

**Complex Networks of Social Support: Exploring the Roles of Parents, Families,  
and Mentors in the Lives of Young Adult Gay and Bisexual Men**

by

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**A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
(Health Behavior and Health Education)  
in the University of Michigan  
2016**

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## ACKNOWLEDGEMENTS

Completion of this dissertation would not have been possible without the support from faculty and the support from my family, partner, and friends. A very special thanks to my advisor, José Bauermeister, for his consistent and endless support throughout this scholarly, intellectual, and personal journey. My gratitude to you will be never-ending. Thank you to my Committee for your dedication, feedback, and words of encouragement. To my mother, Luz Elena Castro, the person I admire most in my life, this is for you. I hope I've made you proud. To my sister, Karina Soler, thank you for keeping me grounded. To my boyfriend, Roberto Sánchez, you have been so patient and kind throughout these last five years. Thank you for listening and for your love. To Jennifer Lee for being such an incredible friend, and Babe Kawaii-Bogue for always having my back, thank you. Jacqueline Higuera and Justin Smith, I'm lucky to have had you as friends throughout this experience. Shout-outs to my cohort (Andi, Bill, Rebecca, and Angeles), to my HBHE doctoral student crew, my Jersey crew, and my Boston crew. All of you have played a special role along the way. Finally, a special thank you to Mrs. Marily O'Connor, my high-school English teacher who took me under her wing and changed the life of this immigrant kid from Colombia. You put me on this path before I even knew it was possible.

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## **ABSTRACT**

Various structural, interactional, and functional characteristics of young adult gay and bisexual men's (YGBM) social support networks remain unexamined in the public health literature. Without clearer understanding of the parent, family, and mentor roles in the lives of YGBM, the linkages between social support and health status also remain unclