................................................................... 24
    - Double Jeopardy ................................................................................................... 29
    - Minority Stress Theory ....................................................................................... 31
    - Combined Effects of Racism And Heterosexism ............................................. 36
  - Part II ...................................................................................................................... 37
    - College Students ................................................................................................ 37
  - Part III ...................................................................................................................... 46
    - Gaps in the Literature ........................................................................................ 46
    - Current Research ............................................................................................... 60

**CHAPTER THREE: METHODS** ............................................................................... 63
  - Participants ............................................................................................................. 63
  - Measures ............................................................................................................... 65
  - Procedure .............................................................................................................. 69
  - Analytic Plan .......................................................................................................... 70

**CHAPTER FOUR: RESULTS** .................................................................................. 76
  - Description of the Sample ................................................................................... 76
  - Preliminary Analysis ............................................................................................. 77
  - Assumptions ......................................................................................................... 78
  - Primary Analyses .................................................................................................. 79

**CHAPTER FIVE: DISCUSSION** ................................................................................ 98
  - Summary of the Findings ..................................................................................... 99
  - Limitations ............................................................................................................ 109
  - Future Research ................................................................................................... 112
  - Clinical Implications ......................................................................................... 114
  - Conclusions .......................................................................................................... 116

References .................................................................................................................... 123

**APPENDICES** ........................................................................................................ 175
  - Appendix A ........................................................................................................... 176
Informed Consent Form ................................................................. 176
Appendix B ................................................................. 177
Select Questions from the SDS Questionnaire ........................................... 177
Appendix C ................................................................. 178
Summary of MANOVA Findings by Main Effects: Questions 1-4 ........... 178
List of Tables

Table 1 General Description of Key Sample Variables...................................................73
Table 2 Description of Sample-Stratified by Broad Racial Categories............................74
Table 3 Description of Sample-Stratified Race by Sexual Orientation............................75
Table 4 Descriptive Statistics for the Outcome Variables..............................................86
Table 5 Correlations Among and Descriptive Statistics for Key Study Variables.............87
Table 6 Main Effects for Race and Sexual Orientation..................................................88
Table 7 η2 Effect Sizes (95% CI) for Race and Sexual Orientation.................................89
Table 8 Main Effects for Single and Double Minority Students.......................................90
Table 9 η2 Effects Sizes (95% CI) Race by Sexual Orientation.......................................91
Table 10 MANOVA Stability of Sexuality-Double Minority..........................................92
Table 11 MANOVA Stability of Sexuality-White............................................................93
Table 12 η2 Effect Sizes (95% CI) for Questioning by Sexual Orientation.......................94
Table 13 Regression Analyses for Relationship between Family Support and Distress among All and Double Minority Students.........................................................95
Table 14 Regression Analyses for Relationship between Friend Support and Distress among All and Double Minority Students.........................................................96
Table 15 Regression Analyses for Relationship between Family Distress and Distress among All and Double Minority Students.........................................................97
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“You may encounter many defeats, but you must not be defeated. In fact, it may be necessary to encounter the defeats so that you can know who you are, what you can rise from, and how you can still come out of it.”

-Maya Angelou
CHAPTER ONE: INTRODUCTION

Racism and heterosexism have been shown to have adverse effects on individuals from various cultural minority groups. Most of the research has focused on racism or heterosexism independently, rather than collectively (i.e., racism and heterosexism). The notion of ‘double jeopardy’ has been utilized to describe the compilation of stress related to experiences with racism and heterosexism (Greene, 1994). Meyer’s (1995; 2003) minority stress theory offers support for this notion. However, minority stress theory has not been widely examined in the treatment-seeking college student population. Evidence suggests that treatment-seeking college students have experienced a slight but persistent increase in distress levels for depression, generalized anxiety, and social anxiety over the last six years (Center for Collegiate Mental Health, 2016). However, students’ distress levels for academic concerns, eating concerns, hostility, substance abuse, and family distress have been flattening or decreasing (CCMH, 2016). Given that not all aspects of mental health have been worsening, more attention from researchers and scholars in the field is warranted.

Considering the evidence for the independent effects of racism and heterosexism, it is not unreasonable to assume that students identifying as both racial/ethnic and sexual minorities are at increased risk for psychological distress. Despite all of the attention given to minority stress theory, the research focus on treatment-seeking college students is limited, particularly for those students identifying as both racial/ethnic and sexual minorities. Hayes, Chun-Kennedy, Edens, and Locke (2011) is the only study that has specifically examined and compared psychological distress, as measured by the Counseling Center Assessment of Psychological Symptoms (CCAPS)’ instruments, in
treatment-seeking and non-treatment seeking college students that identify as both racial/ethnic and sexual minorities. Evidence supporting the double jeopardy hypothesis was mixed. To account for the differences in findings, Hayes et al. (2011) theorizes that resiliency and support systems might aid racial/ethnic, sexual minority treatment-seeking college students in negotiating the complexities of their sexual orientations which in turn might help to develop a more integrated sense of self. Meyer (2010) also provides a rationale for the importance of examining social support in the lives of double minorities.

In order to most thoroughly provide an overview of the present research study, this introduction offers a brief summary of the effects of racism and heterosexism, theoretical background, importance of focusing on college students, and how social support is the opportune way to move forward and contribute to increasing awareness and understanding of treatment-seeking college students that identify as double minorities. Chapter One concludes with a brief discussion of the gaps in the literature and a description of the current research.

**Racism**

Harrell (2000) theorizes that race-related stress has a detrimental effect on the mental health of people of color. Empirical evidence has found that when controlling for levels of general stress experienced by individuals in racially charged social environments, race-related stress accounted for an additional 4%-8% of the variance in outcomes such as negative well-being and psychological distress (Chao, Mallinckrodt, & Wei, 2012). Researchers have found that occurrences of race-related stress have led to general psychological symptoms of distress such as anxiety (Carter, Forsyth, Mazzula, & Williams, 2005; Klonoff, Landrine, & Ullman, 1999), trauma (Carter, 2007), cultural
mistrust (Combs et al., 2006), poor quality of life, less life satisfaction, and depression (Noh & Kaspar, 2003; Utsey & Payne, 2000). The exposure to racist events and race-related stressors often affects an individual’s sense of being (Harrell, 2000; Perrin, 2012). Accordingly, it is safe to assume that experiences of discrimination and racial harassment contribute to the internalization of racism (Speight, 2007). Through the process of internalized racism, oppression becomes normalized and marginalized racial populations accept the negative societal beliefs and stereotypes about themselves, which in turn leads to even more damaging psychosocial and health effects (Speight, 2007).

**Heterosexism**

In the early 2000’s, research on stress, as it relates to heterosexism, became increasingly prominent in the literature. Research on heterosexism has found poor mental health outcomes among sexual minorities (Cochran, Sullivan, & Mays, 2003; de Graaf, Sandfort, & ten Have, 2006; Gilman et al., 2001; Herrell et al., 1999; Koh & Ross, 2006; Matthews, Hughes, Razzano, Johnson, & Cassidy, 2002; Meyer, 2003; Russell & Joyner, 2001; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009; Sandfort, de Graaf, & Bijl, 2003). Over the past few decades, several population-based studies have reported that sexual minorities are at meaningfully elevated risk for acquiring mental health disorders including depression, anxiety, and substance use disorders (Cochran, 2001). Research findings point to the harmful effects of the stigma, victimization, and isolation sexual minorities suffer in a heterosexist society, as well as the psychological stress related to acknowledging and accepting their sexual orientation (Rivers & D’Augelli, 2001). As a result of cultural heterosexism and heterosexist experiences, sexual minorities, to varying degrees, internalize negative and limiting heterosexist messages, which can then lead to
psychological distress (Syzmanski, 2006). Meyer (1995) asserts that internalized heterosexism represents a form of self-blame, and thus will exacerbate the effects of heterosexist events on mental health.

**Double Jeopardy**

If embodying one marginalized status places an individual at risk for psychological distress, might embodying multiple marginalized statuses expose individuals to significantly more risk for such distress? Individuals who identify as both racial/ethnic and sexual minorities are exposed to both racist and heterosexist messages in their daily lives. For example, in a study of Black gay, lesbian, bisexual, and transgender people who attended different Black gay pride festivals held in U.S. cities in 2000, 57% reported experiences of racism and 43% reported experiences of heterosexism in their daily lives (Battle, Cohen, Warren, Fergerson, & Audam, 2002). Likewise, research on the experiences of men of color who have sex with men has demonstrated that members of this group often experience stigma and discrimination due to their racial/ethnic and sexual orientations (Battle et al., 2002; Berube, 2001; Dang & Hu, 2005; Diaz, Ayala, Bein, Henne, & Marin, 2001; Han, 2007; Ramirez, 2003; Teunis, 2007). The literature suggests that these racial/ethnic and sexual minority individuals struggle with a concept known as ‘double jeopardy’ (Almquist, 1975; Cortina, 2001; Epstein, 1973; Ferraro & Farmer, 1996; King, 1988; Reid, 1984). The double jeopardy hypothesis posits that as a result of occupying two marginalized statuses, the combined effects of racial/ethnic and sexual minority group memberships lead to greater negative consequences than occupying one status independently (Greene, 1994). Hence, those that identify as both racial/ethnic and sexual minorities are faced with the unique challenge of integrating two
identities, one pertaining to racial/ethnic culture and the other related to same-sex attracted orientation, in a society that does not fully accept either (Akerlund & Cheung, 2000).

**Theoretical Background**

Minority stress theory is a theoretical framework that can be used in understanding the accumulative distress experienced as a double minority. Minority stress theory (Meyer, 1995; 2003) is primarily based on social stress theory (Dressler, Oths, & Gravless, 2005; Pearlin, 1999). Minority stress is the consequence of “stressful stimuli such as prejudice, discrimination, and attendant hostility from the social environment” (Moritsugu & Sue, 1983, p.164) on the basis of an individual’s social status. Minority stress theory postulates that living as a member of a marginalized group leads to amplified exposure to stressful life events such as discrimination and victimization, which, in turn, have an impact on mental health and well-being (Meyer, 2003). Meyer’s theory has been recognized as the most comprehensible theory, to date, that explains the relatively poorer mental health of sexual minorities in comparison to their heterosexual counterparts (Dressler, Oths, & Gravlee, 2005). Moreover, minority stress theory evaluates the ways in which the unique stressors experienced by minority persons may be related to mental health disparities (Meyer, 2003). Hatzenbuehler (2009) theorizes that health disparities are often linked to stressful experiences of stigma and discrimination that accompany a marginal social identity. Thus, the theory suggests that the heightened susceptibility of sexual minorities stems from their constant exposure to stressors that are unique to their minority status. In turn, minority stressors may directly
affect health, lead to psychological distress (Krieger et al., 2008), and/or potentially affect health behaviors and usage of health services (Hausmann, Jeong, Bost, & Ibrahim, 2008).

A multitude of studies demonstrate links between the minority stress factors discussed and mental health. There is increasing empirical evidence for a relationship between experiencing hate crime victimization, discrimination, prejudices or daily heterosexist hassles and higher levels of psychological distress or feelings of suicidality (Abelson, Lambevski, Crawford, Bartos, & Kippax, 2006; Cox, Van den Berghe, Dewaele, & Vincke, 2008; Friedman, Marshal, Stall, Cheong, & Wright, 2008; Mays & Cochrane, 2001; Silverschanz, Cortina, Konik, & Magley, 2008; Swim, Johnston, & Pearson, 2009). Similarly, the same phenomenon is asserted for expectations of victimization and discrimination (Cox et al., 2008; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Lewis, Derlega, Griffin, & Krowinski, 2003; Meyer, 1995; Van den Berghe, Dewaele, Cox, & Vincke, 2010). Although Meyer’s (1995; 2003) minority stress theory is often-cited to explain higher levels of mental health problems among sexual minorities, evidence for its usefulness among different sexual minority subgroups (namely, racial minorities or college students) is limited (Kuyper & Fokkema, 2011).

**College Students**

As stated above, minority stress theory has not been examined thoroughly in the college student population. Developmentally, college students represent a group of individuals who are on a journey of transitioning from depending on others’ meaning-making processes to creating their own, complex meaning-making processes, their identities, and their relationships (Baxter Magolda, 2001). Traditional college students engage in a process of self-exploration that involves developmentally struggling with
how to integrate their new identity with the existing culture on their respective college campus (Kooyman, Pierce, & Zavadil, 2011).

Research on the mental health of university students has been the subject of increasing attention. Many colleges and universities have reported significant increases in students’ utilization of counseling services (Byrd & McKinney, 2012), the severity of symptoms (Drum, Brownson, Denmark, & Smith, 2009) and the length of treatment (Tosevski, Milovancevic, & Gajic, 2010). Evidence clearly suggests that students face significant psychological issues (Drum et al., 2009). Moreover, college has been known to encompass a number of potential stressors that may lead to increased psychological distress including, but not limited to, academic overload, competition with colleagues, financial hardship, concerns about the future, and continuous pressure to succeed (Tosevski, Milovancevic, & Gajic, 2010). These stressing experiences are often related to an increased risk of anxiety, depressive symptomatology, substance use, and personality disorders, in addition to negative social consequences later in life (Eisenberg, Golberstein, & Gollust, 2007).

For the young adult who identifies as a racial/ethnic as well as a sexual minority group member, the process of identity development becomes even more complex. The student is given the responsibility of concurrently developing a racial/ethnic and sexual identity that differs significantly from the dominant culture (Torres, Jones, & Renn, 2009). Research has traditionally shown that these identity development processes occur independently and that these young adults are at increased risk for stigma and ostracism because of their double minority status. For some of these students, this may increase the risk of poor mental health outcomes because cultural standards of the racial/ethnic
identity may reject their sexual identity more than the dominant culture (Diaz & Kosciw, 2009; Jamil, Harper, & Fernandez, 2009).

Some researchers have explored the experiences of racial/ethnic sexual minority individuals either empirically or theoretically including, but not limited to, Adams and Phillips (2006); Brooks, Inman, Malouf, Klinger, and Kaduvettoor (2008); Chung and Szymanski (2006); Hayes et al. (2011); Narvaez, Meyer, Kertzner, Ouellette, and Gordon (2009); and Szymanski and Gupta (2009).

Of the research conducted, only one study has been empirically conducted specifically examining the experiences of sexual minority (LGB) college students of color. Hayes, Chun-Kennedy et al. (2011) aims to examine whether, among students seeking help from university counseling centers, (a) racial/ethnic minority students reported greater psychological distress than white students reported and (b) LGB students/clients reported more psychological distress than heterosexual students/clients reported. Additionally, the first part of the study, in the context of treatment-seeking, sought to compare the general psychological distress among LGB students of color to the psychological distress experienced by white LGB students and heterosexual students of color, respectively. Hayes, Chun-Kennedy et al. (2011) repeats the same research process in a sample of students drawn from general student bodies from 45 colleges and universities who were not seeking help from counseling centers.

In regards to treatment-seeking college students, Hayes, Chun-Kennedy et al. (2011) found that the general findings supported minority stress theory in that clients of color exhibited more psychological distress than white clients. Additionally, sexual minority clients endorsed symptoms of more psychological distress than heterosexual
clients. Racial/sexual minority student clients endorsed more psychological distress than white sexual minority clients on the Hostility subscale, but lower psychological distress on Substance Use and Social Anxiety subscales, thereby suggesting partial support for double jeopardy hypothesis. Lastly, racial/sexual minority student clients endorsed greater Depression, Substance Use, Anxiety, and Family Concern scores when compared to racial/ethnic heterosexual student clients.

In the context of non-treatment seeking college students, similar results were found demonstrating that racial/ethnic college students exhibited more psychological distress than white students and LGB students reported greater distress than heterosexual students. Contrary to the treatment seeking results indicated above, in the non-treatment seeking sample, racial/sexual minority students and white sexual minority students exhibited similar levels of psychological distress across all eight subscales. This result, then, did not provide any support for double jeopardy hypothesis. Lastly, racial/sexual minority students, when compared to racial/ethnic heterosexual non-treatment seeking students, exhibited higher levels of psychological distress on all subscales except for Eating Concerns.

The authors offer a possible rationale for the mixed support of the aforementioned research findings regarding double jeopardy hypothesis. They suggest that the resiliency, strengths, support systems, and coping mechanisms that same-sex attracted students of color might possess may have helped them to learn to navigate the complexities of their double minority statuses. One of the limitations of the Hayes, Chun-Kennedy et al. (2011) study was that it did not explicitly examine the double jeopardy hypothesis in individuals who are questioning their sexual identity, despite research that highlights the
significant amount of distress that questioning-identified individuals experience (Nelson, Castonguay, & Locke, 2011) in addition to defining their general adult identity.

**Social Support**

Little is known about the strategies that questioning-identified students of color employ in order to deal with stress resulting from discriminatory practices. Limited knowledge about this population’s resilience and positive adaptation in the context of discrimination is available. Until 2010, Meyer’s (2003) minority stress hypothesis was accepted in regards to the experience of embodying multiple marginalized statuses. However, in 2010, Meyer challenged his own hypothesis by theorizing that because of their experience with racism prior to the coming out process, sexual minority individuals of color might possess potential resources and strengths that buffer against the negative effects of psychological distress related to stigmatization. One of the coping resources, well represented in the literature, is social support. Shorter-Gooden (2004) defines social support as an informal encouraging network comprised of extended family and friends in the form of advice, emotional support, and/or material support. For example, data indicate that social support has been considered a key coping strategy for African American women (Christian, Al-Mateen, Webb, & Donatelli, 2000; Neighbors, 1997; Taylor, Hardison, & Chatters, 1996). Additionally, for sexual minority individuals, data purport there are positive relationships between high levels of perceived social support and psychological adjustment, as well as relationship quality (Kurdek, 2005). Moreover, Shorter-Gooden (2004) theorizes that perceptions of social support can often provide social integration, a sense of validation, and support against adversity resulting from embodying marginalized identities. Thus, having social support from peers or family can
serve as a protective mechanism that affords questioning-identified students of color an opportunity to embrace a high level of resilience against stigmas related to their multiple identities (Shorter-Goode, 2004).

**Statement of the Problem**

Much of the literature discusses race and sexual minority-related stress as separate constructs. A noticeable gap in the literature is the lack of consistent reporting of race/ethnicity when discussing sexual minority samples and sexual orientation in racial/ethnic minority samples despite evidence, in the small amount of literature that has been conducted, demonstrating the combined effects of identifying as a double minority. Doing such perpetuates and reflects the assumption that sexual minority people of color do not exist and that their experience is invalid (Moradi et al., 2010). In the literature available, evidence suggests that members of divergent cultural minority groups often experience disproportionate amounts of psychological distress as compared to the general white population (Mays & Cochran, 2001; Hayes, Chun-Kennedy et al., 2011; Szymanski & Stewart, 2010; U.S. Department of Health and Human Services, 2001). Moradi et al. (2010) suggests that attending to populations who experience intersecting multiple minority identities is essential to advance scholarship about minority populations.

Lastly, minority stress has not been thoroughly researched with the treatment-seeking college student population. The college years represent transformation and transition during which older adolescents begin to develop into independent, functioning human beings by solidifying their identities as adults (Kalsner & Pistole, 2003). Many college students may have uncertain sexual identities once they begin their college trajectories (Friedman, Marshal, Stall, Cheong, & Wright, 2008), which may create
additional stress (Hayes, Chun-Kennedy et al., 2011). If individuals who identify as questioning begin to go through the coming out process, there is reason to believe that they may be in acute distress (Heatherington & Lavner, 2008). Because transitions to college and corresponding changes are significantly distressing, when sexual identity development occurs in this stressful context, questioning-identified individuals may be less able to cope than heterosexual students (McAleavey, Castonguay, & Locke, 2011).

The literature presented above highlights that racial/ethnic minorities and sexual minorities are independently distressed. Given this, the combined effects of embodying two marginalized statuses result in even greater psychological distress. Furthermore, when racial/ethnic minority status and questioning-identified status are considered in a treatment-seeking college student population, the literature becomes even smaller. The difficulty of transitioning to college and navigating the self-exploration process may evoke even more distress for questioning-identified students of color because of the complexity associated with negotiating the multiple aspects of their identity. However, while evidence suggests that this population is at increased risk of negative psychological outcomes, there is limited to no research on this plight. Additionally, the research has not begun to examine the absence of a proximal stressor, such as social support, which might effectively buffer the psychological distress experienced by this population.

Most studies have been conducted with college students from a single university, students in the beginning stages of their academic study, and students from a restricted range of fields (e.g., Eisenberg et al., 2007). It is unclear how representative those studies are, given the variance across campuses in demographic characteristics, availability of services, and other factors. As such, a broader and more nuanced examination of college
student mental health is needed to assist the administrators, policymakers, and providers by providing strategies to specifically address the needs of these students, particularly individuals with double minority statuses. To address this gap, the Center for Collegiate Mental Health (CCMH) provides a collaborative, multidisciplinary, practice-research network that pursues the related goals of all stakeholders on a national level, conducting large-scale psychotherapy research and improving the range of clinical tools available to practitioners in the higher-education setting. The current investigator contends that minority stress theory will be supported because the effects of double minority status surface during vulnerable times, particularly when students are questioning an essential aspect of their identity.

**Purpose of Study**

Researchers have only recently begun to examine the intersections of multiple identities and how those intersections impact multiple spheres of development (Abes & Jones, 2004; Abes, Jones, & McEwen, 2007; Jones & McEwen, 2000; King & Baxter Magolda, 2005; Reynolds & Pope, 1991; Stewart, 2002, 2008, 2009). Despite their exploration of these intersections of multiple identities, the current investigator is unaware of any studies that have tested minority stress theory with treatment-seeking, questioning-identified students of color. To better understand and increase knowledge on this population, the current study will address four core research questions.

Accordingly, the first research question seeks to both replicate and address the limitations of Hayes, Chun-Kennedy et al. (2011) by examining whether racial/ethnic minority students experience more distress than white students. The second research question examines whether sexual minority students (LGBQ) experience more distress
than heterosexual students. Also in conjunction with replication of the Hayes’ study, the third research question examines whether those with a double minority identity experience more distress than those with a single minority identity. The fourth and final research question for this portion addresses how the stability of one’s sexual identity influences the amount of distress experienced.

In addition, the investigator seeks to address the role social support plays in influencing psychological distress for treatment-seeking questioning-identified students and those that identify as both questioning and racial/ethnic minorities. Accordingly, the fifth research question examines the relationship between social support and distress moderated by one’s questioning status. The sixth and final research question examines the relationship between social support and psychological distress moderated by one’s questioning status for double minorities, specifically.
CHAPTER TWO: REVIEW OF THE LITERATURE

There is an abundance of research that explains the negative effects of racism and heterosexism on members of cultural minority groups (Mays & Cochran, 2001; Szymanski & Stewart, 2010). Members of these marginalized groups tend to experience greater depressive symptomatology, anxiety, and helplessness as compared to their white, heterosexual-identified counterparts (Hayes, Chun-Kennedy et al., 2011). The majority of the research has examined the impact of racism and heterosexism independently (i.e., racism or heterosexism), rather than collectively (i.e., racism and heterosexism). Meyer (2003) theorized that the experience of stress affiliated with minority statuses could lead to poor mental health outcomes. Thus, it is plausible to theorize that members of multiple minority groups experience additional psychological distress beyond that experienced by members of a single minority group. This possibility is known as the double jeopardy hypothesis (Ferraro & Farmer, 1996). The literature suggests that racial and sexual minority individuals struggle with being a ‘minority within a minority’ (Greene, 1994). As a result of various cultural and familial gender role statuses and expectations, sexual minority individuals of color risk losing social support networks and membership in many racial group communities in exchange for coming out as LGBQ (Greene, 1994). Consequently, people who embody two marginalized statuses are forced to choose which identity is most salient at any given time; however, in reality, all of their identities are constantly in contact with one another and changing in order to create a more integrated, harmonious being.

The full literature review is divided into three parts. In the first, the current researcher begins with a discussion of the independent effects of racism and heterosexism
in order to provide a foundation for understanding the collective impact of racism and heterosexism. Next, further elaboration on the double jeopardy hypothesis is provided, followed by a discussion of the ways in which minority stress theory provides a theoretical framework to explain how individuals with multiple marginalized statuses experience psychological distress. The first section of the literature review concludes with a brief summary of the empirical evidence conducted to date that has explored the experience of embodying multiple marginalized statuses in the context of minority stress theory.

In the second part, the researcher uses the same structure presented in the first to specifically discuss the impact of racism and heterosexism in the college student population. This begins with an examination of the literature on the impact of racism on minority students’ mental health. Next, a review of the literature on the impact of heterosexism on minority students’ mental health is provided. The second section concludes with an exploration of the literature on the combined effects of racism and heterosexism in the context of double jeopardy for college students.

In the last part, the researcher discusses the gaps in the literature as it relates to the process of emerging adulthood, sexual identity and fluidity/exploration, and resiliency in regards to social support. Lastly, a broad overview of the current research and research questions is provided.

Part I.

Racism.

For over 45 years, scholarly thought on racism and its effects has continued to grow, providing a more comprehensive, intricate, and multidimensional view of the
impact of racism (Carter & Reynolds, 2011). *Racism* is defined as “a system of cultural, institutional, and personal values, beliefs, and actions in which individuals or groups are put at a disadvantage based on ethnic or racial characteristics” (Tinsley-Jones, 2001, p. 573) that occurs “through the exercise of power against a racial group as inferior, by individuals and institutions with the intentional or unintentional support of the entire culture” (J. Jones, 1972, p. 172). Carter and Reynolds (2011) reported that understanding the physical and mental health implications of racism and discrimination has been an expanding area of studies in recent years (cf., Brondolo, Gallo, & Myers, 2009; Paradies, 2006; Pascoe & Richman, 2009; Pieterse & Carter, 2007; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Utsey, Chae, Brown, & Kelly, 2002). Currently, the understanding is that racism, as evidenced by discrimination, is generally correlated with poorer health status and that this connection is the strongest in the case of mental health (Williams, Neighbors, & Jackson, 2003). *Discrimination* is defined as the “behavior that creates, maintains, or reinforces advantage for some ‘groups’ and their members over other groups and their members” (Dovidio, Hewstone, Glick, & Esses, 2010, p. 10). One community-based study indicated that lifetime prevalence discrimination based on race (85%), gender (52%), and sexual orientation (47%), were all commonly experienced by Black sexual minority women (Wilson, Okwu, & Mills, 2011). Gee, Spencer, Chen, Yip, and Takeuchi (2007) found that being exposed to racial discrimination was a significant predictor of mental disorders over a 12-month period in a nationally representative sample of 2,047 Asian Americans. Empirical and theoretical literature has reported that racism can sufficiently traumatize, humiliate, anger, hurt, and confuse to prevent optimal physical and mental health in individuals and communities (Adams, 1990; Pierce, 1995;
Harrell, 2000; Szymanski & Gupta, 2009; Sellers, Chavous, & Cooke, 1998; Clark, Anderson, Clark, & Williams, 1999; Perrin, 2012). Moradi and Risco (2006) found that perceived discrimination was positively associated with psychological distress and that a relationship, partially mediated by personal control and perceived discrimination, was linked through personal control to lower self-esteem. Furthermore, racial discrimination has been related to self-reported health problems among Black adults (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006), hypertension in Black women (Cozier et al., 2006), chronic health conditions among Asian Americans (Gee, Spencer, Chen, & Takeuchi, 2007), low birth weight and prematurity among pregnant Arab women (Lauderdale, 2006), breast cancer incidence among Black women (Taylor et al., 2007), apprehension regarding cancer screenings with Latino women (Facione & Facione, 2007), risky sexual health behaviors in Black and South African populations (Kalichman et al., 2006), and drug use in Black families (Gibbons et al., 2007), to name a few examples.

Race-related stress.

Based on the conceptualization of Lazarus and Launier’s (1978) theory of stress, Harrell (2000, p. 44) theorized, “The relevance of stress theory in the study of racism is in the centrality of the transaction between person and environment, whereby the environment affects individual functioning and the behavior of individuals contributes to environmental demands.” Thereby, understanding the specific stress affiliated with racism, as evidenced by (perceived) discrimination, can help to further explain the experience of marginalized populations and their general mental health/well-being.

Harrell (2000) defines race-related stress as: “the race-related transactions between
individuals or groups and their environment that emerge from the dynamics of racism, and that are perceived to tax or exceed existing individual and collective resources or threatens well-being” (p. 44). Racism can be experienced through a number of distinct stressors including racism-related life events, vicarious racism experiences, daily racism microstressors, chronic-contextual stress, collective experiences, and transgenerational transmission. According to Harrell (2000) each type has parallels in three primary sources of stress: episodic stress (direct and vicarious racism experiences); daily hassles (racism microstressors); and chronic strain (chronic-contextual, collective, and transgenerational transmission).

The first, *racism-related life events*, might include events such as being rejected for a mortgage or being harassed by the police. This type of stressor tends to be infrequent and time limited, and result in short- and long-term effects on well-being. The second, *vicarious racism experiences*, might include incidences such as the death of Trayvon Martin or the beating of Rodney King. These types of stressors are experienced indirectly through others’ experiences of racism and have the ability to produce various stressful emotional responses. Third, *daily racism microstressors* are described as racial microaggressions (i.e., “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intention or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color,” Sue et al., 2007, p. 271) which include such things as being followed around while shopping or being approached in restaurants as presumed wait staff. These stressors occur daily and produce a cumulative burden that can have a considerable negative impact on general health. An example of the fourth, *chronic-contextual stress*, would be a well-educated Black
American woman being assumed to have received acceptance to an Ivy League institution based upon affirmative action. In other words, these types of stressors represent the sociopolitical and institutional inequalities experienced by people of color. 

Collective experiences of racism is the fifth category and refers to the social, cultural, and political expressions of racism that are believed to impact a person’s racial group and is emotionally experienced by the individual. An example of this would be television shows or books in which Blacks are portrayed as criminals or substance abusers. The final category, transgenerational transmission of group traumas, might be described as the history of the enslavement of African people or removal of American Indians from their native lands (Harrell, 2000). This stressor refers to the impact that the historical context of an individual’s racial group membership has on illuminating the effects of present-day racism-related stress.

The types of race-related stress discussed above explain how people of color might conceptualize their experiences with racism, which ultimately provides researchers with knowledge about the ways in which these stresses could affect the mental health of people of color. It is important to note that most of the research conducted on racism and stress frames the issue as primarily a Black-White racial issue, which falsely implies that Black American individuals are the only people discussed in the context of the phrase “people of color” affected by the stress connected to racism (Perrin, 2012). This, in turn, often excludes other populations such as Latino/a, biracial/multiracial, American Indian, Asian American, or other ethnic minorities that also face overwhelming and assiduous experiences of racism. In a study conducted by Chao (2006), results indicated that racism-related stress was a shared experience among all five ethnic groups included in
the study (African Americans, Asian Americans, Chicanos, Native Americans, and international students).

For instance, a common misconception is that Asian Americans are well adjusted and blossoming in the U.S. compared to other racial minority groups (Ying, Lee, & Tsai, 2000). There is, however, an emergent body of research proposing that Asian Americans have higher rates of mental illnesses than previously assumed (Miller, Yang, Farrell, & Lin, 2011). Ying et al. (2000) found that race-related stress was positively correlated to mental health problems in Asian Americans. In a sample of 158 Chinese American school-aged youth, Grossman and Liang (2008) found that racism-related stress was a significant predictor of depressive symptoms. Similarly, research has reported that Asian Americans deal with racism on a daily basis and are often the victims of racial intolerance (Alvarez, Juang, & Liang, 2006; Wong & Halgin, 2006; Ying et al., 2000). Goto, Gee, and Takeuchi (2002) found more than 20% of the Chinese Americans included in their study reported unfair treatment in their daily lives based upon their race, ethnicity, language, and/or accent. Moreover, Alvarez et al. (2006) showed that a vast percentage of Asian Americans reported incidents of racial microaggressions. In the same study, 99% of participants reported that they had witnessed some form of racism directed toward other Asian Americans (Alvarez et al., 2006). Hence, as stated previously, Asian Americans, as well as, other racial minority groups, are likely to expend a substantial amount of psychological, emotional, and physical energy coping with the effects of racism-related stress (Harrell, 2000; Utsey, Bolden, & Brown, 2001).

Although the aforementioned research demonstrates particular connections between experiences with racism to certain mental health effects, the research presented
also inadequately describes or assesses the entirety of the psychological impact of racism on racial minority communities. One of the key facets required to fully assess the impact of racism is the exploration of the internalization of racism by racial minority communities. Speight (2007) encourages individuals to understand that racism is not only interpersonal, but also spans across cultural and structural realms. For Speight (2007), racism is considered a condition that constantly violates communities of color physically, socially, materially, spiritually, and psychologically. Speight uses Young’s (1990) research to discuss the criteria that can be used to determine how groups are oppressed and the specific ways and conditions in which racism functions. The most relevant condition to the current research is that of cultural imperialism because it functions as the conduit through which many minority groups begin to internalize their oppression. *Cultural imperialism*, as defined by Young (1990) involves the process of universalizing and establishing the dominant group’s experiences and cultures as the normative standard. Thus, the dominant group has the ability to set the normative standard and render anything other than that perspective as “the other” or invisible (Young, 1990). Accordingly, minority groups are deemed invisible while simultaneously internalizing the dominant group’s stereotyped images of themselves during the exploration process for a more refined identity. Once internalization occurs, minority groups not only have to battle their oppressors, but also have to battle themselves. Therefore, any discussion of the mental health effects of racism would be incomplete and inadequate without considering the impact of internalized racism.
**Internalized racism.**

*Internalized racism* refers to “the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves” (Williams & Williams, 2000, p.255). For Speight (2007), internalized racism refers to cultural imperialism, as well as the domination, structure, and normalcy of a racialized society. Accordingly, in order to institutionalize and normalize oppressive racism, internalization of the dominant group’s values, norms, and ideas must occur. Young (1990) theorized that this acceptance, the internalization of racism, maintains the malignant self-perpetuating cycle of oppression, as a result of the constraints that racism imposes in both self-development and self-determination. Thereby, the dominant group’s capacity for defining and naming what is normal, real, and appropriate is further established and reinscribed. These marginalized racial populations begin to “think, feel, and act in ways that demonstrate the devaluation of their group and of themselves as members of that group” (Hardiman & Jackson, 1997, p.21) because they look to the dominant group’s images and ideals in order to construct a sense of self which serves to colonize and continuously recolonize them (Speight, 2007). Thereby, racial minorities cease to independently define themselves instead and contribute to the pattern of self-degradation and self-alienation based on internalized assumptions of significant inferiority. While Speight (2007) agrees that experiences of discrimination, racial harassment, and discriminatory harassment are detrimental to the mental health of racial minorities, these experiences also greatly contribute to internalized racism, which is identified as one of the most damaging psychological injuries of racism. Speight posited that internalized racism is not easily seen, counted, or measured and does not involve one wrongdoer and one consequent
victim, but instead has been adopted and resides in the psyche of the marginalized being. Therefore, understanding the psychological injury caused by internalized racism is important because it provides context for comprehending how the construction of meaning of a particular racial incident contributes to possible negative mental health effects and increased psychological distress in racial minorities.

**Heterosexism.**

Similar to the term racism, heterosexism has been coined as the norm for society and the basis upon which same-sex attracted behaviors have been denied, deprecated, and repudiated (Herek, 1995). *Heterosexism* is an ideological system of oppression that operates on individual, institutional, and cultural levels and encourages heterosexist events, including prejudice, harassment, discrimination, and violence against those individuals that do not identify as heterosexual (Herek, 2004; Szymanski, 2005). Heterosexism is considered a societal form of oppression that consciously and unconsciously focuses on imposing systematic negative perspectives, beliefs, and policies aimed towards same-sex attracted individuals (Miville & Ferguson, 2006). Stigmatization and oppression, including violence, toward people who identify as same-sex attracted has been well documented in the literature (e.g., Berrill, 1992; Herek, Cogan, Gillis, & Glunt, 1998; Herek, Gillis, & Cogan, 2009; Herek & Glunt, 1995). Research has shown that many same-sex attracted individuals have experienced heterosexist occurrences, including prejudice, harassment, discrimination, and violence, and that these experiences are related to adverse psychological, health, and job-related consequences such as somatic reactions, increased sense of vulnerability, self-blame, decreased self-worth, internalized heterosexism, depression, substance abuse, and suicidal ideation and/or
attempts (Herek, Gillis, & Cogan, 2009; Lewis, Derlega, Berndt, Morris, & Rose, 2002; Lewis, Derlega, Griffin & Krowinski, 2003; Mays & Cochran, 2001; Waldo, 1999). For example, in a nationally representative sample of the U.S. population, Mays and Cochran (2001) found that lesbian, gay, and bisexual individuals were twice as likely as heterosexual-identified individuals to report discrimination in their lifetimes, such as being harassed in their communities or unfairly terminated from their job by their employer. Research has also found that the more that individuals reported incidents of heterosexism, the more they tended to report psychological distress, a fear of being assaulted, and extreme changes in behavior in efforts to avoid future incidents of prejudice (Diaz, Ayala, Bein, Henne, & Marin, 2003; Herek, Gillis, & Cogan, 2009; Lewis et al, 2001; Waldo, 1999). Research has implied that same sex attracted individuals can become psychologically distressed as a result of expecting experiences of discrimination, even in the absence of those events actually occurring (Hatzenbuehler et al., 2008; Meyer, 1995). In other words, same sex attracted individuals can hear about heterosexist events occurring in the lives of others and in turn, incur vicarious stress related to such instances (e.g., Noelle, 2002).

A growing body of evidence suggests that sexual minorities may be at higher risk for mental health and psychiatric disorders than their heterosexual counterparts, as a result of experiences with heterosexist-related discrimination (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Mays & Cochran, 2001; Meyer, 2003). For example, research has found such links with anxiety disorders, mood disorders and substance abuse disorders (Gilman et al., 2001; Sandfort, de Graaf, & Bijl, 2003) and with suicidal ideation and attempts (Cochran & Mays, 2009;
In a meta-analysis, Meyer (2003) concluded that the odds of lifetime mood and anxiety disorders were twice as high for lesbian, gay, and bisexual individuals as for heterosexual-identified individuals. Moreover, Bostwick, Boyd, Hughes, and McCabe (2010) found that among men, any sexual minority status tended to be associated with a higher prevalence of lifetime mood and anxiety disorders and among women, any sexual minority identity was linked with higher rates of lifetime and past-year mood and anxiety disorders. Additionally, Bostwick et al. (2010) study found that bisexual identity and behavior were also strongly and perniciously related to a heightened risk of mood and anxiety disorders for both men and women over both lifetime and past-year time frames.

**Heterosexism-related stress.**

Similar to race-related stress, research has been conducted on stress related to the effects of heterosexism. This type of stress has been termed “gay-related stress” for individuals that identify as gay or lesbian. Lindquist and Hirabayashi (1979) defined *gay-related stress* as a “marginal” sexual minority status, in which the individual’s sexual identity status contends with another role that the individual is representing. They suggested that gay-related stress is unique from other minority stressors because gay men and lesbian women may not have a cultural identity outside of the mainstream and unlike members of other minority groups (e.g., racial/ethnic minorities), gay men and lesbian women may easily mask their sexual minority stress. Some examples of gay-related stressors are the processes of coming out to family members and friends or being exposed
as a same-sex attracted individual and being ridiculed as a result (Rotheram-Borus, Hunter, & Rosario, 1994).

Heterosexism has been identified as the social and cultural oppression experienced by same-sex attracted individuals; however, its impact on said individuals has been conceptualized as minority stress (Balsam, Beadnell, & Molina, 2013). Some of the stressors experienced as a condition of heterosexism include discrimination and daily hassles, which have both been shown to have negative effects on psychological well-being (Miller & Kaiser, 2001; Miller & Major, 2000; Swim, Johnston, & Pearson, 2009). Daily hassles have been defined as the commonplace irritating and distressing demands that often characterize everyday transactions with the environment (Wheaton, 1996).

Similar to other stressors, experience with discrimination can present itself in the form of major life events (e.g., sudden traumas or life changing events which are relatively intermittent) and daily hassles (distressing everyday communications), both of which can have damaging effects on psychological well-being because they can potentially strain the resources available to address certain circumstances (Miller & Kaiser, 2001; Miller & Major, 2000) and can, in turn, cause long-term psychological, physical, health, social, and functional (e.g., job performance) effects (Harrell, 2000). More particularly, heterosexist daily hassles have been defined as statements or actions that reflect or communicate inimical, depreciating, or pillorying attitudes and beliefs about same-sex attracted individuals that are entrenched in people’s daily lives (Swim, Johnston, & Pearson, 2009). These often include jokes, expressions of stereotypes and insults, threats of violence, exclusion from conversation or events, hostile treatment, and fear of having one’s sexual orientation disclosed (see Swim, Pearson, & Johnston, 2007). They are not
identical to chronic stressors but, collectively, are relatively frequent, again in juxtaposition to major life events. Moreover, other types of daily hassles have been associated with an assortment of effects including threats to psychological well-being (e.g., depression; Bouteyre, Maurel, & Bernaud, 2007) and biophysical consequences (e.g., increases in cortisol levels; Ice, 2005), as well as behavioral responses harmful to the self (e.g., smoking; Guthrie, Young, Boyd, & Kintner, 2001) and harmful to others (e.g., criminal behavior; Eitle & Turner, 2003). As such, heterosexist hassles are hard to evade, infiltrate individual’s daily lives, and occur across multiple interpersonal spheres (Swim, Pearson, & Johnston, 2007). Swim, Johnston, and Pearson (2009) posit that heterosexist hassles have the potential to affect individuals in a variety of ways including mood, self-esteem, identity, and meta-perceptions (e.g., perceptions about others’ views of same-sex attracted individuals), which can lead to the internalization of oppressive ideologies about same-sex attraction, also known as internalized heterosexism.

Internalized heterosexism.

Often, it is presumed that same-sex attracted individuals have the option of concealing their sexual identity. Those who are more open to disclosing their sexual orientation are exposed to increased risk of external stressors; however, those individuals that choose to conceal their identity may be at increased risk for more internal stressors (Ragins, Singh, & Cornwell, 2007). Internalized heterosexism (IH) is the internalization by lesbian, gay, and bisexual-identified individuals of negative attitudes, stereotypes, and assumptions about same-sex attraction that are prevalent in society (Szymanski, Kashubeck-West, & Meyer, 2008). Internalized heterosexism can range from mild (the tendency to self-doubt) to severe (overt self-hatred and self-destructive behaviors) and


often negatively affect same-sex attracted individuals and lead to psychological distress throughout the course of their lives (Brown, 1988; Malyon, 1982; Szymanski, 2005). For example, Szymanski and Chung (2003) reported that lesbian internalized heterosexism was correlated with a variety of negative mental health outcomes, such as depression, decreased social support, and higher levels of demoralization. Hence, it is important to note that internalized heterosexism (similar to the detrimental impact of internalized racism discussed earlier) plays a critical role as a triggering factor in several aspects of illness and may affect both the progression of illness and decision-making processes related to the individual’s health and illness prevention (Williamson, 2000).

**Double Jeopardy.**

The literature presented above demonstrates researchers’ tendency to focus only on the effects of racism or heterosexism, independently, without taking into consideration the cumulative effects of the stress experienced as a result of identifying as both a racial and sexual minority. For example, Black sexual minority women experience stigma and discrimination within the Black community based on their sexual orientation (Battle & Crum, 2007; Bowleg et al., 2003; Greene, 1994) and within the sexual minority community based on their race (Battle & Crum, 2007; Loiacano, 1989). Bowleg (2012) posited that the experiences of Black sexual minority women cannot be deduced from research documenting disparities among “Blacks,” “sexual minorities,” or “women” as singular groups. From the perspective of intersectionality, social identities and associated inequities depend upon and construct one another (Bowleg, 2008; Cole, 2009). A given combination of marginalized social statuses creates an idiosyncratic experience that is different from that which is created by the combination of any fewer of those statuses,
including unique discrimination experiences (Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015). Bowleg’s (2012) study demonstrated important differences in exposure to discrimination and associated mental health risks that exist within unidimensional groupings such as those listed above. Categorization based on one marginalized status alone fails to account for experiencing intersecting oppressions based on multiple marginalized statuses (Collins, 2000).

In order to address this discrepancy, double jeopardy theorists have explicitly focused their studies on people with more than one stigmatized social status (Browne & Misra, 2003). The term double jeopardy is traditionally used by scholars who are interested in emphasizing the accumulative disadvantage experienced by people with multiple subordinate-group statuses (Almquist, 1975; Cortina, 2001; King, 1988; Epstein, 1973; Reid, 1984). Double jeopardy was initially introduced in the early 1970’s to describe dual discrimination on the basis of racism and sexism (Beale, 1979). By 1988, research had advanced to include discrimination based on sexual orientation (King, 1988). Originally, research on double jeopardy was grounded in the experience of Black American women; however, research further investigated the approach with Asian American women (Lien, 1994), Asian American sexual minorities (Chung & Katayama, 1998), Black American sexual minorities (Bowleg, Huang, Brooks, Black, & Burkholder 2003; Carbado, 2000), Latino immigrant women (de Synder, Cervantes, & Padilla, 1990), and Native American lesbians (Witt, 1981).

Studying double or multiple jeopardies is geared towards understanding and explaining how disadvantage accrues to shape the experience of discrimination for people with intersecting stigmatized group statuses (Hancock, 2007). There are two general
models that conceptualize research on double jeopardy: the interactive model and the additive model. The interactive model argues that a person’s marginalized identities interact in a collaborative way. In other words, the identities are combined and experience discrimination as a “multiply marginalized other” (Crenshaw, 1993; Settles, 2006). Researchers advocating for the additive model argue that an individual with two or more intersecting identities experience the idiosyncratic forms of oppression linked with each of their subsidiary identities summed together (Purdie-Vaughns & Eibach, 2008). The more stigmatized identities an individual has, the more cumulative discrimination he or she will experience (Almquist, 1975; Epstein, 1973). Hence, double jeopardy models predict that individuals with multiple marginalized identities will experience more prejudice and discrimination than those with a single marginalized identity. For the purposes of the present study, the additive model will be explored further. More specifically, the current research tends to focus on understanding psychological distress for those individuals that identify as a double minority.

**Minority Stress Theory.**

One way to understand the distress experienced as a double minority may be with minority stress theory. Minority stress theory proposes that individuals from stigmatized social categories experience unique stressors in higher incidences than those stressors experienced by individuals not embodying a stigmatized social status. However, in order to understand minority stress theory, one must have a basic understanding of general stress. Stress has been defined as “any condition having the potential to arouse the adaptive machinery of the individual” (Pearlin, 1999a, p.163). It is important to highlight those potential factors that could initiate or cause stress, also known as ‘stressors.’
Stressors (individual and social) are events and conditions that cause change and require an individual to adapt to the new situation or life circumstance (Dohrenwend, 1998). The concept of social stress extends stress literature by suggesting that conditions in the social environment (e.g., discriminatory remarks, social exclusion, etc.) are not only primarily personal events but are also sources of stress that require individuals to adapt to new situations and life circumstances. Theoretical literature asserts that conflict or dissonance between the individual and their experience of society is the essence of all social stress (Allison, 1998; Barnett, Biener, & Baruch, 1987; Clark, Anderson, Clark, & Williams, 1999; Lazarus & Folkman, 1984; Meyer, 1995; Mirowsky & Ross, 2003; Pearlin, 1999). Theories about stress have focused on understanding the personal events that initiate stress (e.g., motorcycle accident, death of a child, etc.), rather than the social elements, such as prejudice and stigma (Lazarus & Folkman, 1984; Hobfoll, 2004; Pearlin, 1999). However, Meyer (2003) theorizes that social stress suggests that conditions in the social environment are also sources of stress that could potentially lead to mentally and physically ill effects. Moreover, many studies have also examined the additive and interactive links of events based upon an individual’s social categories that relate to psychological distress (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Fife & Wright, 2000; Jetten, Branscombe, Schmitt, & Spears, 2001; Meyer, 2003; Szymanski & Owens, 2009). Thus, experiencing social stress (e.g., prejudice or discrimination) could have an extensive impact on individuals belonging to multiple stigmatized social categories related to race/ethnicity, gender, socioeconomic status, sexuality, etc.

One extension of social stress is minority stress, the excess stress to which individuals from stigmatized social categories are exposed to as a result of their social,
often a minority, status or position (Meyer, 1995, 2003; Meyer, Schwartz, & Frost, 2008). Brooks (1981) defined minority stress as the stress associated with “categorically ascribed inferior status and blocked access to legitimate social and economic opportunities (p.78).” Brooks (1981) also asserted that lesbians experienced more stress than heterosexual women, due to various forms of discrimination, which ultimately lead to a threatened self-esteem and a reduced sense of security. Meyer (1995, 2003) expanded Brooks’ theory by focusing his attention on gay-identified men, in addition to lesbian-identified women. Meyer (1995, 2003) sought to account for the unique stressors that gay and lesbian-identified individuals encountered due to their membership in a socially stigmatized group.

In developing the theory of the minority stress model, Meyer (2003) postulated a list of basic assumptions about the nature of minority stress: a) minority stress is unique and is additive to the general stressors that all people experience, and thus, stigmatized people have more of a responsibility to develop an adaptation effort above what is traditionally required of others who are not a part of a stigmatized group; b) minority stress is chronic as it relates to stable, fundamental social and cultural configurations; and c) minority stress is socially based and established from social processes, institutions, and constructions beyond the individual.

Meyer (2003) also described minority stress processes along a distal-proximal continuum because of the emphasis placed on external social conditions and structures impacting individuals, as well as the prominence placed on conceptualizations of stress that seem most germane to minority stress. Meyer (1995) and Meyer and Dean (1998) proposed three primary processes of minority stress that should be considered relevant to
lesbian, gay, and bisexual individuals. In order from distal to proximal, they include: a) external, objective stressful events and conditions (both chronic and acute stress), b) expectations of said events and the attentiveness required by the expectation, and c) the internalization of negative societal attitudes.

Distal stressors are defined as objective events and conditions that do not depend on an individual’s perceptions or appraisals, although their report depends on awareness and ascription (Kobrynowicz & Branscombe, 1997; Operario & Fiske, 2001). Thus, distal stressors can be seen as independent of personal identification with the assigned minority status (Diamond, 2000). For example, a man could have a romantic relationship with another man but not identify as gay (Laumann, Gagnon, Michael, & Michaels, 1994). Nonetheless, if others perceive him as gay, he may suffer from stressors associated with prejudice toward lesbian, gay, bisexual-identified individuals. Contrarily, proximal stressors are defined as subjective because they rely on individual perceptions and appraisals of their sexual orientation status. In other words, proximal stressors are related to self-identification as lesbian, gay, or bisexual (Meyer, 2003). For example, due to the subjective nature of the proximal process, one lesbian-identified individual may conceal her sexual identity while another lesbian-identified individual may be more vigilant in her interactions with perceived heterosexual-identified individuals. Hence, such identities differ in the meanings individuals attach to them and the stress experienced by such individuals. Minority identity is linked to numerous forms of stress processes; thus, some same-sex attracted individuals may have expectations of rejection, conceal their sexual identities, or internalize stigma (Meyer, 2003). Moreover, research has suggested that concealment of one’s sexual orientation is also a critical process (2003). Concealment of
sexual orientation can be categorized as a proximal stressor because its stress effect is connected to an individual’s internal psychological processes (Cole, Kemeny, Taylor, & Visscher, 1996a, 1996b; DiPlacido, 1998; Jourard, 1971; Pennebaker, 1995).

Minority stress theory is derived from several sociological and social psychological theories that address the discrimination, microaggressions, and other challenges that minority individuals face (Meyer, 2003). Minority stress theory discusses the adverse effect of social conditions, such as prejudice and stigma, on the lives of affected individuals and groups (e.g., Allport, 1954; Crocker, Major, & Steele, 1998). Minority stress theory posits that people of disadvantaged social status (e.g., due to their race, gender, and/or sexual orientation) are exposed to social stress (e.g., discriminatory events) and resources (e.g., social support) related to the social status, and these social factors determine the impact of social status on mental health outcomes (Meyer, 2003). In particular, social stress is considered to mediate the relationship between social status and mental health (Meyer, 2003). According to minority stress theory, individuals who experience microaggressions because of both their racial/ethnic and sexual minority identities may be particularly vulnerable to poor mental and physical health (Balsam et al., 2011; Meyer, 2003). Allison (1998) and Clark et al. (1999) theorized that the disharmony between the individual and the dominant culture can be onerous and the resultant stress, significant. Contrary to Brooks’ (1981) theory that minority stress theory is a function of inferior status, Meyer (1995, 2003) contended that it was conflicting ideologies that caused stress. Meyer posited that disparities in mental health disorders are often linked to stressful experiences of stigma and discrimination that accompany the minority social identity. Thus, as a causal theory of mental disorders and well-being, the
unique stress that causes mental health problems leads people in disadvantaged social positions to have higher rates of mental disorders. Seemingly, this minority stress hypothesis has been supported; several studies and a meta-analysis of large-scale studies showed that, as predicted, LGB individuals had more mood, anxiety, and substance-use disorders than heterosexuals (Meyer, 2003).

**Combined Effects of Racism And Heterosexism.**

The literature presented thus far has articulated that racism and heterosexism can independently lead to psychological distress. The theory of double jeopardy posits that the combined effects of racism and heterosexism also contribute to higher incidences of psychological distress in individuals with multiple marginalized statuses. Accordingly, this section of the current study is focused on presenting the empirical evidence exploring the collective impact of racism and heterosexism utilizing minority stress theory.

Within the past decade, further research on minority stress theory, as it applies to same-sex attracted persons of color has been conducted. Although much additional work remains to be done, there is consistent evidence that these same-sex attracted persons of color do indeed experience environmental stressors related to their race and sexual orientation and that encountering such stressors does increase their likelihood of experiencing negative mental health consequences (Matthews & Adams, 2009; Meyer, 1995, 2003; Lewis, Derlega, Berndt, Morris, & Rose, 2001; Szymanski & Sung, 2010). For instance, individuals of color may experience discrimination within the predominantly White, mainstream, same-sex attracted community, as they may be objectified and eroticized by White LGBT individuals who are seeking to fulfill an exotic or passionate fantasy (Diaz, 1998; Han, 2001; Martinez & Sullivan, 1998). Chae and
Yoshikawa (2008) found that perceived depreciation of Asian American gay men by White gay men was associated with depression and sexual risk behavior among Asian American gay men. In another study, Diaz et al.’s (2001) study of gay and bisexual Latino men found that stress related to their sexual minority status, as well as to self-esteem, predicted psychological distress within this sample. Another survey of gay, lesbian, bisexual, and transgender Asian and Pacific Islander (API) men and women in New York found that 82% had personally experienced racism in the LGBT community and 96% believed that heterosexism was a problem in API communities (Dang & Hu, 2005). This differential treatment in both the community of color and mainstream White LGBT community may lead some same-sex attracted people of color to conceal certain aspects of their various identities depending on the context of their interactions with others, thus experiencing varying degrees of visibility and invisibility within their own communities as well (Crawford, Allison, Zamboni, & Soto, 2002; Fukuyama & Ferguson, 2000; Morales 1989).

Part II.

College Students.

The preceding section offered a thorough review of the literature that demonstrates the deleterious effects of racism and heterosexism, independently (e.g., racism or heterosexism) as well as combined (e.g., racism and heterosexism), on individuals embodying two marginalized statuses. The current researcher has hypothesized that one possible way to better understand the double jeopardy hypothesis may be with minority stress theory. The research on minority stress theory has primarily been conducted in the general adult population; however, little attention has been given to
college students. Research on this population has demonstrated that they experience significant mental health concerns that could benefit from further research. More specifically, increased attention should be given to treatment-seeking college students. Evidence indicates that college students face severe psychological issues (Drum, Brownson, Burton, & Smith, 2009). Little empirical attention has been given specifically to the experiences of college students, despite variable evidence that indicates an increase in the number of students who have a psychiatric disorder or who are currently seeking treatment. According to Hunt and Eisenberg (2010), the number of college-age individuals with mental illness is increasing. Almost 50% of college-age individuals have been diagnosed with a psychiatric disorder, this suggests that being in college should be considered a buffer or an indicator of a “better” status (Blanco et al., 2008). Eating disorders (Kurth, Krahn, Nairn, & Drewnowsk, 1995), self-injurious behavior (Serras, Saules, Cranford, & Eisenberg, 2010), anxiety-related problems (Eisenberg, Gollust, Golberstein, & Hefner, 2007), and alcohol abuse (Cranford, Eisenberg, & Serras, 2009) have been identified as common problems among college students. According to the American College Health Association (2011), depression among college students has also been identified as a very common psychological outcome of distress. Approximately 10% of college students are diagnosed with or treated for depressive symptomatology on a yearly basis and more than 30% of students report having felt too depressed to complete daily functions at least once during the past year (American College Health Association, 2011). Furthermore, each year 10% of college students seriously consider suicide; 1.5% attempt suicide; and 1,100 die by suicide (American College Health Association, 2009).
Most of the existing research on psychological distress has focused on the adult non-treatment seeking population. However, approximately 1.8 million students who are enrolled in United States colleges and universities seek treatment from their campus counseling centers each year (American College Health Association, 2011). Research has indicated that the services provided by college counseling centers are effective at relieving students’ psychological distress, facilitating academic functioning, and aiding campus retention efforts (Minami et al., 2009; Vonk & Thyer, 1999; Wilson, Mason, & Ewing, 1997). However, there is evidence that suggests that utilization of university counseling center services is inconsistent across various student racial/ethnic or sexual minority populations (Hayes, Youn et al., 2011). Because treatment-seeking college students are voluntarily admitting they experience psychological distress, researchers are better able to fully assess and address mental health outcomes, contributing factors, and effective interventions.

Similar to the research discussed in Part I, the impact of racism and heterosexism in the college student literature have primarily been examined separately, rather than collectively. The following section begins with an examination of the literature on the impact of racism on minority students’ mental health. Next, a review of the literature on the impact of heterosexism on sexual minority college students is provided. Lastly, the section concludes with an exploration of the literature on the combined effects of racism and heterosexism in the context of double jeopardy.

**Racism and college students.**

Racial/ethnic minorities have a long history of experiencing disparities in general life outcomes across multiple spheres (e.g., education, employment, and physical and
mental healthcare). Although the mental health of racial/ethnic minority college students is influenced by general stressors affecting all college students, including general academic stressors (Grayson, 1998), their mental health is also likely to be negatively affected by additional stressors, including experiences with racism and discrimination, traumatic stress, educational hegemony, insensitive comments, and questions of belonging on a college campus (Goodman & West-Olatunji, 2010; Okazaki, 2009; Smedley, Myers, & Harrell, 1993). Greer and Brown (2011) theorized that tolerating negative stereotypes, perceived discrimination, and cultural incongruity might place racial/ethnic minority students at risk for increased psychological distress.

Research has found that racial minority status negatively affects mental health, with consequences such as general psychological distress (Neville, Heppner, Ji, & Thye, 2004) and depression and anxiety symptoms (Jones, Cross, & DeFour, 2007; Kessler, Mickelson, & Williams, 1999). Additionally, Liang and Fassinger (2008) found that racism-related stress was related to lower self-esteem, interpersonal, and career concerns in a sample of 134 Asian American college students. These unique racialized stressors have been referred to as minority status stress and can lead to heightened feelings of not belonging and impede with students’ overall adjustment to college (Smedley, Myers, & Harrell, 1993). Racial minority status stressors have been linked to adverse college outcomes such as low-grade point average, poor psychological health, low social involvement, and decreased academic motivation (e.g., Greer & Chwalisz, 2007; Prillerman, Myers, & Smedley, 1989). Greer (2008) tested racial minority status stressors as predictors of overall levels of perceived stress and academic performance for African American students attending a Historically Black College and University. The results
indicated that racial minority stressors were the strongest predictors of overall levels of perceived stress, but were not predictive of academic performance.

Moreover, research indicates that students of color generally experience greater distress and are more likely to seek help from university counseling centers when their concerns are related to depression, general anxiety, hostility, family concerns, social anxiety, eating concerns, and academic issues (Hayes, Youn et al., 2011). Among students of color, utilization of campus counseling services has been contingent upon greater psychological distress, less family support, and a history of previous psychological problems. Hayes, Youn et al. (2011) found that among students of color, help seekers were more than 3 times as likely than non-help seekers to have been hospitalized for mental health concerns; 37% of the help seekers engaged in non-suicidal self-injurious behavior, which was more than two times the rate of non-help seekers; 36% of the help seekers had seriously contemplated suicide, as compared with 17% of students who did not seek help; and 16% of the help seekers had actually attempted suicide, whereas approximately 6% of students who did not seek help had previously attempted suicide. In general distress scores, students of color who sought help at university counseling centers were about half a standard deviation greater than for students of color who did not seek help at a university counseling center (Hayes, Youn et al., 2011).

**Heterosexism and college students.**

Minority stress theory and empirical research indicate that sexual minorities are at high risk of experiencing distal stressors as a function of having a sexual minority status (Meyer, 2003). Several researchers have found evidence supporting the higher rates of psychological distress in sexual minority individuals. McDermott and Schwartz (2013)
found that sexual minority emerging adult college men endorsed greater distress than heterosexual men with regard to questioning their gender role philosophies. Perhaps the increased distress is due to the fact that sexual minority men are forced to question their roles as men because they do not prescribe to the dominant heterosexist perceptions of masculinity (McDermott & Schwartz, 2013). Oswalt and Wyatt (2011) also found that lesbian, gay, bisexual, and questioning students consistently reported higher levels of mental health distress that resulted in academic concerns when compared to heterosexual-identified students.

A study conducted by Nelson, Castonguay, and Locke (2011) demonstrated that questioning-identified women reported statistically significantly higher rates on eating concerns (at a moderate level) than heterosexual women. Questioning-identified women also reported statistically significantly higher rates than bisexual women on eating concerns, at a moderate level, and lesbian women at both moderate and high levels. The study found that rates for questioning men were statistically significantly higher than heterosexual men on eating concerns, but only at the moderate level. The researchers hypothesized that these findings may be consistent with research suggesting that identity confusion or conflict may serve as a risk factor for eating concerns (e.g., Hooper & Garner, 1986). However, the findings may also suggest that identification within the lesbian, gay, bisexual, and transgender community may serve as a protective factor, assuming that questioning-identified individuals are typically less connected with that community.

Furthermore, research has found that 20% of students presenting at university counseling centers for treatment identify as sexual minorities (McAleavey, Castonguay,
In the aforementioned study, sexual minority students were 2-3 times more likely to be in counseling and indicated more distress (at intake) than their heterosexual peers. Additionally, when compared to heterosexual individuals, research suggests that sexual minorities are at higher risk for psychological distress (e.g., Bolton & Sareen, 2011; Cochran, Sullivan, & Mays, 2003; King et al., 2008; Mustanski, Garofalo, & Emerson, 2010; Safren & Heimberg, 1999). A meta-analysis indicated that lesbian, gay, and bisexual adults were 1.5 times more likely to be at risk for depression and anxiety disorders, 2 times more likely to have a suicide attempt, and 1.5 times more likely to have alcohol and other substance use dependence when compared to heterosexual adults (King et al., 2008). Thus, it is not surprising that sexual minority individuals tend to use mental health services more frequently than heterosexual-identified individuals (Cochran, Sullivan, & Mays, 2003; McAleavey et al., 2011). Given the rates of utilization and severity of concerns of sexual minority students at university counseling centers, it is important to gain more knowledge about the environmental factors that may help to reduce these risks.

**Combined effects of racism and heterosexism for college students.**

Although there have been a few studies conducted that provide information about same-sex attracted students of color, only one study has examined the double jeopardy hypothesis and minority stress theory. Hayes, Chun-Kennedy et al. (2011) sought to investigate psychological distress among college students who identified as both racial and sexual minorities. Data for the study were obtained from a pilot study conducted by the Center for Collegiate Mental Health (CCMH) and the CCMH-Student Affairs Administrators in Higher Education (NASPA) survey. Thus, analyses were conducted
for both a treatment seeking population and a non-treatment seeking population. Because of the relevance of Hayes, Chun-Kennedy et al. (2011) to the current study, it is described in considerable detail.

_Treatment seeking._ The first research question addressed was whether (a) among students seeking help from university counseling centers \( n = 31,866 \), racial/ethnic minority clients would report greater psychological distress than would European American clients and (b) non-heterosexual clients would report greater distress than would heterosexual clients. Due to small numbers from some of the minority groups, all racial minority clients were combined into a single group, as were all lesbian, gay, and bisexual clients. A multivariate analysis of variance (MANOVA) was conducted in which eight subscales of the Counseling Center Assessment of Psychological Symptoms (CCAPS) functioned as dependent variables and the two independent variables were race/ethnicity and sexual orientation. The MANOVA was found to be statistically significant. Follow-up analyses of variance (ANOVAs) demonstrated that racial/ethnic minority clients tended to report more distress than did European American students on the CCAPS Depression, Hostility, Family Distress, and Academic Distress subscales, and European American students tended to report more distress in relation to substance use. Lesbian, gay, and bisexual clients reported greater distress than did heterosexual clients on the CCAPS Depression, Eating Concerns, Generalized Anxiety, Hostility, Family Distress, and Social Anxiety subscales. Heterosexual clients did not report greater distress than lesbian, gay, or bisexual clients on any of the subscales.

The next research question investigated whether the psychological distress reported by racial/ethnic sexual minority clients would be greater in comparison to both
European American clients and heterosexual racial/minority clients. For the lesbian, gay, and bisexual clients only, a MANOVA was conducted in which the eight subscales of the CCAPS were the dependent variables and race/ethnicity was the independent variable. The MANOVA was found to be statistically significant. Follow-up ANOVAs indicated that racial/ethnic minority LGB clients had higher Hostility scores but lower Substance Use and Social Anxiety scores than did European American lesbian, gay, and bisexual clients. Next, for racial/ethnic minority clients only, another MANOVA was conducted in which the eight subscales of the CCAPS were the dependent variables and sexual orientation was the independent variable. The MANOVA was statistically significant. Follow-up ANOVAs indicated that lesbian, gay, and bisexual racial/ethnic minority clients had higher Depression, Substance Use, Generalized Anxiety, and Family Distress scores than did heterosexual racial/ethnic minority clients.

Non-treatment seeking. The same process was repeated in a sample drawn from the general student bodies of 45 colleges and universities (n = 30,290). All analyses were replicated. For the first analysis, the MANOVA was again found to be statistically significant. The follow-up ANOVAs demonstrated that racial/ethnic minority students reported more distress than did European American students on Depression, Hostility, Family Concerns, Social Anxiety, and Academic Distress subscales; however, European American students endorsed more distress related to Substance Use. Additionally, LGB non-treatment seeking students reported greater distress on all eight subscales, as opposed to results that treatment-seeking students only endorsed greater distress (relative to heterosexual students) on six subscales. Contrary to prior findings from treatment-seeking students, the second MANOVA, for lesbian, gay, and bisexual non-treatment
seeking students only was not statistically significant. According to the findings, racial/ethnic minority lesbian, gay, and bisexual students and European lesbian, gay, and bisexual students reported similar amounts of distress across the eight subscales of the CCAPS. Finally, for the third analysis, the results revealed that the MANOVA was statistically significant and lesbian, gay, and bisexual racial/ethnic minority students had higher scores on all subscales except Eating Concerns than did heterosexual racial/ethnic minority students. Thus, for lesbian, gay, and bisexual individuals in the general student body, belonging to a racial/ethnic minority group did not appear to be associated with any form of heightened psychological distress; therefore, the evidence did not support the double jeopardy hypothesis. Furthermore, there was also a general lack of support found for the double jeopardy hypothesis among double minority students who sought help from campus counseling centers. Contrary to these results, it is important to note that there was support for double jeopardy when comparing lesbian, gay, and bisexual students of color in relation to heterosexual students of color, whether treatment seeking or non-treatment seeking. Hence, the data suggest that the double jeopardy hypothesis holds for lesbian, gay, and bisexual students of color, but only when compared to heterosexual students of color.

Part III.

Gaps in the Literature.

After thoroughly reviewing the literature, it is clear that racial/ethnic and sexual minority, treatment seeking college students tend to experience heightened levels of psychological distress. However, research on these double minorities remains sparse. This researcher has identified three key areas taken into consideration when embarking
on the current research study: (1) the process of emerging adulthood; (2) sexual identity and fluidity/exploration; and (3) resiliency in regards to social support.

*Emerging adulthood.* Despite the extensive evidence supporting minority stress theory, research pertaining to college students is sparse. The college years represent a developmentally challenging transition to adulthood. Emerging adulthood (18-25 years old) is a distinctive time in the developmental process. This timeframe encompasses an exploration and substantiation of identities and philosophies (Arnett, 2004). During emerging adulthood, individuals go through many neurological and physiological changes that often impact their cognitive and socio-emotional developmental processes (Tanner & Arnett, 2009). As individuals transition from adolescence to young adulthood, maturation of their brain, along with environmental changes, challenge their ability to think critically about the world around them and solidify their identities without the pressure of managing typical adult obligations (Arnett, 2004; Bronfenbrenner, 1992; Tanner, Arnett, & Leis, 2009). Arnett (2000, 2004, 2006, 2007) maintains that the idiosyncratic features of emerging adulthood include negotiating experiences of instability, heightened self-focus, identity exploration, and feelings of transition. Exploring various facets of identity and sustaining flexible commitments in identity realms, such as work, education, race, and religion is conventional in emerging adulthood (Cote, 2006; Kroger & Marcia, 2011). When conflict among the values materializes, reconciling these differences with regard to an individual’s personal and social identities becomes particularly challenging and requires constant negotiation. Furthermore, paths of development are diverse in sequence and timing with no one set of identity labels reverberating with all modern-day emerging adults (Morgan, 2012).
The concept of identity is always presumed and widely discussed; however, diversely understood in the literature. The study of identity has been a hallmark of student development research. Many of the theories used in student affairs focus on identity as a developmental progression from simple, conferred ideas about oneself to more complex understandings of what encompasses identity (Marcia, 1993; Quintana, 2007). Moreover, most established theories mark development through progressive, linear stages or statuses that lead to an end result of internalized, synthesized, and permanent identities (Torres et al., 2009). Much of the literature has been anchored in the work of Erik Erikson, which queries how individuals come to know and understand their sense of self and their relationships with others. Erikson (1968) defined identity as “the ability to experience one’s self as something that has continuity and sameness, and to act accordingly” (p.42). His emphasis on a primarily internal and unconscious developmental process disregarded the contributions of social identity such as race, gender, and class. Josselson (1996) extended the definition of identity to be, “living our identity is much like breathing…We don’t have to ask ourselves each morning who we are. We simply are…Identity is never fixed; it continually evolves” (p.29). However, absent from these aforementioned and historical definitions are acknowledgments of the substantial influence of social identities such as race, gender, class, sexuality, and religion. More complex understandings recognize that identity is defined at both intrapersonal and interpersonal levels, consists of individual, relational, and collective identities, and includes multiple identities or spheres of identity that intersect and amalgamate with each other (Vignoles, Schwartz, & Luyckx, 2011). This perspective shifts views to a more sociological lens that directly identifies that the social world as one that is patterned by
structures of inequality and systems of both privilege and oppression (Abes & Kasch, 2007; Croteau, Talbot, Lance, & Evans, 2002; Torres, 2009; Weber, 2010) and considerably influenced by context (Jones, 2009). Hence, the starting point of refining identity theories is recognizing that individual identities cannot be separated from structures of inequality and social vicinities (Morgan, 2012).

Researchers have worked to shift the conceptualization of identity development to be a more active, multi-dimensional, and non-linear process in which there exists space for multiple trajectories and components that can be considered in the process of healthy identity formation. What do intersecting multiple identities mean in the construction of identity or sense of self? The question of what it means to live an authentic life or to express an authentic sense of self is ubiquitous in the identity literature. The need to manage advantaged and oppressed identities, as well as the tensions and interactions between both realms, brings about an awareness of both the internal and external influences on the possibility of fulfilling a level of considerable authenticity (Morgan, 2012). The reality is that context can complicate the way that individuals define themselves and contribute to levels of distress if not given sufficient attention and addressed with productive coping mechanisms. Archer and Grey (2009) asserted that stagnated identity development has been associated with poorer adjustment. As such, the college years have often been characterized as a time when individuals explore various parts of their identity and it appears reasonable to assume that exploration of their racial/ethnic and sexual identities are a significant part of this process (Morgan, 2012). Given the late onset of adult responsibilities and the prolonged time youth are taking to
explore their identity and question worldviews, at least within the United States, emerging adulthood is certainly a time frame in need of further investigation.

**Sexual identity and exploration.** An individual’s sexual orientation and sexual identity do not necessarily align entirely (Glover, Galliher, & Lamere, 2009; Savin-Williams, 2006). *Sexual orientation* has been defined as the early-developing, non-mutable, physiological predisposition toward configurations of sexual and romantic thoughts, affiliations, affections, or desires with members of the same sex, the other sex, both sexes, or neither sex (American Psychological Association, 2009; Diamond, 2005). *Sexual identity* has been conceptualized as an individual’s self-concept, comprising their cognitive and emotional understandings about the meaning and significance around sexual orientation predisposition and other aspects of their sexuality (APA, 2009; Horowitz & Newcomb, 2001; Savin-Williams, 2011). Often, when an individual chooses a sexual orientation label, it represents a conscious acknowledgement and internalization of one’s sexual orientation (Mohr, 2002). However, definitions and labels ascribed to sexual minorities may not describe their actual sexual attractions, relationships, fantasies, or behaviors (Morgan, 2012). Morgan suggested that sexual identity development is likely more emotional for young girls and sexual for adolescent boys (2012). Studies have suggested that boys become aware of same-sex feelings at approximately age 10 and girls at around age 11 (Omoto & Kurtzman, 2006). The study also suggested that self-labeling tends to occur about five years after the initial point of awareness (Telingator & Woyewodzic, 2011), followed by dating and sexual activities (Diamond & Savin-Williams, 2009). For example, in U.S.-based samples of sexual minority adults, women tended to endorse older ages of first awareness, same-sex occurrences, and self-
identification (Floyd & Bakeman, 2006; Grov et al., 2006). In these studies, no racial or ethnic differences regarding age of self-identification were found; however, racial and ethnic minorities were less likely to be out to parents and others. Floyd and Stein (2002) proposed that a fear of stigma, rejection, and other implications could influence sexual minority adolescents’ decisions to compartmentalize and hide their sexual identity until emerging adulthood when there is more freedom from parental control and peer stress from high school. They suggested that youth may be at elevated risk for mental health concerns because they may not have developed sufficient internal coping mechanisms or may lack the social and community support to help them navigate challenges that arise related to their identity development (Floyd & Stein, 2002).

Although emerging adulthood offers numerous possibilities, it is crucial to recognize that the transition to adulthood is still often equated with heteronormative milestones (Friedman et al., 2012). Heterosexual identities are often established without critical consideration or awareness due to the invisibility created by compulsory heteronormativity. Although lacking in empirical evidence, Worthington, Savoy, Dillon, and Vernaglia (2002) presented a model of heterosexual identity development in which heterosexuals cultivate and query their sexual identities through five identity phases: (1) unexplored commitment; (2) active exploration; (3) deepening and commitment; (4) diffusion; and (5) synthesis. Through this process, heterosexuals embark on a journey of query that transcends typical socially-mandated routes of examination. This process can take the form of cognitive or behavioral exploration with “symbolic or real sexual activities with same-sex partners” while maintaining the “privileged status associated with identification as heterosexual” (Worthington et al., 2002, p.517). However, little
research has explicated how the questioning process actually occurs. Per Worthington et al. (2002), participants indicated they had thoughts about and questioned their sexualities; however, the details of the questioning processes were often underdeveloped or absent. As noted earlier, sexual identity development is complex, multifaceted, and often a fluid process (Telingator & Woyewodzic, 2011). Sexual questioning processes can be defined as “struggles over identifying and authenticating subjective experiences of same-sex and other-sex attractions (Diamond, 2005, p.12). According to Morgan and Thompson (2011), sexual identity questioning is frequently left unreported in most studies, due to underdeveloped methodologies related to “questioning” status. In these studies, information on those with questioning statuses is gathered as a by-product rather than through a systematic, specific line of inquiry. Questioning sexual orientation does not require cognitive or behavioral participation in same-sex actions; thereby, this process may be more socially acceptable (Morgan & Thompson, 2011). Although this process of questioning is fairly passive, it exemplifies a willingness to surpass heteronormative assumptions and highlights an often-invisible identity. Hollander (2000) noted that most theories regarding sexual orientation identity development includes a period of uncertainty which involves questioning a presumed orientation, reflecting on attractions and imaginations, and/or experimenting with same- or other-sex partners. Research conducted has indicated that uncertainty about sexual orientation is associated with strong emotions, psychological distress, and maladjustment (BarAnan, Wilson, & Gilbert, 2009; Berman, Montgomery, & Kurtines, 2004; Carver et al., 2004; Espelage, Aragon, Birkett, & Koenig, 2008; Luyckx et al., 2008; Poteat, Aragon, Espelage, & Koenig, 2009; Weary, Marsh, & McCormick, 1994; Williams, Connolly, Pepler, & Craig, 2005). For
instance, adolescents who identified as uncertain about their sexual orientation or who self-labeled as “questioning” endorsed greater depressive symptoms, suicidal thoughts, and lower self-esteem than their peers who identified as more certain of their heterosexuality (Carver et al., 2004; Espelage et al., 2008; Poteat et al., 2009; Williams et al., 2005). Both heterosexual and sexual minority men are vulnerable to cultural constrictions and risk stigmatization when exploring, challenging, and substantiating their sexual identities through experiences of sexual identity questioning (Morgan, Steiner, & Thompson, 2010). Moreover, heterosexual men are often forced to foreclose on sexual minority identities because questioning processes can be miscomprehended as acts challenging traditional masculinity and evidencing automatic same-sex attraction labels (2010). In efforts to intentionally disrupt the construct of invisible heteronormativity, the term ‘queer’ has been used to challenge binary constructs of sexuality (Gamson, 1995; Roseneil, 2000). For example, Diamond’s (2008) emerging adult group of women explained that they rejected traditional sexual orientation labels as an intentional rejection of sex-based orientations, a sign reflecting openness to change, and a statement that the labels do not accurately reflect their lived experiences. It has been argued that the term ‘gay’ does not account for individuals who claim or manage multiple identities or fluid/flux in identity (Calzo, Antonucci, Mays, & Cochran, 2011).

Most models of sexual identity development fail to examine the function of multiple individual differences (e.g., race, ethnicity, socioeconomic status, gender, etc.). Questioning processes appear on a continuum of unelaborated to elaborated exploration and the processes differ significantly (Worthington et al., 2002). In understanding the impact of sexual orientation uncertainty, both group-specific minority stress and general
psychological processes must be contemplated (Hatzenbuehler, 2009). Individuals who embrace a more fluid sexual orientation may feel ostracized from both the heterosexual and same-sex attracted communities. Furthermore, individuals identifying as a double minority might be at increased risk of poor mental health outcomes because norms within the racial/ethnic community may reject the sexual identity uncertainty, causing a significant loss of social support. Because of the unique exposure to same-sex attracted individuals to minority stress, uncertainty or questioning may affect them more than heterosexual-identified individuals (Hatzenbuehler, 2009).

In sum, research on this population (i.e., questioning-identified emerging adults/college students) is sparse. By neglecting questioning-identified individuals in the literature, the field continues to marginalize them and their experiences, as well as ignore the distal and proximal stressors that serve as significant risk factors that could lead to increased negative mental health outcomes. Furthermore, if these questioning-identified individuals also identify as racial/ethnic minorities, the empirical evidence provides further rationale for the importance of examining this group. Currently, no extant research studies have been conducted with treatment-seeking, questioning-identified students of color that examines the double jeopardy nature of their lived experiences. Therefore, the current research serves to fulfill a sufficient gap in the literature.

Social support. Meyer (2010) discusses two hypotheses: (1) risk hypothesis and (2) resilience hypothesis. According to the risk hypothesis, sexual minorities of color are exposed to greater stress than White sexual minorities as a function of experiencing both racism and heterosexism. The risk hypothesis assumes that because of the rejection experienced within the sexual minority and racial minority communities, sexual
minorities of color often receive less support than White sexual minorities which contributes to decreased well-being. In contrast, the resilience hypothesis suggests that sexual minorities of color may be protected against the effects of excess stress related to heterosexism because of their prior experience with racism, which in turn could contribute to better well-being than White sexual minorities. In other words, sexual minorities of color may have greater coping capacity to minority stress than White sexual minorities. Herrick, Egan, Coulter, Friedman, and Stall (2014) suggested that the origin of resilience remains unknown and does not appear to be simply an individual characteristic inherent in some people and absent in others; rather, resilience can best be conceptualized by two primary factors: adaptation and process. Adaptation refers to positively making the necessary adjustments in the face of adversity and peril. Process refers to understanding that resiliency is both complex and fluid and is modulated by genetic and environmental facets. As such, individuals have the capacity to learn and demonstrate a variety of resiliencies over time while developing nuanced protective factors, as needed. Thus, resilience can and often does transmute the relationship between stress and health outcomes (Kertzner, Meyer, Frost, & Stirrat, 2009). For example, resilience explains the consistent findings in U.S. population studies that demonstrate Black individuals do not have higher rates of most mental disorders despite experiencing excess minority stress (Kertzner et al., 2009). Given this resiliency argument, it can be presumed that Black-identified individuals have good coping capacities and skills (personal and community resources) and therefore, the potential of negative effects of stress are challenged and depleted. Despite the appeal of this argument, Schwartz and Meyer (2012) suggested that this frame of thinking is antithetical to stress theory, which
suggests that disadvantaged groups have greater exposure to stress and greater barriers to resources. Thereby, these two arguments confuse the broad understanding of social stress theory and the stress-illness relationship. Nonetheless, the implications for mental health have received some research over the years and have become more apparent. Individuals with high resiliency tend to have less negative mental health effects and individuals with low resiliency report increased negative mental health effects (Holden, Bradford, Hall, & Belton, 2013). Holden et al. found that individuals with higher resiliency are associated with better treatment responses and outcomes.

Examples of strategies developed to help cope with and serve as protective factors against racism and/or heterosexism include: confronting prejudice, creating safe spaces or supportive networks, minimizing the prevalence and effect of stigma, and active self-acceptance and perseverance efforts (Adams, Cahill, & Ackerlind, 2005; Bowleg et al., 2003; Della, Wilson, & Miller, 2002). Little theory exists about how people with multiple marginalized statuses may demonstrate resilience despite minority stress (Greene, 1994; Stepakoff & Bowleg, 1998); however, for the current study, social support will be further explored.

Social support is considered a psychosocial coping resource that positively affects individuals’ personal capital such as self-esteem and self-efficacy, and in turn, buffers the negative effects of stress (Thoits, 1995). Many research studies have revealed that social support is associated with better psychological and physical health in the general population (Cohen, 2004). Cohen elaborated and stated that social relationships often promote health and well-being by way of two means: promotion of social connectedness and stress buffering. In an internet-based survey of 1,381 sexual minorities, higher
perceived social support was associated with lower depression and anxiety (Lehavot & Simoni, 2011). Furthermore, perceived social support was moderately to highly correlated with increased life satisfaction, decreased depression, and lessened feelings of loneliness in samples of lesbian-identified women from both university and community samples (Keleher, Wei, & Liao, 2010).

Social support from family and friends has been considered a significant factor in negotiating multiple minority statuses. Family and friend support has been associated with decreased depression and suicide risk in sexual minority young adults (Ryan, Huebner, Diaz, & Sanchez, 2009) and lessened internalized heterosexism in bisexual young adult college students (Sheets & Mohr, 2009). In Ryan et al. (2009), researchers asserted that sexual minority adolescents “who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse (p.350)” compared with peers that endorsed no to little family rejection. Robinson (1995) claimed that adolescents experienced increased global self-worth when there was a strong perception of parental support. Moreover, empirical evidence suggests that parents’ responses significantly influence sexual minority identity development in adolescents and young adults and plays a fundamental role in the development of an internal sense of self (Branje, van Aken, & van Lieshout, 2002; Bregman, Malik, Page, Makynen, & Lindahl, 2013). Thus, affirmation from family members is connected to increased self-esteem, improved health, decreased substance use, and better
psychological well-being among sexual minority adolescents and young adults (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

Research has confirmed that a social support network can help those who identify as a sexual minority navigate minority stress. One study found that some sexual minorities have sought refuge in communities called “House and Ball,” after being rejected by their biological families due to their sexual minority identity (Wong, Schrager, Holloway, Meyer, & Kipke, 2014). Researchers described these communities as identity-affirming spaces that facilitate the development of friendships and community among individuals with similar backgrounds and experiences (Wong et al., 2014). In these communities, “houses” resemble family-like entities connected to national social networks and “balls” are social events/parties/competitions hosted by different houses (Wong et al., 2014). House parents offer both emotional and instrumental support by providing financial assistance and offering basic necessities such as shelter, food, clothing, and transportation. These researchers studied the effects of “House and Ball” communities and confirmed that support and connection to social networks buffer the effects of minority stress regarding psychological well-being (2014). Findings also revealed a significant interaction between distal minority stress and the number of people providing instrumental support within study participants’ social networks. Overall, the Wong et al. study results demonstrated how participants’ connections to their social networks moderated the effects of minority stress on their mental health.

Contrary to research demonstrating the importance of familial support is research that suggests friend social support is the most significant factor for decreasing negative symptomatology in sexual minority individuals. A study conducted by Oetjen and
Rothblum (2000) found that lesbian-identified women reported that friend social support was associated with greater lessening of depressive symptoms than was family social support when both social support systems were entered in a regression analysis. Additionally, Masini and Barrett (2007) found that sexual minority adults aged 50 and older reported that friend social support was more associated with significantly improved quality of life, lowered depressive and anxiety-related symptoms, and diminished internalized heterosexism than was family social support. In summary, whether referring to friend or family social support, much of the literature has indicated that social support for minority stressors is important for sexual minorities and these individuals often thrive when connected to affirming social networks.

Baumeister and Leary (1995) suggested that feeling connected to community often represents an extension of the foundational human desire to belong which is positively associated with individual and social outcomes and crucial to developing a collective sense of identity (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Gamson, 1995). Given the significance of community connectedness, it is imperative to explore whether subgroups of sexual minorities or those embodying multiple marginalized identities differ in the degree to which they feel connected to the LGBT community. Racial and ethnic sexual minorities may feel less connected to the LGBT community because many aspects of the LGBT community are White and male-oriented (Han, 2007). Thereby, racial and ethnic sexual minorities may feel invisible and marginalized as a function of racism experienced in these communities (Binnie & Skeggs, 2004; Han, 2007). Utilizing an intersectionality perspective can be beneficial in understanding possible ways that sexual minorities of color may define and experience community
connectedness. For example, studies with Black-identified lesbian women have
demonstrated differences in norms related to sex and gender roles typical of White
lesbian-identified communities (e.g., butch and femme dichotomy) and how those norms
do not accurately describe or apply to Black lesbian communities (Wilson, 2009). This is
important to note as Meyer (2003) discussed the importance of group-level coping
resources in mitigating minority stress with individuals embodying multiple marginalized
statuses.

These findings highlight the importance of learning more about this population
and the psychological impact of the distal and proximal stressors that contribute to the
minority stress faced by university counseling center, treatment-seeking students.
Minority stress theory posits that the increased stress faced by minority individuals leads
to an increased level of psychological distress, particularly when individuals are unable to
successfully increase their capacity to cope. Minority stress theory provides a framework
for extending the research towards a more strengths-based approach by assessing how
social support influences the level of proximal distress experienced. More specifically,
through minority stress theory, the current research can examine if social support affects
levels of psychological distress.

**Current Research.**

The aforementioned section described three significant gaps in the literature: (1)
the process of emerging adulthood; (2) sexual identity and fluidity/exploration; and (3)
resiliency in regards to social support. As a result of the developmental processes
occurring during the college years and the likelihood for added psychological distress as
a by-product of embodying multiple marginalized statuses, further exploration of
minority stress theory, as evidenced in university counseling center treatment-seeking, same-sex attracted students of color, more particularly those that are questioning their sexual identity, is warranted. Until 2009, the studies available on the mental health of treatment-seeking college students provided mixed results and made it extremely difficult to identify definitive, clinically meaningful conclusions. The studies that were available were not intended or designed to provide empirical evidence or reliable data on the mental health needs of college students. To address this major discrepancy in the field, the Center for Collegiate Mental Health (CCMH) was developed. One of the primary goals of CCMH is to provide a better understanding of the psychological needs of college students by bridging the gap between practice and research. CCMH describes college student mental health on a national level while simultaneously conducting large-scale psychotherapy research and improving the range of clinical tools available to practitioners in university counseling centers (CCMH, 2012).

CCMH found that treatment seekers were experiencing more distress than non-treatment seeking populations (CCMH, 2011). Accordingly, the best way to assess psychological distress among divergent populations is by examining distressed individuals who are voluntarily seeking treatment. Most research conducted on these populations is built on studies that tend to have small, local samples whose findings are difficult to generalize. One solution to this problem is to utilize a resource, such as CCMH, which collects data nationally from a diverse array of counseling centers. As evidenced by Locke, Bieschke, Castonguay, and Hayes (2012), CCMH provides a platform to examine a population that receives little to no empirical exploration in the literature. As such, CCMH allows the current researcher to examine data collected from
numerous colleges and universities across the United States in efforts to make more appropriate generalizations of findings to university counseling center, treatment-seeking, questioning-identified students of color.

Furthermore, Hayes, Chun-Kennedy et al. (2011) hypothesized the importance of examining coping resources and resilience in regards to accounting for the lack of support for the double jeopardy hypothesis. Accordingly, the current research aims to replicate and extend the research of Hayes et al. by addressing the following research questions: (1) Do racial/ethnic minority students experience more distress than white students? (2) Do sexual minority students (LGBQ) experience more distress than heterosexual students? (3) Do those with a double minority identity experience more distress than those with a single minority identity? (4) How does the stability of one’s sexual identity influence the amount of distress experienced? (5) Is the relationship between social support and psychological distress moderated by one’s questioning status? (6) For double minorities, is the relationship between social support and distress moderated by one’s questioning status?
CHAPTER THREE: METHODS

Participants

Center for the Study of Collegiate Mental Health (CCMH)

Participants were drawn via data collected from 2012-2015 from the Center for Collegiate Mental Health (CCMH). CCMH is an international, multi-disciplinary, member-driven, practice-research-network developed in response to a need for bridging the gap between research and practice regarding college students seeking treatment. CCMH is focused on providing accurate and up-to-date information about the mental health of college students in support of the effort to serve the needs of mental health providers, administrators, researchers, and the general public (Locke et al., 2012). CCMH is comprised of over 400 participating college and university counseling centers in the United States and abroad that use a common data management system providing anonymized data for both clinical and research purposes. Participating institutions vary in student population size, ranging from 1,500 to 40,000 students. Each CCMH counseling center routinely collects data via two standardized instruments. The first instrument is the Standardized Data Set (SDS), which students typically complete during the intake process of the course of treatment. The second instrument is the Counseling Center Assessment of Psychological Symptoms (CCAPS), which is a psychometrically rigorous assessment tool that is free, clinically useful for college counseling centers, and contributes valuable information to the science of mental health in college students. The CCAPS exists in both a 62-item version (often distributed at intake) and a shorter 34-item version for repeated measurement or brief assessment (CCMH, 2012).
For inclusion in the present study, students must have been administered the CCAPS-62 at intake and provided information related to age, race, sexual orientation, family support, and friend support on the SDS. Further information regarding data cleaning is discussed in Chapter Four. In total, 60,871 participants were included in this study. Participant ages ranged from 18-25 ($M=20.74$, $SD=1.64$). The majority of participants identified as White (71.1%). The remaining participants identified as one of the following: Black/African-American (9.7%), American Indian or Alaskan Native (0.3%), Asian/Asian American (5.6%), Hispanic/Latino/a (8.3%), Native Hawaiian or Pacific Islander (0.2%), or Multi-racial (4.8%). Of the participants, 64.5% identified as women and 35.5% as men. Most participants were undergraduate (94.2%) and 5.8% were graduate students. The preponderance of participants identified as heterosexual (88.7%), 1.6% identified as lesbian, 2.6% identified as gay, 5.0% as bisexual, and 2.2% as questioning. Exclusionary criteria included transgender-identified and international students. Though it is essential for future studies to include these students, they were outside the scope of the present study for methodological reasons.

Given the study’s intent to replicate Hayes, Chun-Kennedy et al.’s (2011) study, all racial/ethnic participants were collapsed to form a single “racial/ethnic minority group.” For similar reasons, all participants that identified as lesbian, gay, bisexual, and questioning were collapsed to form a single sexual minority group however, the current study’s research questions require multiple analyses of different sexual minority statuses. Thus, although the racial/ethnic participants remained grouped, there was a more fluid exploration of independent sexual minority statuses. See Tables 1-3 for more descriptive sample statistics.
Measures

**Standardized Data Set (SDS).** The SDS (CCMH, 2012) currently contains eight major components which obtains information regarding demographics (i.e., gender, race, sexual orientation, etc.), presenting concerns, and mental health history for treatment-seeking college students. The SDS has been revised numerous times since its original development in efforts to improve questions/answers contributing to new sections of assessment to balance the needs of researchers and practitioners (CCMH, 2017b). SDS items collect relevant information linked to treatment provided to students receiving services; however, does not provide empirical data regarding levels of distress. For this study, only the Client Information component was utilized. Sample SDS questions include, “What is your race/ethnicity” and “What is your gender identity.”

Two SDS items (22 and 23) were used to measure social support in the current study. Item 22 assesses family support: “Please indicate how much you agree with this statement: I get the emotional help and support I need from my family.” The item is on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Item 23 assesses friend support: “Please indicate how much you agree with this statement: I get the emotional help and support I need from my social network (e.g., friends & acquaintances).” The item is on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Per review of the literature and having discussions with some of the CCMH staff, it does not appear that these items have been used as a measure of social support in any previous research studies. No additional information about the two questions was available.
College Center Assessment of Psychological Symptoms (CCAPS). The CCAPS’ self-report instruments are used to measure specific areas of psychological distress in treatment-seeking college students. There are currently two forms of the CCAPS, the CCAPS-34 and the CCAPS-62. Only the CCAPS-62 is used in this study. The longer version of the CCAPS has a total of 62 items, with each item corresponding to one of eight subscales. The subscales included on the CCAPS-62 are: Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, Substance Use and Family Distress.

For this study, only seven of the CCAPS-62 subscales were used to assess levels of psychological distress in treatment-seeking college students (the rationale for the omission of the Family Distress subscale is given below). The Depression subscale seeks to measure student depressive symptomatology (e.g., “I feel isolated and alone,” and “I lose touch with reality”). The Generalized Anxiety subscale seeks to assess for fears of panic attacks, sleep difficulties, and other symptoms of anxiety (e.g., “My heart races for no good reason” and “I am easily frightened or startled”). The Social Anxiety subscale assesses comfort around people and feelings of self-consciousness (e.g., “I am shy around others” and “I am concerned that other people do not like me”). The Academic Distress subscale focuses on academic confidence, motivation, and concentration (e.g., “I am not able to concentrate as well as usual” and “I am unable to keep up with my school work”). The Eating Concerns subscale consists of questions about eating habits and thoughts (e.g., “I feel out of control when I eat” and “The less I eat, the better I feel about myself”). The Hostility subscale captures concerns around temper and acts or thoughts of violence towards others (e.g., “I have difficulty controlling my anger” and “I feel
irritable”). The Substance Use subscale assesses controlled substance use (e.g., “I use drugs more than I should” and “I drink alcohol frequently”).

The last CCAPS-62 subscale, the Family Distress subscale, assesses for history of family abuse, feelings toward family, and information about hope for family interactions (e.g., “I get sad or angry when I think of my family” and “There is a history of abuse in my family”). McAleavey et al. (2012) reported good internal consistency and that the Family Distress scale was correlated with the Self-Report Family Inventory total score ($r = .62$). Although there is not a significant amount of information available on the Family Distress subscale, information is readily available for the Self-Report Family Inventory (SFI). SFI is positioned on two specific constructs, family competence and family style (Beavers & Hampson, 2000). Family competence is related to the structure and adaptive elasticity of the family system (Hamilton & Carr, 2016). High levels of competency are indicative of the capacity to adapt the family system structure to effectively deal with stressful situations (Hamilton & Carr, 2016). Family style is theorized as a family’s method of interaction, either ranging from families who perceive most satisfaction coming from within the family or outside the family system (Hamilton & Carr, 2016). Movement between family styles is facilitated by high competence and affiliated with improved family functioning (Hamilton & Carr, 2016). The SFI has been deemed a reliable and valid family assessment measure. The Family Distress subscale is only on the CCAPS-62; therefore, not included or measured on the CCAPS-34 or Distress Index (DI). In the present study, the Family Distress scale was used as a measure of social support given that the subscale inquiries about the student’s perception of
feeling loved by his/her family members, which in turn provides information about the presence or lack of social support.

Additionally, to address the last two research questions of the study, the CCAPS’ Distress Index (DI) was used as the primary measure of overall psychological distress. The DI was created in response to CCMH member requests for an amalgamated measure of overall distress (Nordberg et al., in press) despite controversial literature regarding the psychometric properties and clinical bases of utilizing a total-score approach (CCMH, 2015). In order to allow for flawless integration between the CCAPS-62 and CCAPS-34 over time, the DI is calculated only from CCAPS-34 specific items (i.e., Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use). The DI was developed by evaluating numerous different models, including a second-order factor model, a bifactor model, and a simple total score composed of every item on the CCAPS (CCMH, 2017a). Upon completion of these analyses, the bifactor model was deemed the best fit (CCMH, 2017a).

The CCAPS-62 items were developed via a collaborative process with 15-20 university counseling center clinicians who had a particular interest in providing useful and relevant clinical assessment tools for their other counseling center peers. To begin, the clinicians proposed themed subscales and created an initial pool of 167 items. After an iterative process of proposing and agreeing on a number of items for inclusion, the CCAPS-62 was further developed using statistical analyses such as exploratory factor analysis (EFA) and confirmatory factor analysis (CFA). In a principal study, 2,155 counseling center clients completed the CCAPS-62 at their initial appointment (Locke et al., 2011). The results of the EFA identified a 9-factor model which included a ninth
subscale (Spirituality), which was later removed. After completion of a CFA, the results generated the current assessment tool which includes 62 items and 8 factors (Locke et al., 2011). This final 8-factor model was implemented with a sample of 22,060 students seeking treatment at university counseling centers.

Locke et al. (2011) reported good internal consistencies for Depression (.92), Eating Concerns (.93), Substance Use (.89), Generalized Anxiety (.84), Hostility (.86), Social Anxiety (.82), Family Distress (.84), Academic Distress (.80), and the Distress Index (.92). Subscales on the CCAPS have also correlated with other established measures of distress. Using a Pearson product-moment correlation, McAleavey et al. (2012) found that the Depression subscale was highly correlated with the Beck Depression Inventory (BDI) ($r = .82$); the Eating Concerns subscale was correlated with the Eating Attitudes Test-26 ($r = .58$); the Substance Use subscale was correlated with the Alcohol Use Disorders Identification Test ($r = .60$); the Generalized Anxiety subscale was correlated with the Beck Anxiety Inventory ($r = .69$); the Social Anxiety subscale was highly correlated with the Social Phobia Diagnostic Questionnaire ($r = .75$); the Academic Distress subscale was correlated with the Academic Adjustment subscale of the Student Adaptation to College Questionnaire ($r = -.69$); and the Hostility subscale was correlated to the Trait Anger subscales of the STAXI-2. One-week test-retest stability coefficients were between .78 and .93 for each of the eight subscales. Furthermore, two-week test-retest stability coefficients were between .76 and .92 indicating that the scales are stable over short periods of time (McAleavey et al., 2012).

**Procedure**
All counseling centers contributing data to CCMH were required to first receive approval through their respective college or university Institutional Review Board (IRB). Additionally, CCMH received IRB approval from The Pennsylvania State University in order to acquire data from those contributing counseling centers.

Participants were instructed to complete an informed consent form giving permission to contribute their de-identified information to CCMH for research purposes (see Appendix B). Participants were administered a SDS and CCAPS-62 at their initial intake appointment via the Titanium Electronic Medical Record (EMR) system. Completion of the CCAPS-62 typically takes students between seven to ten minutes to complete. Data were collated by CCMH and then cleaned of identifiable indicators. Data utilized in this study were collected from 2012-2015. Of the total data set, cases were selected by first identifying those institutions that specifically administered the CCAPS-62 at intake, and then by those participants having answered the required SDS items.

**Analytic Plan**

Data were cleaned and prepared for analysis. Specific information regarding the process for analyzing missing data, multicollinearity, normality, homoscedasticity, and clarifying criteria for inclusion of cases is discussed further in Chapter Four.

The first portion of the study examined whether treatment-seeking racial/ethnic minority college students reported more psychological distress than treatment-seeking white college students and whether treatment-seeking sexual minority students reported more psychological distress than heterosexual students. Next, there was an assessment of the level of psychological distress amongst double minority students in comparison to the
distress experienced by both white sexual minority students and racial/ethnic minority heterosexual-identified students. Subsequently, the psychological distress amongst questioning-identified students compared to heterosexual-identified students, as well as, questioning-identified students compared to LGB-identified students was assessed. Further, double minority (racial/ethnic and questioning status) students’ levels of distress were compared to the distress experienced by white questioning-identified students and racial/ethnic minority heterosexual-identified students, respectively.

To compare the psychological distress of racial/ethnic minority students to white students and sexual minority students to heterosexual students, a MANOVA was conducted in which seven of the subscales of the CCAPS served as dependent variables and race/ethnicity and sexual orientation were the independent variables. Follow-up ANOVAs were then conducted. To compare the psychological distress of racial/ethnic sexual minority students to White sexual minority students and racial/ethnic minority heterosexual students, a MANOVA was conducted in which seven of the CCAPS subscales were deemed the dependent variables and race/ethnicity was the independent variable for LGBQ students only. Follow up ANOVAs were then conducted. Next, for racial/ethnic minorities only, a MANOVA was conducted in which the seven subscales of the CCAPS were the dependent variables and sexual orientation was the independent variable. Follow up ANOVAs were also conducted. To assess the influence of the stability of one’s identity on the amount of distress experienced, a 2x5 MANOVA was conducted in which seven of the CCAPS subscales served as the dependent variables and sexual orientation and race were the independent variables. Next, follow-up ANOVAs were conducted.
For the second portion of the study, the investigator sought to assess the role questioning status played in influencing the relationship between social support (per SDS item #22- Family Support; SDS item #23- Friend Support; and the Family Distress subscale from CCAPS-62) and psychological distress (per the Distress Index). To examine these two research questions, a series of linear regression analyses were conducted using the Hayes PROCESS Macro (Hayes, 2013). One of the constraints programmed into PROCESS is that only a single independent variable can be listed in the x=part of the command line (Hayes, 2013). Therefore, six separate regression analyses, using the Distress Index as the outcome variable, one of the social support items as the predictor variable, and questioning status as the moderator variable were conducted. In the first three moderation models, all questioning identified students were included; however, the last three moderation models only included those that identified as a double minority (racial/ethnic minority and questioning status). Although gender was not a critical variable in this study, previous literature has identified existence of moderate gender effects as it relates to social support and psychological distress (Bowker & Ramsay, 2011; Lee & Goldstein, 2016; Levesque, 2011). Therefore, gender was included as a co-variate in each of the six moderation models.
# Table 1

*General Description of Key Sample Variables*

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<tr>
<th>Variable Name</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Women</td>
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<tr>
<td>Men</td>
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<td>Gay</td>
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<td>Bisexual</td>
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<td>Questioning</td>
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<tr>
<td>$SD = 1.64$</td>
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Table 2

*Description of Sample-Stratified by Broad Racial Categories*

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<th>Race</th>
<th>White (n)</th>
<th>Minority (n)</th>
<th>White (%)</th>
<th>Minority (%)</th>
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<td><strong>Gender</strong></td>
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<td>27,318</td>
<td>11,963</td>
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<tr>
<td>Man</td>
<td>15,937</td>
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<td><strong>Sexual Orientation</strong></td>
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</tr>
<tr>
<td>Heterosexual</td>
<td>38,755</td>
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</tr>
<tr>
<td>Bisexual</td>
<td>2,042</td>
<td>974</td>
<td>4.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Questioning</td>
<td>834</td>
<td>489</td>
<td>1.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Academic Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freshman</td>
<td>10,226</td>
<td>4,055</td>
<td>23.6%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Sophomore</td>
<td>10,220</td>
<td>4,099</td>
<td>23.6%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Junior</td>
<td>10,618</td>
<td>4,351</td>
<td>24.6%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Senior</td>
<td>9,760</td>
<td>4,031</td>
<td>22.6%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Graduate/Professional Student</td>
<td>2,431</td>
<td>1,080</td>
<td>5.6%</td>
<td>6.1%</td>
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</table>
Table 3

*Description of Sample Stratified Race by Sexual Orientation (n)*

<table>
<thead>
<tr>
<th>Race</th>
<th>White</th>
<th>AA</th>
<th>AI/AN</th>
<th>AA/A</th>
<th>H/L</th>
<th>NH/PI</th>
<th>Multi</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
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<tr>
<td>Woman</td>
<td>27,318</td>
<td>4,189</td>
<td>135</td>
<td>2,175</td>
<td>3,410</td>
<td>90</td>
<td>1,964</td>
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<tr>
<td>Man</td>
<td>15,937</td>
<td>1,730</td>
<td>64</td>
<td>1,221</td>
<td>1,624</td>
<td>55</td>
<td>959</td>
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<td><strong>Sexual Orientation</strong></td>
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</tr>
<tr>
<td>Heterosexual</td>
<td>38,755</td>
<td>5,111</td>
<td>168</td>
<td>3,063</td>
<td>4,313</td>
<td>132</td>
<td>2,458</td>
</tr>
<tr>
<td>Lesbian</td>
<td>584</td>
<td>147</td>
<td>6</td>
<td>37</td>
<td>102</td>
<td>1</td>
<td>64</td>
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<tr>
<td>Gay</td>
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<td>162</td>
<td>5</td>
<td>72</td>
<td>220</td>
<td>7</td>
<td>85</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2042</td>
<td>323</td>
<td>11</td>
<td>137</td>
<td>269</td>
<td>3</td>
<td>231</td>
</tr>
<tr>
<td>Questioning</td>
<td>834</td>
<td>176</td>
<td>9</td>
<td>87</td>
<td>130</td>
<td>2</td>
<td>85</td>
</tr>
</tbody>
</table>

*Note: AA means African American; AI/AN means American Indian/Alaska Native; AA/A means Asian American/Asian; H/L means Hispanic/Latino; NH/PI means native Hawaiian/Pacific Islander; Multi means Multiracial (n= 60,871)*
CHAPTER FOUR: RESULTS

This chapter provides a summary of the results of statistical analyses conducted to examine the specific research questions, as described in the preceding chapters.

Description of the Sample

The final data set used for analysis was a combination of CCMH data collected from 2012-2015. The original data set included participants who completed two specific measures: the CCAPS-62 and SDS. Duplicate clients/cases were examined and only the initial administration of the SDS and CCAPS-62 cases were retained ($n = 164,158$). The mean, standard deviation, skewness, kurtosis, and standard errors were calculated for all student outcome variables and can be found in Table 4. Since student status, race/ethnicity, sexual orientation, and gender (man or woman, specifically) were all important variables of interest, cases with missing data were eliminated. If cases had missing variables on any items of the CCAPS-62 or the social support questions on the SDS, they were also eliminated. Cases were removed if a participant self-identified their race/ethnicity, gender, or sexual orientation in a way that could not be categorized. For example, if the self-identified response to sexual orientation was “sapiosexual-pansexual,” the case was eliminated due to lack of clarity about how this response would be categorized and the decreased likelihood that this self-identified response would be frequently written in by other participants. Race/ethnicity having a written in response of “other” is another example of an eliminated case due to decreased capacity to categorize the response.

After dropping non-students, the sample decreased to 156,550. Dropping transgender or self-identified gender decreased the sample size to 147,405. The sample
size decreased to 139,197 if participants did not identify as heterosexual, lesbian, gay, bisexual, or questioning. Participants were dropped if they self-identified their race and/or did not endorse one of the seven classifications used in this study, decreasing the sample size to 126,615. Participants who did not answer the family support question dropped the sample size to 75,615. Participants who did not answer the friend support question dropped the sample to 74,003.

Client age was restricted to 18-25 and cases above age 25 were eliminated because the literature consistently determined 18-25 to be classified as emerging adulthood which was a foundational point of the study (Arnett, 2004). Moreover, choosing this specific age range assists with generalizability of results to other university counseling center treatment-seeking populations. After restricting the age range, the sample size decreased to 61,070. Lastly, after deleting cases that did not have a Distress Index score for assessing two of the main research questions, the final sample size for this research was 60,871.

**Preliminary Analysis**

The primary statistical program utilized to clean the data and conduct the MANOVA and ANOVA analyses for the study was STATA (release 15). SPSS was used to complete the regression analyses. Data were examined to determine if there were any problems with missing data due to non-response or other issues. Little’s MCAR test in Stata was conducted and it was determined that the missing data set values were missing completely at random (MCAR). Given the large sample size, it was reasonable to utilize listwise deletion to drop cases in which there were missing data on variables of interest (Tabachnick & Fidell, 2013). Next, both univariate and multivariate outliers were
investigated. Analysis revealed no outliers were included in the final sample. To make statistical significance more stringent and meaningful a $p \leq 0.001$ was established as the standard.

**Assumptions**

Tabachnick and Fidell (2013) emphasize the importance of screening data to insure testing assumptions are met prior to data analysis. The current investigation utilized a Multivariate Analysis of Variance (MANOVA) approach which encompasses the following assumptions: normality, linearity, homogeneity of variance, absence of outliers, and absence of multicollinearity. Histograms of the residuals were used to examine normality, linearity, and homogeneity of variance (Tabachnick & Fidell, 2013). Examination of the residual plots revealed that data followed a linear pattern and that there were no issues related to the violation of homogeneity of variance. However, data did not appear to be normally distributed. Next, the distribution for each variable was evaluated for skewness and kurtosis. Tabachnick and Fidell (2013) note that the significance level of skewness and the impact of the departure from zero kurtosis diminishes with large samples and does not have a tendency to deviate enough from normality to make a substantive difference in the analysis. Furthermore, Tabachnick and Fidell (2013) clearly note that the assumption of normality is evaluated with respect to the sampling distribution of means (not the distribution of scores) and the Central Limit Theorem predicts normality in decently sized samples ($N \geq 30$) with respect to grouped data. Therefore, because the assumption of normality was not required, data transformation was not conducted. To assess for the absence of multicollinearity, the correlation coefficients between the predictor variables were examined. Multicollinearity
can be identified by correlations greater than .70 (Tabachnick & Fidell, 2013). Upon examination, there were no associations indicative that the data were collinear.

**Primary Analyses**

*Question 1: Do racial/ethnic minority students experience more distress than white students?*

*Question 2: Do sexual minority students (LGBQ) experience more distress than heterosexual students?*

In order to address the aforementioned two questions, a MANOVA test was conducted which involved a comparison of the means of white and racial/ethnic minorities as well as heterosexual and sexual minority (LGBQ) participants. A MANOVA was conducted in which seven subscales of the CCAPS served as dependent variables and the two independent variables were race/ethnicity and sexual orientation. Gender was not a critical variable in this portion of the study. The MANOVA was statistically significant for race/ethnicity, $F(7,60863) = 309.22$, partial eta squared = 0.0343 and sexual orientation, $F(7,60863) = 145.13$, $p < 0.001$, partial eta squared = 0.0164. As reflected in Table 6, follow-up ANOVAs revealed that racial/ethnic minority students reported more distress than White students on Depression, Eating Concerns, Hostility, and Academic Distress and white students reported more distress related to Substance Use and Generalized Anxiety. There were no differences in regard to Social Anxiety for white and racial/ethnic minority students. LGBQ students reported more distress than heterosexual students on all seven subscales (i.e., Depression, Eating Concerns, Substance Use, Generalized Anxiety, Hostility, Social Anxiety, and Academic Distress).
Question 3: Do those with a double minority identity experience more distress than those with a single minority identity?

Next, the psychological distress reported by double minority (racial and sexual minority) students was compared to both white LGBQ and racial/ethnic heterosexual students. First, for LGBQ students only, a MANOVA was conducted in which the seven subscales of the CCAPS were the dependent variables and race/ethnicity was the independent variable. The MANOVA was statistically significant, $F(7,6863) = 31.64, p < .001$, partial eta squared = 0.0313. As reflected in Table 8, follow-up ANOVAs indicated that double minority students had greater Depression, Eating Concerns, Hostility, and Academic Distress scores as compared to white LGBQ students. However, white LGBQ students evidenced significantly higher Generalized Anxiety and Social Anxiety scale scores, with heightened Substance Use scores noted as well. Second, for racial/ethnic minority students only, a MANOVA was conducted in which the seven subscales of the CCAPS were the dependent variables and sexual orientation was the independent variable. The MANOVA was statistically significant, $F(7,53992) = 284.24, p < 0.001$, partial eta squared = 0.0355. As reflected in Table 10, follow-up ANOVAs indicated that double minority students had greater distress on all seven subscales (i.e., Depression, Eating Concerns, Substance Use, Generalized Anxiety, Hostility, Social Anxiety, and Academic Distress) when compared to heterosexual racial/ethnic minority students.

Question 4: How does the stability of one’s sexual identity influence the amount of distress experienced?

A 2x5 MANOVA was conducted in which the seven subscales of the CCAPS served as dependent variables and sexual orientation and race were the independent
variables. For racial/ethnic sexual minorities, the MANOVA was statistically significant, $F(28,63477.2) = 15.33, p < 0.001$, partial eta squared $= 0.0067$. For white sexual minorities, the MANOVA was also deemed statistically significant, $F(28, 155919) = 34.55, p < 0.001$, partial eta squared $= 0.0062$. As reflected in Tables 10 and 11, follow-up ANOVAs indicated that questioning-identified students reported greater distress on all seven subscales when compared to heterosexual-identified students. When compared to LGB-identified students, questioning-identified students endorsed more distress on all subscales except for Substance Use. Next, double minority status was compared to single minority (white questioning and racial/ethnic heterosexual) status. The follow-up ANOVAs indicated that double minority students reported greater distress on the Depression, Eating Concerns, Hostility and Academic Distress subscales than White questioning-identified students. However, White questioning-identified students endorsed greater distress on the Substance Use, Generalized Anxiety, and Social Anxiety subscales. When compared to racial/ethnic heterosexual students, double minority students endorsed higher distress scores on all seven subscales of the CCAPS.

**Question 5: Is the relationship between social support and distress moderated by one’s questioning status?**

To address this question, a series of linear regression analyses were conducted using the Hayes PROCESS Macro (Hayes, 2013). The set of regression analyses tested three moderation models. It is important to note that one of the constraints programmed into PROCESS is that only a single independent variable can be listed in the $x$=part of the command line (Hayes, 2013). Therefore, for each model, one of the three predictor variables (SDS #22- Family Support; SDS #23- Friend Support; or Family Distress
subscale from CCAPS-62) was entered into the model. In all of the models, gender was included as a co-variante given that women comprised almost 65% of the sample and gender has been evidenced as correlated with social support in the literature (Adamczyk & Segrin, 2015; Lee & Goldstein, 2016). Furthermore, the Distress Index served as the outcome variable and sexual orientation status (categorized as LGB, heterosexual, and questioning) served as the moderator variable. For all moderation analyses in the study, variables of interest were centered before analysis in efforts to make the constant more meaningful and interpretable. For each model, dummy codes were used to support the three-level categorical sexual orientation moderator. Thus, two interaction terms were included in the models to accurately represent the data. To account for running multiple models on the same outcome variables, the significance was more stringently established, p < .02.

**Family support.** Overall, model one was significant and explained 9% of the variance in psychological distress ($R^2 = .091$, $F_{(6,60684)} = 1019.11$, $p < .001$). When the interaction terms between sexual orientation and family support were added to the regression model, there was no significant proportion of the variance explained, $\Delta R^2 = .000$, $\Delta F(2,60864) = 12.31$, $p = .001$, $b = -.1419$, $p < .01$ for LGB or $\Delta R^2 = .000$, $\Delta F(2,60864) = 12.31$, $p = .001$, $b = -.1287$, $p < .01$ for questioning status. Thus, when family support is increased, overall distress is decreased. For questioning status specifically, the impact of increased family support has the least effect in the model.

**Friend support.** Overall, model two was statistically significant and explained 10% of the variance in psychological distress ($R^2 = .10$, $F_{(6,60684)} = 1110.21$, $p < .001$). When the interaction terms between sexual orientation and friend support were added to
the regression model, there was no significant proportion of the variance explained, $\Delta R^2 = .000$, $\Delta F(2,60864) = 11.65$, $p = .001$, $b = -.1600$, $p<.01$ for LGB or $\Delta R^2 = .000$, $\Delta F(2,60864) = 11.65$, $p = .001$, $b = -.1622$, $p>.02$ for questioning status. Thus, when friend support is increased, overall distress is decreased. For questioning status specifically, friend support did not significantly moderate the model per established significance levels. If $p < .03$, questioning status would have demonstrated a moderation effect.

_Family distress._ Overall, model three was also statistically significant and explained 17% of the variance in psychological distress ($R^2 = .17$, $F(6,60684) = 2035.89$, $p < .001$). When the interaction terms between sexual orientation and family distress were added to the regression model, there was no significant proportion of the variance explained, $\Delta R^2 = .000$, $\Delta F(2,60864) = 23.47$, $p = .001$, $b = .2842$, $p<.01$ for LGB or $\Delta R^2 = .000$, $\Delta F(2,60864) = 23.47$, $p = .001$, $b = .2660$, $p<.01$ for questioning status. Thus, as family distress increased, overall distress increased. Results indicated that questioning status significantly moderated the relationship between family distress and overall distress. Additionally, those with questioning status experienced the least distress in this model.

_Question 6: For double minorities, is the relationship between social support and distress moderated by one’s questioning status?_

To address this question, the same modality as discussed in the aforementioned question was implemented; however, the specific sample for this question was specified as double minority (racial/ethnic questioning minority) students. Thus, model one was
family support, model two was friend support, and model three was family distress. The DI remained the dependent variable. The interaction terms remained the same.

**Family support.** Overall, model one was statistically significant and explained 10% of the variance in psychological distress ($R^2 = .10, F_{(6,17609)} = 313.94, p < .001$). When the interaction terms between sexual orientation and family support were added to the regression model, there was no significant proportion of the variance explained, $\Delta R^2 = .000, \Delta F(2,17609) = 2.62, p = .07, b = -.1612, p<.01$ for LGB or $\Delta R^2 = .000, \Delta F(2,17609) = 2.62, p = .07, b = -.1301, p<.01$ for questioning status. Thus, results are similar to model one for questioning only students. Questioning status did not significantly moderate the relationship between family support and psychological distress. No significant interactions were found.

**Friend support.** Overall, model two was statistically significant and explained 7% of the variance in psychological distress ($R^2 = .07, F_{(6,17609)} = 232.37, p < .001$). When the interaction terms between sexual orientation and friend support were added to the regression model, there was no significant proportion of the variance explained, $\Delta R^2 = .000, \Delta F(2,17609) = 2.50, p = .08, b = -.1257, p<.01$ for LGB or $\Delta R^2 = .000, \Delta F(2,17609) = 2.50, p = .08, b = -.1746, p<.01$ for questioning status. Questioning status did not significantly moderate the relationship between friend support and psychological distress. No significant interactions found.

**Family distress.** Overall, model three was statistically significant and explained 19% of the variance in psychological distress ($R^2 = .19, F_{(6,17609)} = 673.04, p < .001$). When the interaction terms between sexual orientation and family distress were added to the regression model, there was no significant proportion of the variance explained, $\Delta R^2$
= .000, $\Delta F(2,17609) = 8.75, \ p = .000, \ b = .3193, \ p<.02$ for LGB or $\Delta R^2 = .000$,

$\Delta F(2,17609) = 8.75, \ p = .000, \ b = .2562, \ p<.02$ for questioning status. Questioning status significantly moderated the relationship between family distress and psychological distress for double minorities which is congruent with the findings for family distress in the previous question. It is important to note that questioning-identified individuals experienced the least amount of distress in the model.

Contextual discussion of the aforementioned results will occur in the next chapter. Additionally, exploration of theoretical considerations, clinical and research implications, as well as, limitations, and future directions will be explicated.
Table 4

Descriptive Statistics for the Outcome Variables

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Std. Error</th>
<th>Kurtosis</th>
<th>Std. Error</th>
<th>Coefficient Alpha</th>
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<tbody>
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<td>Depression</td>
<td>1.68</td>
<td>0.94</td>
<td>0.07</td>
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<td>GenAnxiety</td>
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<td>.84</td>
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<td>Academic</td>
<td>1.88</td>
<td>1.01</td>
<td>0.04</td>
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<td>Eating</td>
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<td>2.22</td>
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<td>.02</td>
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<td>0.52</td>
<td>.01</td>
<td>2.38</td>
<td>.02</td>
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**Table 5**

*Correlations Among and Descriptive Statistics for Key Study Variables*

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<td>2.Eating</td>
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<td>0.20**</td>
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<td>0.17**</td>
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<td>0.26**</td>
<td>0.47**</td>
<td>1.000</td>
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<td>0.40**</td>
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<td>0.31**</td>
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<td>7.Family</td>
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<td>0.22**</td>
<td>0.11**</td>
<td>0.33**</td>
<td>0.39**</td>
<td>0.24**</td>
<td>1.000</td>
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<td>8.Academic</td>
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<td>0.23**</td>
<td>0.19**</td>
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<td>9.FamSupport</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.Sexual Orientation</td>
<td>0.12**</td>
<td>0.07**</td>
<td>0.03**</td>
<td>0.10**</td>
<td>0.08**</td>
<td>0.10**</td>
<td>0.13**</td>
<td>0.05**</td>
<td>-0.11**</td>
<td>-0.02**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.Race</td>
<td>-0.04**</td>
<td>0.00</td>
<td>0.09**</td>
<td>0.04**</td>
<td>-0.10**</td>
<td>0.01**</td>
<td>-0.11**</td>
<td>-0.04**</td>
<td>0.11**</td>
<td>0.11**</td>
<td>-0.03**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.Gender</td>
<td>0.08**</td>
<td>0.23**</td>
<td>-0.10**</td>
<td>0.17**</td>
<td>-0.01**</td>
<td>0.06**</td>
<td>0.10**</td>
<td>-0.01**</td>
<td>-0.01**</td>
<td>-0.01**</td>
<td>0.06**</td>
<td>0.00</td>
<td>-0.05**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>14.Age</td>
<td>-0.01*</td>
<td>-0.01</td>
<td>0.07**</td>
<td>0.03**</td>
<td>0.02**</td>
<td>-0.01</td>
<td>0.04**</td>
<td>0.06**</td>
<td>-0.04**</td>
<td>-0.02**</td>
<td>0.01*</td>
<td>-0.05**</td>
<td>-0.06**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>15.DistressIndex</td>
<td>0.90**</td>
<td>0.39**</td>
<td>0.24**</td>
<td>0.83**</td>
<td>0.65**</td>
<td>0.59**</td>
<td>0.40**</td>
<td>0.67**</td>
<td>-0.28**</td>
<td>-0.28**</td>
<td>0.13**</td>
<td>-0.00</td>
<td>0.07**</td>
<td>0.03**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed).**
*Correlation is significant at the 0.05 level (2-tailed).
### Table 6

**Main Effects for Race and Sexual Orientation**

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>Race/Ethnicity</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>European American</td>
<td>Racial/Ethnic Minority</td>
</tr>
<tr>
<td></td>
<td>(n = 43,255)</td>
<td>(n = 17,616)</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>1.65 0.93</td>
<td>1.76&lt;sup&gt;a&lt;/sup&gt; 0.96</td>
</tr>
<tr>
<td><strong>Eating Concerns</strong></td>
<td>1.01 0.90</td>
<td>1.05&lt;sup&gt;a&lt;/sup&gt; 0.88</td>
</tr>
<tr>
<td><strong>Substance Use</strong></td>
<td>0.84&lt;sup&gt;a&lt;/sup&gt; 0.89</td>
<td>0.68 0.85</td>
</tr>
<tr>
<td><strong>Generalized Anxiety</strong></td>
<td>1.73&lt;sup&gt;a&lt;/sup&gt; 0.94</td>
<td>1.69 0.93</td>
</tr>
<tr>
<td><strong>Hostility</strong></td>
<td>0.98 0.83</td>
<td>1.18&lt;sup&gt;a&lt;/sup&gt; 0.94</td>
</tr>
<tr>
<td><strong>Social Anxiety</strong></td>
<td>1.92 0.97</td>
<td>1.92 0.95</td>
</tr>
<tr>
<td><strong>Academic Distress</strong></td>
<td>1.85 1.01</td>
<td>1.96&lt;sup&gt;a&lt;/sup&gt; 1.03</td>
</tr>
</tbody>
</table>

<sup>a</sup>Mean significantly elevated above within-group comparison, \( p \leq 0.001 \). LGBQ = lesbian, gay, bisexual, and questioning.

CCAPS = Counseling Center Assessment of Psychological Symptoms.
Table 7

$\eta^2$ Effect Sizes (95% CI) for Race and Sexual Orientation

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>Minority vs. European American</th>
<th>LGBQ vs. Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0.0030 (0.0022-0.0039)</td>
<td>0.0130 (0.0113-0.0149)</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>0.0003 (0.0001-0.0007)</td>
<td>0.0045 (0.0035-0.0056)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.0072 (0.0059-0.0086)</td>
<td>0.0009 (0.0005-0.0014)</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>0.0005 (0.0002-0.0009)</td>
<td>0.0096 (0.0081-0.0112)</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.0106 (0.0091-0.0123)</td>
<td>0.0066 (0.0054-0.0079)</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>0.0000 (-0.0007)</td>
<td>0.0093 (0.0079-0.0109)</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>0.0023 (0.0016-0.0032)</td>
<td>0.0025 (0.0018-0.0033)</td>
</tr>
</tbody>
</table>

CCAPS = Counseling Center Assessment of Psychological Symptoms.
Table 8

*Main Effects for Single and Double Minority Students*

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>LGBQ</th>
<th></th>
<th>Heterosexual</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>European American</td>
<td>Racial/Ethnic Minority</td>
<td>European American</td>
<td>Racial/Ethnic Minority</td>
</tr>
<tr>
<td></td>
<td>(n = 4,500)</td>
<td>(n = 2,371)</td>
<td>(n = 38,755)</td>
<td>(n = 15,245)</td>
</tr>
<tr>
<td>Depression</td>
<td>1.96&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.99&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.02&lt;sup&gt;a,c&lt;/sup&gt;</td>
<td>0.91&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>1.18&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.93&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.21&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.92&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.88&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.91&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.85&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.94&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>2.00&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>0.92&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.92&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.92&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.16&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.87&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.38&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>0.98&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>2.21&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>0.95&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.12&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.95&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>2.00&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.98&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.07&lt;sup&gt;a,c&lt;/sup&gt;</td>
<td>1.02&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Mean significantly elevated above within-group comparison, \( p \leq 0.05 \).
<sup>b</sup>Mean significantly elevated above within-group comparison, \( p \leq 0.001 \).
<sup>c</sup>Mean significantly elevated above between-group comparison, \( p \leq 0.001 \).
LGBQ = lesbian, gay, bisexual, and questioning.
CCAPS = Counseling Center Assessment of Psychological Symptoms.
Table 9

$\eta^2$ Effect Sizes (95% CI) Race by Sexual Orientation

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>LGBQ—Minority vs. European American</th>
<th>Heterosexual—Minority vs. European American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0.0009 (0.0000-0.0028)</td>
<td>0.0027 (0.0019-0.0037)</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>0.0003 (-0.0016)</td>
<td>0.0002 (0.0000-0.0005)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.0004 (-0.0019)</td>
<td>0.0092 (0.0076-0.0108)</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>0.0023 (0.0006-0.0051)</td>
<td>0.0005 (0.0002-0.0010)</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.0131 (0.0083-0.0189)</td>
<td>0.0096 (0.0080-0.0113)</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>0.0021 (0.0005-0.0049)</td>
<td>0.0000 (-0.0001)</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>0.0014 (0.0002-0.0037)</td>
<td>0.0023 (0.0015-0.0031)</td>
</tr>
</tbody>
</table>

CCAPS = Counseling Center Assessment of Psychological Symptoms.
Table 10

**MANOVA Stability of Sexuality-Double Minority**

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>Lesbian (n = 357)</th>
<th>Gay (n = 551)</th>
<th>Bisexual (n = 974)</th>
<th>Questioning (n = 489)</th>
<th>Heterosexual (n = 15,245)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Depression</td>
<td>1.86d</td>
<td>0.97</td>
<td>1.91a,c,1</td>
<td>0.91</td>
<td>2.08a</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>1.06c</td>
<td>0.89</td>
<td>1.17b,1</td>
<td>0.91</td>
<td>1.24a</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.82b</td>
<td>0.93</td>
<td>0.87a</td>
<td>0.94</td>
<td>0.87a</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>1.80c,1</td>
<td>0.90</td>
<td>1.80c,d</td>
<td>0.93</td>
<td>2.01a,1</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.46a,1</td>
<td>1.05</td>
<td>1.17d,g,1</td>
<td>0.91</td>
<td>1.48a,b,1</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>1.91d,f,1</td>
<td>0.94</td>
<td>2.09a</td>
<td>0.99</td>
<td>2.15a,1</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>1.97</td>
<td>1.04</td>
<td>1.93d,f</td>
<td>1.02</td>
<td>2.16a,1</td>
</tr>
</tbody>
</table>

*Mean significantly different from heterosexual, p < 0.001.
*bMean significantly different from heterosexual, p < 0.01.
*cMean significantly different from heterosexual, p < 0.05.
*dMean significantly different from bisexual, p < 0.01.
*eMean significantly different from bisexual, p < 0.05.
*fMean significantly different from questioning, p < 0.01.
*gMean significantly different from questioning, p < 0.05.
*hMean significantly different from gay, p < 0.05.
*iMean significantly different from gay, p < 0.01.
*jMean significantly different from white p <0.01.
;kMean significantly different from white p <0.05.
Table 11

**MANOVA Stability of Sexuality-White**

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>Lesbian (n = 584)</th>
<th>Gay (n = 1,040)</th>
<th>Bisexual (n = 2,042)</th>
<th>Questioning (n = 834)</th>
<th>Heterosexual (n = 38,755)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Depression</td>
<td>1.89&lt;sup&gt;a,e,f&lt;/sup&gt;</td>
<td>0.94</td>
<td>1.77&lt;sup&gt;a,d,f&lt;/sup&gt;</td>
<td>0.89</td>
<td>2.02&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>1.08&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>0.93</td>
<td>1.03&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>0.86</td>
<td>1.24&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.84</td>
<td>0.92</td>
<td>0.94&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.92</td>
<td>0.87</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>1.99&lt;sup&gt;a,e,h&lt;/sup&gt;</td>
<td>0.96</td>
<td>1.75&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>0.86</td>
<td>2.12&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.15&lt;sup&gt;a,h&lt;/sup&gt;</td>
<td>0.89</td>
<td>0.98&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>0.80</td>
<td>1.25&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>2.11&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>1.00</td>
<td>2.02&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.94</td>
<td>2.25&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>1.93</td>
<td>1.00</td>
<td>1.88&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td>0.99</td>
<td>2.04&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Mean significantly different from heterosexual, p < 0.001.
<sup>b</sup>Mean significantly different from heterosexual, p < 0.01.
<sup>c</sup>Mean significantly different from heterosexual, p < 0.05.
<sup>d</sup>Mean significantly different from bisexual, p < 0.01.
<sup>e</sup>Mean significantly different from bisexual, p < 0.05.
<sup>f</sup>Mean significantly different from questioning, p < 0.01.
<sup>g</sup>Mean significantly different from questioning, p < 0.05.
<sup>h</sup>Mean significantly different from gay, p < 0.05.
Table 12

$\eta^2$ Effect Sizes (95% CI) for Questioning by Sexual Orientation

<table>
<thead>
<tr>
<th>CCAPS Subscale</th>
<th>Questioning—Minority vs. European American</th>
<th>LGB—Minority vs. European American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0.0003 (0.0000-0.0032)</td>
<td>0.0009 (0.0000-0.0032)</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>0.0006 (0.0000-0.0016)</td>
<td>0.0002 (0.0000-0.0016)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0.0016 (0.0008-0.0088)</td>
<td>0.0002 (0.0000-0.0016)</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>0.0048 (0.0002-0.0150)</td>
<td>0.0019 (0.0003-0.0049)</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.0096 (0.0019-0.0226)</td>
<td>0.0139 (0.0085-0.0207)</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>0.0094 (0.0019-0.0224)</td>
<td>0.0014 (0.0001-0.0040)</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>0.0010 (0.0000-0.0032)</td>
<td>0.0014 (0.0001-0.0041)</td>
</tr>
</tbody>
</table>

CCAPS = Counseling Center Assessment of Psychological Symptoms.
Table 13

*Regression Analyses for Relationship between Family Support and Distress among All and Double Minority Students*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th>Double Minority Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>Gender</td>
<td>0.12</td>
<td>0.01</td>
</tr>
<tr>
<td>Family support</td>
<td>-0.18</td>
<td>0.00</td>
</tr>
<tr>
<td>Sexual orientation status (SOS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGB vs. others</td>
<td>0.23</td>
<td>0.01</td>
</tr>
<tr>
<td>Questioning vs others</td>
<td>0.34</td>
<td>0.02</td>
</tr>
<tr>
<td>Family support X SOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support X LGB</td>
<td>0.04</td>
<td>0.01</td>
</tr>
<tr>
<td>Support X Questioning</td>
<td>0.05</td>
<td>0.02</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>12.31**</td>
<td></td>
</tr>
</tbody>
</table>

Note: Total N = 60,871; Double Minority N = 17,616. Sexual Orientation represented as two dummy coded variables. Support variable mean centered.

*p < .05. **p < .01.
Table 14

Regression Analyses for Relationship between Friend Support and Distress among All and Double Minority Students

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th></th>
<th>Double Minority Sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>Gender</td>
<td>0.16</td>
<td>0.01</td>
<td>0.17</td>
<td>0.01</td>
</tr>
<tr>
<td>Friend support</td>
<td>-0.20</td>
<td>0.00</td>
<td>-0.16</td>
<td>0.01</td>
</tr>
<tr>
<td>Sexual orientation status (SOS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGB vs. others</td>
<td>0.31</td>
<td>0.01</td>
<td>0.30</td>
<td>0.02</td>
</tr>
<tr>
<td>Questioning vs others</td>
<td>0.36</td>
<td>0.02</td>
<td>0.31</td>
<td>0.04</td>
</tr>
<tr>
<td>Friend support X SOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support X LGB</td>
<td>0.04</td>
<td>0.01</td>
<td>0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>Support X Questioning</td>
<td>0.04</td>
<td>0.02</td>
<td>0.01</td>
<td>0.03</td>
</tr>
<tr>
<td>$R^2$</td>
<td>0.10</td>
<td></td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>11.65**</td>
<td></td>
<td>2.50</td>
<td></td>
</tr>
</tbody>
</table>

Note: Total N = 60,871; Double Minority N = 17,616. Sexual Orientation represented as two dummy coded variables. Support variable mean centered.

*p < .05, **p < .01.
Table 15

Regression Analyses for Relationship between Family Distress and Distress among All and Double Minority Students

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th></th>
<th>Double Minority Sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>Gender</td>
<td>0.06</td>
<td>0.01</td>
<td>0.08</td>
<td>0.01</td>
</tr>
<tr>
<td>Family Distress</td>
<td>0.35</td>
<td>0.04</td>
<td>0.38</td>
<td>0.01</td>
</tr>
<tr>
<td>Sexual orientation status (SOS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGB vs. others</td>
<td>0.18</td>
<td>0.01</td>
<td>0.18</td>
<td>0.02</td>
</tr>
<tr>
<td>Questioning vs others</td>
<td>0.31</td>
<td>0.02</td>
<td>0.29</td>
<td>0.04</td>
</tr>
<tr>
<td>Family Distress X SOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress X LGB</td>
<td>-0.07</td>
<td>0.01</td>
<td>-0.06</td>
<td>0.01</td>
</tr>
<tr>
<td>Distress X Questioning</td>
<td>-0.08</td>
<td>0.02</td>
<td>-0.12</td>
<td>0.04</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.17</td>
<td></td>
<td>.19</td>
<td></td>
</tr>
</tbody>
</table>

$F$ for change in $R^2$ 23.47** 8.75**

*Note: Total N = 60,871; Double Minority N = 17,616. Sexual Orientation represented as two dummy coded variables. Support variable mean centered.
*p < .05. **p < .01.
CHAPTER FIVE: DISCUSSION

Much of the previous literature has examined stress associated with identifying as a racial minority, independent of sexual orientation; however, there is ample empirical evidence demonstrating the negative physical and psychological effects presented as a function of identifying as a double minority (Greene, 1994; Hayes, Chun-Kennedy et al., 2011; Mays & Cochran, 2001). As discussed in Chapter Two, it is not the embodiment of a specific race or sexual orientation that contributes to the negative effects. Instead, the deleterious effects of systematic oppression (racism/heterosexism) is what often underwrites the experience of increased “race-related” (Harrell, 2000) and “gay-related” (Lindquist & Hirabayashi, 1979) stress. Often, these experiences are exacerbated by internalized racism and heterosexism (Carter & Reynolds, 2011; Szymanski, Kashubeck-West & Meyer, 2008). Meyer’s (1995; 2003) minority stress theory (MST) provides a framework for understanding the adverse effect of social conditions, such as prejudice and stigma, on the lives of individuals with multiple marginalized statuses.

There is a multitude of research that examines stress as a function of MST in the average adult population; however, minimal attention has been directed towards college students. The traditional college years, also known as emerging adulthood (18-25 years old), represent a significant developmental milestone as students work towards exploring their autonomy and substantiating their identities (Arnett, 2004). During this time, students utilize both internal and external processes of negotiation as they explore the various aspects of their being, to include management of advantaged and oppressed social identities within structures of inequality and social vicinities (Morgan, 2012). Increasing their sense of awareness as it relates to their racial/ethnic and sexual identities is an essential part of this process (Morgan, 2012). Greer and
Brown (2011) posited that negative stereotypes, perceived discrimination, and cultural incompatibility might place these students at risk for increased psychological distress.

Research on college students has gained attention over the years. Colleges and universities have reported significant increases in students’ utilization rates of counseling services (Byrd & McKinney, 2012; CCMH, 2017a) and the severity of symptoms (Drum, Brownson, Denmark, & Smith, 2009). Evidence clearly suggests that students experience notable mental health concerns (Tosevski, Milovancevic, & Gajic, 2010), particularly for the emerging adult who also identifies as a double minority (Torres, Jones, & Renn, 2009). Nonetheless, little empirical attention has been allocated to the experiences of double minority college students seeking mental health treatment. Prior to the completion of this research, only one study had examined double jeopardy hypothesis and MST in an effort to investigate psychological distress among college students who identified as a dual minority (Hayes, Chun-Kennedy et al., 2011).

After thoroughly reviewing the literature, it was clear that research on double minority treatment-seeking college students was sparse, but warranted attention. If evidence reveals that this population is at increased risk of negative psychological outcomes, why does the literature continue to disregard them? Moreover, the question becomes, why has research perpetually depended on a risk perspective and not explored the possibility of a resiliency framework, to include social support, if it might effectively mitigate the distress experienced by this population?

Summary of the Findings

Research Questions 1-3

The first objective of this study was to replicate a portion of Hayes, Chun-Kennedy et al. (2011) by assessing whether treatment-seeking (1) racial/ethnic minority students reported
greater psychological distress than white students; (2) sexual minority students reported greater
distress than heterosexual students; and (3) double minority (racial LGBQ) students reported
greater distress than single minority students (white sexual minority and heterosexual racial
minority students, respectively).

Results were predominantly consistent with results found in Hayes, Chun-Kennedy et al.
(2011). Racial/ethnic minority students reported greater psychological distress than white
students related to depression, hostility, and academics. Congruent with Hayes, Chun-Kennedy
et al. (2011), findings demonstrated no significant differences regarding social anxiety; however,
white students reported more distress related to substance use.

For sexual minority (LGBQ) students, as compared to heterosexual students, results
showed more distress across all seven subscales. This result is contrary to Hayes, Chun-Kennedy
et al. (2011), which noted comparable distress between sexual minorities and heterosexuals
associated with substance use and academic distress. Consistent with previous literature, these
findings provide additional evidence that individuals with marginalized statuses are often
exposed to greater social stressors and appear to be at increased risk of worsening mental health
outcomes (Herek, Gillis, & Cogan, 2009; Pieterse & Carter, 2007).

Findings for the last query were also similar to Hayes, Chun-Kennedy et al. (2011), with
a few exceptions. Hayes, Chun-Kennedy et al. (2011) found no evidence for additive distress for
having a double minority status when comparing LGB students of color with white sexual
minority students, except regarding hostility. However, it is imperative to note that for both
Hayes, Chun-Kennedy et al. (2011) and this study, racial/ethnic minority students endorsed more
distress than white students on hostility across all sexual orientations; thus, this was not a unique
finding for LGBQ racial minority students. One distinct difference identified between Hayes,
Chun-Kennedy et al. (2011) and the current study is that Hayes found that double minorities (LGB racial/ethnic students) did not score higher than white sexual minorities on any other dimension of the CCAPS. Contrastingly, current findings revealed that LGBQ racial/ethnic students scored higher on depression and eating concerns. It should be noted however, that while there was such a difference, effects were small. Nonetheless, this finding suggests that there is minimal support for the double jeopardy hypothesis as it was materialized in this context.

When comparing LGB racial/ethnic students with heterosexual racial minority students, the results became a bit more interesting. LGB racial/ethnic minorities endorsed statistically significant more distress, on all seven subscales, than racial/ethnic heterosexual students. However, with further probing, it appeared that only small differences between the two groups existed, except for the hostility scale. This researcher is unaware if there is any literature that provides guidelines for qualifying what measurements are required to attribute these differences as support for the double jeopardy hypothesis. However, given the small effects found amongst the groups and the inability of this research to verify causality, it is difficult to confidently assert that differences could be accounted for by the construct of double minority. On the other hand, there is also insufficient evidence to counter the claim. Thus, these findings are indicative of the need for further research to be conducted, specifically looking at what criteria warrant full support for double jeopardy hypothesis and what empirically based instruments might assist in facilitating this process.

As previously stated, the first objective was to replicate Hayes, Chun-Kennedy et al. (2011). Overall, majority of the findings were corroborated, thereby increasing the capacity for opportunities to generalize these findings to a larger treatment-seeking college student population. See Appendix C for summary of findings.
Research Question 4

The second objective of the current study was to address the limitations of and expand upon Hayes, Chun-Kennedy et al. (2011). As noted in Chapter Two, Hayes et al. found partial support for double jeopardy (only for double minorities when compared to heterosexual racial minorities); however, from the research, no cause for this finding could be ascertained. From one perspective, the researchers emphasized that others should not assume that those individuals who identify as both ethnic and racial minorities experience heightened distress as a function of their double minority status. At the same time, the researchers posited that the findings were significant and encouraged others to consider environmental factors that could cause or possibly aggravate clients’ difficulties in depression, substance use, generalized anxiety, and family concerns.

In efforts to extend the literature and take these recommendations seriously, the second objective of this study was to assess how stability of one’s sexual identity influences the amount of distress experienced. As noted, there has been a lack of sufficient support for double jeopardy. One possible option to consider was exploring the populations that have been included and/or excluded from the analyses. In Hayes, Chun-Kennedy et al. (2011), only heterosexual and LGB individuals were included; however, what about those that identify as questioning their sexuality? In the preceding chapters, research was provided regarding the complexities involved in the process of emerging adulthood (Arnett, 2007). During that time, individuals are forced to reconcile tensions and interactions amongst their social identities and their authentic selves (Archer & Grey, 2009). The reality is that context can complicate how individuals define themselves and can indirectly exacerbate levels of distress without understanding the nuances of
their circumstances and access to sufficient resources to cope with levels of distress (Morgan, 2012).

Literature on questioning-identified, treatment-seeking college students is even more challenging to find than double minority (racial and sexual minority, specifically) research. Furthermore, most studies have been qualitative in nature or have sampled from one university with no diversity as it relates to demographic variables. To address this gap, CCMH data was used. The first analyses assessed questioning-identified students’ overall distress as compared to heterosexual students. Findings indicated that questioning students are indeed more distressed. Large effects were related to hostility and social anxiety. Moderate effects were found with regards to generalized anxiety. When questioning-identified students were compared to LGB students, questioning students endorsed more distress than LGB, with the exception of the substance use scale. However, only small effects were found. These populations were actually quite similar.

Next, racial/ethnic minority questioning students were compared to white questioning students. Again, the findings were not clinically significant. Racial minority questioning students evidenced higher hostility, while white questioning students reported greater social anxiety and generalized anxiety. Intriguingly, these results are analogous to Hayes, Chun-Kennedy et al.’s (2011) findings for racial minorities compared to white individuals, when sexual orientation is not a focal point. Thus, if questioning is classified as a minority status and in this analysis, functioning as a secondary marginalized status with race, these findings do not support double jeopardy either. Questioning does not appear to have an additive effect in this case.
Lastly, racial minority questioning students’ levels of distress was compared to racial heterosexual students’ levels of distress. In this case, findings supported double minority stress; however, the effects were small.

Thus far, support for double minority status has been somewhat mixed. In relation to all findings, there were no gross differences amongst the various populations compared, including treatment-seeking double minority college students, particularly those with questioning status. In other words, double minorities did not evidence more distress than non-double minorities in most cases. However, it is worth noting that there were differences in distress levels. One possible hypothesis for these findings might be that the individual’s level of distress, as a double minority, could be attributed to their perception of racism and heterosexism.

Although empirical literature suggests that race-related stress and racism can lead to damaging effects for people of color (Chao, 2006; Carter, 2007; Clark et al., 1999; Harrell, 2000; Perrin, 2012; Johnson & Arbona, 2006; Williams, Neighbors, & Jackson, 2003; Feagin, 2002), other researchers note that the experience of racism is predicated on the operationalization and conceptualization of racism. This, in turn is impacted by an individual’s understanding and acknowledgment of racism as a reality (Pieterse, Neville, Todd, & Carter, 2012; Williams & Mohammed, 2009; Paradies, 2006; Pascoe & Richman, 2009; Lee & Ahn, 2011; Brondolo et al., 2009). Perceived racism is defined as the subjective and objective experience of prejudice and/or discrimination (Rowles & Duan, 2012; Vines, Baird, McNeilly, Hertz-Picciotto, Light, & Stevens, 2006). The theoretical underpinnings of perceived racism as a vulnerability factor are four-fold: First, individuals with heightened levels of race-related stress report greater numbers of stressful life events, thus implying greater experience with stressful situations and stimuli (Harrell, 2000; Utsey, 1998). Second, individuals reporting higher levels of race-related stress
may be more likely to assess stressful events as threats instead of challenges, thereby increasing the likelihood of negative emotional responses (Sellers et al., 2003; Utsey & Ponterotto, 1996). Third, when times are significantly stressful, individuals with elevated levels of perceived racism have a tendency to avoid engaging in active, problem-focused coping behaviors (Clarke, 2006; Utsey, Ponterotto, Reynolds, & Cancelli, 2000). Lastly, chronic perceptions of racism may, over time, be etiologically implicated in physiological effects such as heart disease or acute coronary events (Brondolo, Rieppi, Kelly, & Gerin, 2003; Williams et al., 2003). Research findings indicate that perceived racism is inversely linked with psychological well-being and positively associated with psychological distress among marginalized groups (Clark, Anderson, Clark, & Williams, 1999; Kressin, Raymond, & Manze, 2008; Lee & Ahn, 2011; Pascoe & Richman, 2009; Utsey, 1998). Utsey, Chae, Brown, and Kelly (2002) found that for people of color, cultural racism was related to lower levels of quality of life and that African American individuals reported more experiences of individual and cultural race-related stress than other racial/ethnic minority groups. Nonetheless, the study found that not all people of color experienced equal levels of institutional race-related stress. Carter et al. (2005) posited not all individuals who have encounters with racism report psychological symptoms.

Other research, in addition to Carter et al. (2005), contests the assertion that there are direct links between heterosexism and negative psychological consequences for same-sex attracted individuals. For instance, Lewis and Derlega (2000) found that self-reported experiences with gay-related stressors were not related to measures of self-esteem. Comparably, in a longitudinal study, Rosario, Schrimshaw, Hunter, and Gwadz (2002) found that experiencing gay-related stressors was not generally related to psychological well-being either six months or a year after the gay-related stressors were reported. One concept used to describe this finding is
perceived heterosexism. *Perceived heterosexism* refers to an individual’s capacity or inclination to recognize and acknowledge a stigma that fundamentally privileges heterosexuality and disparages all other orientations (Moradi et al., 2010). Stigma consciousness (SC) has been proposed as an individual difference variable that reflects the degree to which members of a marginalized group (e.g., women, sexual minority individuals, racial minority individuals, people living with disabilities) expect to be stereotyped by others (Pinel, 1999). Pinel’s work on stigma consciousness suggests that not all members of a minority group “approach their stereotyped status with the same mind-sets” (p. 126). In Pinel’s study, those same-sex attracted individuals high in stigma consciousness demonstrated a higher likelihood that they would perceive discrimination directed toward them. Hence, the findings of this study suggest that negative mental consequences, as a result of heterosexist harassment, rejection, and discrimination, are contingent upon the perception of such stigma and its effects.

Accordingly, it is hypothesized that stress reactions depend on an individual’s perception that the event or experience is negative and unsolicited. Likewise, the individual’s ability to cope with the stressful experience must be ineffective. Therefore, how an individual perceives an event is essential in the event being experienced as stressful (Lazarus & Folkman, 1984; Slavin, Rainer, McCreary, & Gowda, 1991). Thus, as stated previously, understanding where people are in their identity development and their capacity to internalize and/or perceive oppression could be critical to understanding the factors that account for the different outcomes and effects of living as a double minority.

**Research Questions 5 and 6**

The last research questions intended to build upon the resiliency perspective which postulates that double minorities may be protected against the negative effects of excessive
minority stress due to greater coping capacity associated with having a visible minority status. In addition, these questions were designed to examine supportive networks as protective factors against stress related to embodying marginalized identities. Accordingly, these questions sought to evaluate whether (1) the relationship between social support and psychological distress is moderated by one’s questioning status and if (2) the relationship between social support and psychological distress is moderated by one’s questioning status for double minorities, more specifically.

The primary research questions are specifically geared towards questioning college students as they are the identified focal sample of this dissertation. However, in order to have a more comprehensive approach to discuss moderation, sexual orientation was trichotomized (in other words, sorted into three categories: heterosexual, LGB, and questioning) and placed as the moderating variable for all models included in the study. Due to PROCESS Macro only allowing one independent variable to be entered into the moderating equation, six individual models were constructed (refer to Chapter Three for more information). In an effort to make interpretation and comparison more streamlined regarding social support, findings are discussed per the level of support (e.g., family, friend, or family distress) instead of the specific research questions.

Findings demonstrated a negative relationship between family support and general distress in a stepwise gradient. For all sexual orientations included in the study, family support mattered. As family support increased, overall distress decreased. However, one interesting outcome was the magnitude of family support for individuals who identified as heterosexual. In other words, if one identifies as heterosexual and has family support, that person’s reduction in overall distress is higher than for LGB individuals, followed by questioning students. Moreover, if one identifies as questioning, family support will alleviate the overall distress at a reduced rate.
When double minority status is specified in the model assessing the relationship between family support and general distress, with sexual orientation as the moderating variable, those interactions are no longer significant. Thus, there are no meaningful differences between heterosexual, LGB, or questioning college students on this dimension. When comparing the models, discussing possible contributing factors to the identified differences is challenging.

Could the differences be a function of salience, invisibility, and/or stability of identity? Does the research align with heterosexual college students needing more family support than either LGB or questioning students? All of these questions are interesting and warrant further exploration, as they go beyond the scope of this research.

Similar to the findings for family support in the first model, friend support also appeared to be significant for moderation; however, there were only moderating effects for heterosexual and LGB identities. Questioning status did not moderate the relationship between friend support and overall distress. It is important to reiterate that a more stringent significance level (p < .02) was chosen to account for running multiple different analyses with the same outcome variable. Findings indicated that if a p < .05 was used, questioning status would have moderated the relationship between friend support and distress. Again, heterosexuals appeared to benefit most from friend support in its relationship to distress. In this domain, questioning students seemingly experienced more relief than LGB students (regarding decreased distress); however, the effect appeared to be trivial and the difference not statistically significant. When double minorities are considered, there are no significant moderating effects for LGB or questioning status. As noted, if p < .05, LGB status would then be significant for a moderating effect. In this model, questioning-identified students appeared to benefit most from increased family support, followed by heterosexual students. LGB status appeared to experience the least impact of friend support.
on overall distress level. Nevertheless, in both of these models, the interaction of sexual orientation does not account for a significant amount of the variance.

Across all models, family distress accounted for the most variance in a model, despite no significant variance increase due to the interactions. For this model, the results are the same that were found for family support, but in the opposite direction. Increased family distress leads to increased levels of general distress. In this context, questioning and LGB status evince significant moderating effects. Interestingly, questioning students appeared to evidence the least family distress, followed by LGB students. There was a significant difference between distress experienced by heterosexual students. It would be interesting to explore if non-heterosexuality, in this context, served as a buffer for family distress and overall distress.

When double minority status is considered for the last model, there are significant moderating effects for LGB and questioning statuses on the relationship between family distress and general distress. In fact, it was interesting to note that this family distress model operated in the same direction as demonstrated in the larger sample regarding moderating effects on the relationship between family distress and general distress, when double minority status was not accounted for. Again, family distress is most significant for heterosexual students, with questioning students evidencing the least amount of family distress. The question remains, what is the significance of these findings? What is present in the relationship between family distress and overall distress for heterosexuals that is not seen with LGB or questioning students? Given the limited research available on the questioning population, particularly in context to other treatment seeking minorities, this would be valuable to explore for future research.

**Limitations**
Numerous considerations frame the discussion of the aforementioned findings. One of the most notable limitations is the origin of the data set. The sample is taken from a clinical setting which implies that the sample is distressed, by definition. Given this sample type, it is plausible that the baseline of distress is not representative of the overall college student population, particularly those that identify as double minorities, and thus contributed to the difficulty in discriminating meaningful differences in this study. Future studies might consider sampling from both a non-clinical and clinical population to better assess the variability in levels of distress.

Another limitation is that the research collapsed all racial/ethnic minorities into one group despite important sociocultural differences between them on the basis of the current study’s theoretical model calling for examination of racial/ethnic minority status. Future studies should take into account the uniqueness of these American disadvantaged social statuses.

Additionally, the current study used an already established psychometrically sound instrument, the CCAPS-62; however, although the research questions stemmed from social stress, double jeopardy, and minority stress theories, this study’s research design did not directly test the impact of stress and instead used social group status as a proxy indicator of distress (Aneshensel & Pearlin, 1987). Hence, although some support for minority stress, social stress, and double jeopardy was provided, this study did not explicitly test whether these results are the direct effect of specific stressors or other factors. As such, findings must be considered cautiously and understood within the context.

Another constraint was related to the social support moderation model. Social support was in part measured by two one-item SDS questions. The questions were on a Likert scale and assessed the extent to which a respondent agreed or disagreed with the given statement. Although the items appeared to have face validity, there was no additional psychometric
information, making it difficult to assess construct validity. The CCAPS-62 Family Distress scale was also used to measure social support construct. The Family Distress scale was more robust, asked questions about family support, and also encompassed a historical item about past abuse in the family; therefore, providing a picture of one’s relationship to the family. The presence of family distress was operationalized as the lack of social support. The assumption was that increased family distress/lack of social support would be indicative of increased overall distress (as measured by the Distress Index).

Prior to this study, no other studies conducted had used the Family Distress scale to measure social support in this context. Ultimately, this appeared to be a good decision as Family Distress accounted for majority of the variance in the last two research questions. Of note, it is unclear if respondents were referencing their family of origin (which may be rejecting them because of their sexual minority status) or family of choice (similar to the House and Ball communities discussed in Chapter Two). This is important to consider as it could account for the variability in social support per each sexual orientation, to include those that identified as double minorities. In addition, further psychometric data should be collected to support operationalizing the Family Distress scale as a measure of social support.

Further, using PROCESS Macro limited the study’s ability to collectively measure all of the social support constructs simultaneously and instead required the construction of separate models for each aspect (i.e., family support, friend support, family distress). Future studies might consider developing a latent social support variable using Structural Equation Modeling (SEM) to assess how the variables fit together.

Given the strong empirical support for the influence of social support on mitigating life stress, future research should consider using a more empirically sound and robust measure of
social support that measures varying levels of support such as tangible (help with getting to work/instrumental), belonging (social companionship), appraisal (availability of confidants), and self-esteem support. These types of support can provide more extensive data on stress and coping capacities in double minorities, particularly those with questioning status.

**Future Research**

This study tested research questions stemming from minority stress and double jeopardy theories about group differences in well-being and distress. Clearly, this research provides only a partial test of minority stress and its results, like most studies, cannot directly prove or disprove the veracity of the models. Future research should examine mechanisms underlying the relationship between disadvantaged social statuses and mental health. A more progressive step would be for researchers to holistically investigate and demonstrate how group differences are in fact, caused by excess stress for those embodying marginalized identities. Stereotype threat, navigating sociopolitical systems, access to resources, imposter syndrome, campus climate issues, perceived discrimination, identity development processes, racial/ethnic group membership and belongingness, and salience and/or visibility of identity are all factors that could account for the variance in distress levels for double minorities. This study collected data at one particular time; however, levels of distress shift according to context and salience of a stressor at any given moment. Double minorities and their level of distress might wax and wane; thus, future research could consider exploring the utility of an Ecological Momentary Assessment (EMA). EMA methods often avoid recent and apex biases typically associated with cross-sectional data (Kahneman, 1999), as well as sampling biases affiliated with scheduled diary research (Stone & Shiffman, 2002). Real-time responses collected are a better measure than retrospective recall used in traditional methodologies (Stone et al., 1998). This methodology
would also allow the respondents to have more self-control (occurs in their natural environment); be more present in recalling their affect, thoughts and behaviors; and submit data at multiple points (repeated measures); ultimately capturing the variability of experiences more accurately. This methodology would also provide a platform for generating new questions about changes that may occur as a consequence of different environmental stressors or situations.

Another avenue of research would be authenticating and developing psychometrically sound research designs for measuring intersectionality. This study primarily functioned from an additive approach, which assumes the more disadvantaged identities one has, the more stress burden that person experiences; which ultimately contributes to chronically impaired mental health outcomes. Many of the findings were inconsistent, particularly as they related to double minority status. Thus, designing studies with sound intersectional approaches provides more information about the experience of embodying all of those identities. This research will be much more informative than studying these identities separately. Further, researchers would be able to explore specific intersections instead of being limited to unsubstantiated hypotheses about groups as a whole.

Given the context of emerging adulthood as identity transformation via multiple pathways of exploration, research designs that incorporate an expansive range of health and well-being outcomes will produce much more nuanced and contextualized understandings of this population. In turn, this will yield more opportunities to develop truly useful interventions for individuals with multiple disadvantaged statuses.

When considering methodological challenges, many of them have been well documented and often are associated with definitions and conceptualizations of constructs such as what constitutes “questioning,” accessing statistically adequate and representative samples of racial
and sexual minorities, and the lack of collaboration between fields (i.e., minority health, sociology, psychology, biology, etc.). These errors often contribute to “hidden populations” (Meyer & Wilson, 2009; Rothblum, 2007) suffering in silence and perpetually decompensating due to systematic structures of oppression. Moreover, methodological challenges multiply in research involving between-group designs that examine factors unique to one group’s experience in efforts to explain a difference in outcomes (see Schwartz & Meyer, 2010 for a more thorough discussion).

Lastly, given that CCMH is the largest organization retrieving hundreds of thousands’ worth of data from treatment-seeking emerging adults and are committed to integrating both research and practice, it would be interesting to explore how could additional measures explore more of these sociocultural nuances; thereby, increasing the capacity for researchers to more fully assess for the effects of minority stress theory.

**Clinical Implications**

As noted earlier, findings indicated higher levels of overall distress for racial and sexual minorities, respectively. However, findings provided mixed support for the double jeopardy hypothesis. In other words, those embodying two marginalized statuses did not exhibit more distress when compared to those that did not. Though the double jeopardy hypothesis has been explored in the literature and is theoretically comprehensible, research findings continue to exhibit inconsistent and minimal empirical support. One explanation is the resiliency perspective which hypothesizes that because double minorities have good coping proficiencies and skills, they may be protected against the damaging effects of stress related to discrimination and prejudice (Moradi et al., 2010; Meyer, 2010). Additionally, another possible explanation for the lack of double jeopardy hypothesis support is related to the visibility of status. For example, if a
client is Black and lesbian, it is possible that having learned to exist in the world as a racial minority (visible minority status) provided a solid foundation and sense of self; thereby contributing to a sense of mastery and decreased perception of stress, as it relates to heterosexism.

It is important to note that the current study used a pre-existing data set and therefore, was restricted in fully being able to explore the nuances of embodying a double minority status and possible protective factors beyond social support. Nonetheless, the findings propose a few clinical implications to consider. First, it is imperative that clinicians do not assume that college students with a double minority status seeking treatment in a counseling center are more distressed than other college students not identifying as a double minority. This assumption has not been supported by empirical data. As previously noted, there are multiple factors that could serve as protective factors against additive stress for double minorities. In fact, Frost and Meyer (2008) found that many respondents rejected the notion of identity conflict and were fully capable of differentiating between external sources of stress and internal identity cohesiveness.

Next, due to the mechanism by which the minority stress framework specifies the stress and coping pathways by which those with marginalized statuses understand how this experience connects to their physical and mental health, clinical interventions would benefit from specifically targeting those pathways that are more probable to change, with the intention of reducing incidence of negative health outcomes (Frost, 2017). Additionally, Meyer (2010) noted the impact of resilience and social support on reconciling distal and proximal stressors. As such, clinicians must be intentional with their discussions regarding identity development, language, and possible interpersonal disconnects in the therapeutic alliance which could inhibit their capacity to build meaningful social networks. This requires clinicians to be introspective and
open to the process of continued self-growth. We are no longer in the times of only being able to address “the presenting concern.” It is imperative to process how individuals, particularly emerging adults identifying as double minorities, understand their existence in the world, the salience of their identities at any given time, and the importance of increasing social capital and personal survival toolboxes.

**Conclusions**

The author’s intention with the construction of research questions was a tiered approach. The first objective was to replicate Hayes, Chun-Kennedy et al. (2011) study to establish the foundation for understanding the relationship between race and psychological distress, as well as sexual orientation and psychological distress. This is consistent with how the literature has traditionally explored “race-related stress” and “gay-related stress,” which was demonstrated in Chapters One and Two. Once the evidence was substantiated for assessing racial and sexual minorities independently, following a tiered approach, the next step was to assess the effect of identifying as both a racial and sexual minority (LGBQ) in the context of psychological distress. The findings did not clearly support a double jeopardy hypothesis. For example, distress rates for treatment-seeking racial LGBQ and white LGBQ college students were quite similar in degree. However, distress rates of treatment-seeking racial LGBQ minorities when compared to treatment-seeking racial minority heterosexual college students were not as clearly defined. In fact, very small effects, with the exception of the academic distress scale, were found. In other words, it is true that treatment-seeking racial LGBQ minority students exhibit more distress than treatment-seeking racial minority heterosexual students; however, the levels of distress are not clinically that significant.
Thus, at this time in the research design, the results did not provide strong evidence for the double jeopardy hypothesis. As in all research, the intention is to contribute relevant, meaningful information to the existing literature. Aligned with the intent for adhering to a tiered approach, the researcher had to consider who was not represented. There is considerable information on racial/ethnic minorities, as well as, those that identify as LGB; however, where are “questioning” individuals in the data?

As discussed in Chapter Two, emerging adulthood is a transformational process for individuals ages 18-25, who are trying to negotiate multiple private and social identities. Accordingly, this researcher became very interested in exploring the questioning population and how this population functioned in comparison to those that identify as treatment-seeking heterosexual, lesbian, gay, or bisexual students. Also, assessing how questioning fits in the context of double minority status has not been explored to date, to this researcher’s knowledge, particularly in the college student population.

Sexual orientation identity is a process in which one explores a series of linear stages (e.g., Cass, 1979; Troiden, 1989; D’Augelli, 1994); however, movement within the stages can be nonlinear and one’s sexual identity may transition over time. The construct of sexual orientation is comprised of sexual attraction, arousals, identities, behaviors, and fantasies that individuals have for the same sex, the other sex, or both sexes (LeVay & Baldwin, 2012). Weber (1998) purported that sexual orientation may transmute at the individual and sociocultural levels. Hence, salience and fluidity of any particular identity varies according to a multitude of contextual factors, at any given time.

In the extensive literature search conducted prior to this study, there was limited theoretical and empirical research on this population. One possible explanation is the challenge
of understanding the very construct of questioning. In most cases, questioning appears to be defined more in regards to a status rather than an actual sexual identity. In practice, researchers have historically categorized participants into one of three distinct classifications on the sexual orientation continuum: heterosexual, bisexual, or gay/lesbian (Vrangalova & Savin-Williams, 2012). However, in recent years, researchers have asserted that the traditional 3-classification method of sexual orientation identity fails to provide a nuanced identity status for those individuals that fall “in-between” on the continuum (Vrangalova & Savin-Williams, 2012). Further, research on the 3-classification sexual orientation system demonstrates that sexual orientation identities are frequently inconsistent with other sexual orientation aspects. Years of research on sexual minority populations have revealed that many gay and lesbian-identified individuals do not endorse an exclusively same-sex orientation and have likely reported some opposite sex attraction and/or past partners (Diamond, 2008; Rosario, Schrimshaw, Hunter, & Braun, 2006; Savin-Williams, 2005). Similar inconsistencies (e.g., balance of sexual attraction and behavior) exist in bisexual (Diamond, 2008; Weinrich & Klein, 2002) and heterosexual men and women (Hoburg, Konik, Williams, & Crawford, 2004; Vrangalova & Savin-Williams, 2010).

Compared to the existing literature on sexual minority groups’ processes of questioning sexual identity, heterosexual identity processes have received little empirical attention (Worthington, Savoy, Dillon, & Vernaglia, 2002). Morgan, Steiner, and Thompson (2010), as well as Morgan and Thompson (2011), purported that there is an invisibility of questioning processes amongst heterosexual men and women that could be explained by hegemonic masculinity and compulsory heterosexuality, both of which function within a culture of heteronormativity. Further, Frankel (2004) asserts that having a heterosexual identity is central
but not salient, and thus is invisible as a function of forced exploration foreclosure. The researchers thus conclude that social norms have led to inaccurate beliefs that questioning processes must occur only among sexual minorities (Morgan, Steiner, & Thompson, 2010). Both of Morgan et al.’s studies (2010; 2011) aimed to examine sexual orientation processes among heterosexual men and women. In regards to sexual orientation processes, participants were instructed to answer two open-ended questions: (1) “Have you thought much about and/or questioned your sexual orientation? If yes, when do you first remember thinking about your sexual orientation? If no, why do you think you have never thought about this?” (2) “What has been important in developing your sexual orientation? Please be as specific as possible.” In both studies, preliminary analyses categorized heterosexual participants responses into two classifications: questioning and non-questioning (heterosexual). Questioning narratives included those in which the participant explicitly claimed or implicitly outlined that they had thought about or questioned their sexual orientation in the past, was currently questioning their sexual orientation, or had considered future changes to their sexual identity (Morgan, Steiner, and Thompson, 2010; Morgan & Thompson, 2011). Similarly, heterosexuals were classified in the non-questioning categories if they described having never questioning their sexual orientation. Results indicated that two-thirds of “exclusively straight”-identified women (Morgan & Thompson, 2011) and 50 percent of “exclusively straight” –identified men (Morgan, Steiner, & Thompson, 2010) endorsed having questioned their sexual orientation. For men and women, questioning experiences provided new information about heterosexual and sexual minority identity development processes which challenged them to reconfigure their own sexual identities (Morgan, Steiner, & Thompson, 2010; Morgan & Thompson, 2011). In large part, heterosexual-questioning men sustained their original heterosexual identities before and after questioning.
instead of configuring a completely new sexual identity. Thus, heterosexual-questioning men continued to enjoy the privileged status associated with heteronormativity that serves as protection from marginalization and stigma (Morgan, Steiner, & Thompson, 2011). This sense of safety provides a platform for heterosexual-questioning men to reconsider the personal components of their sexual identities (e.g., sexual values, preferred partners, sexual activities, etc.). For women, the results indicated that questioning sexual identity is a fairly common practice in college (Morgan & Thompson, 2010). Despite 50% of heterosexual men stating that they questioned their sexual orientation, a higher percentage of women endorsed questioning processes. Taken into context, it is probable that there is more societal flexibility for women to explore alternate sexual identities (Morgan & Thompson, 2010). It is important to note that results from both studies noted that men and women expressed the importance of social context when engaging in sexual orientation questioning.

Sexual identity exploration and uncertainty can continue well after one has endorsed a same- or different-sex sexual identity (Weinberg, Williams, & Pryor, 1994). It has been hypothesized that continued uncertainty for individuals is a result from the pressure to conform to traditional sexual orientation binaries (Weinberg et al., 1994). Thus, individuals’ decisions about romantic partners may be impacted. Further, since the gender of one’s partner is a commonly used to deduce sexual orientation (Ross, Dobinson, & Eady, 2010), choosing to be in an opposite sex relationship increases the likelihood of being perceived as heterosexual, just as being in a same-sex relationship increases the likelihood of being perceived as a sexual minority (Dyar, Schick, Feinstein, & Davila, 2017).

Given all of this information, understanding who is defined and captured in the questioning literature is critical. Future longitudinal research should be conducted in order to
examine questioning sexual orientation processes in emerging adults in more depth as this will assist in increasing understanding of this specific developmental period in which they are beginning to explore and adopt alternative sexual identities (Savin-Williams & Diamond, 2000). Also, future research should develop more expansive studies that explore sexual orientation processes across its various components and dimensions.

Lastly, prior to completion of the current study, numerous discussions were held regarding the social support variable. Initially, the question was: does social support moderate the relationship between questioning status and overall distress for those with a single or double minority status. This is important to consider. The question that must be asked is, how would these analyses have contributed to furthering the literature for double minority college students? In answering this question, one must consider the other analyses that have already been conducted. Ultimately, it is reasonable to assume that a case could have been made for either moderating question. For this particular study, the other research questions had already demonstrated evidence for the relationship between questioning status and psychological distress. Thus, the next logical step was to complement the literature on social support and further the literature on questioning status and see how questioning status moderates the relationship that has already been established between social support and general distress in emerging adults.

In closing, as extensively discussed in the literature review, LGBQ individuals from racial/ethnic minority groups, who face amplified stress with respect to their marginalized identities, represent multiple understudied populations (Huang et al., 2010; Moradi, DeBlaere & Huang, 2010). Disparities have been consistently documented between minority populations across multiple domains of health (for a review, see Williams & Mann, 2017). These pernicious
differences in health are speculated to be caused by the devalued and marginalized statuses surrounding double minorities that stem from a prevailing culture of stigma (Bockting, Miner, Swinburne, Hamilton, & Coleman, 2013; Hatzenbuehler, Phelan, & Link, 2013; Herek, 2007; Meyer, 2003; Williams & Mann, 2017). The models have asserted that minority individuals are continuously exposed to greater amounts of social stress as a result of their stigmatized status and have traditionally had less access to coping resources than their non-minority peers (e.g., Meyer, Schwartz, & Frost, 2008).

Studies employing the minority stress framework have concluded that exposure to a variety of social stressors is related to a multitude of mental health problems including: mood and anxiety disorders, depressive symptoms, substance abuse, and suicidal ideation, as well as, lower levels of psychological and social well-being (see Meyer & Frost, 2013 for review), particularly as individuals enter into emerging adulthood (Arnett, 2004). However, recent research calls for implementation of a resiliency perspective which explores potential protective factors that may account for the variability in distress levels for those that embody multiple marginalized status.

Although there is still much to be done, minority stress theory has provided a unifying framework for understanding the social origins of sexual minority health disparities, and produced a body of evidence that challenges the assumption that such difference in health outcomes are inherent to double minority identities in and of themselves (Frost, 2017). Research must develop more deliberate, multidimensional methodologies geared towards increasing understanding and addressing the many negative sociopolitical realities that so chronically and harmfully affect those with multiple marginalized statuses.
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APPENDICES
Appendix A

Informed Consent Form

CAPS participates in a national research project designed to improve our services and expand the knowledge about college student mental health. We participate by contributing anonymous, numeric data provided by those who use our services (and are over 18 years old) to a database managed by researchers at Penn State University. Data is stripped of all personally identifying information and then combined with anonymous, numeric data from other colleges nationwide for statistical analysis. Because data cannot be linked to specific individuals, there are virtually no risks contributing data. With your permission, we would like to contribute anonymous, numeric data from the questionnaires you just completed. Your decision is voluntary and will not affect the services you receive. If you have questions or concerns, you may contact Dr. Ben Locke at bdl10@psu.edu.

Will you allow your anonymous, numeric responses to be contributed?
Yes
No
Appendix B

Select Questions from the SDS Questionnaire

1. Attended counseling for mental health concerns
2. Received treatment for alcohol or drug use
3. Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)
4. Seriously considered attempting suicide
5. Made a suicide attempt
6. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)
7. Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror
8. Please select the traumatic event(s) you have experienced
9. *Please indicate how much you agree with this statement: “I get the emotional help and support I need from my family.”
10. *Please indicate how much you agree with this statement: “I get the emotional help and support I need from my social network (e.g., friends & acquaintances).”
11. *Age
12. *What is your gender identity?
13. *What was your sex at birth?
14. *Do you consider yourself to be: (heterosexual, lesbian, gay, bisexual, questioning, self-identify---please specify)
15. Since puberty, with whom have you had sexual experience(s)?
16. *What is your race/ethnicity?
17. *Are you an international student?
18. Relationship status
19. Religious or spiritual preference
20. To what extent does your religious or spiritual preference play an important role in your life?
21. Current academic status
22. Are you a first-generation student?

*Denotes items assessed in the analytic process
## Appendix C

### Summary of MANOVA Findings by Main Effects: Questions 1-4

<table>
<thead>
<tr>
<th>Question</th>
<th>CCAPS Subscales</th>
<th>Depression</th>
<th>GenAnxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Race</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Q2. Sexual Orientation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Q3. Race X Sexual Orientation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Q4a. Questioning vs. Heterosexual</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Q4b. Questioning vs. LGB</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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</table>

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<tr>
<th>Subscale</th>
<th>Depression</th>
<th>GenAnxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCAPS Depression</td>
<td>Yes, racial/ethnic minorities endorsed more distress than white (large effect)</td>
<td>Yes, questioning students endorsed more distress than LGB students (small effects)</td>
</tr>
<tr>
<td>CCAPS GenAnxiety</td>
<td>Yes, white students endorsed more distress than racial/ethnic</td>
<td>Yes, questioning students endorsed more distress than LGB students (small effects)</td>
</tr>
<tr>
<td></td>
<td>Social Anxiety</td>
<td>No</td>
</tr>
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<td>----------------</td>
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<td>----</td>
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<tr>
<td>Academic</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Eating</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Students endorsed more distress than heterosexual students.

LGBQ students endorsed more distress than double minority students.

Questioning students endorsed more distress than LGB students.

Racial/ethnic minorities endorsed more distress than white students.

Double minority students endorsed more distress than white students and racial/ethnic heterosexual students.

Questioning students endorsed more distress than heterosexual students.

No significant effects.
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>race/ethnic minorities endorsed more distress than white (large effect)</th>
<th>Yes</th>
<th>LGBQ endorsed more distress than heterosexual students (large effect)</th>
<th>Yes</th>
<th>double minority students endorsed more distress than white students and racial/ethnic heterosexual students (small effect)</th>
<th>Yes</th>
<th>(small effects)</th>
<th>No</th>
<th>No sig. effects</th>
</tr>
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<tbody>
<tr>
<td>Hostility</td>
<td></td>
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</tr>
<tr>
<td>Substance</td>
<td>Yes</td>
<td>white students endorsed more distress than racial/ethnic students (large effect)</td>
<td>Yes</td>
<td>LGBQ endorsed more distress than heterosexual students (moderate to large effect)</td>
<td>Yes</td>
<td>white students endorsed more distress than double minority students (large effect)</td>
<td>No</td>
<td>No sig. effects</td>
<td>No</td>
<td>No sig. effects</td>
</tr>
</tbody>
</table>
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**Student Engagement Award**
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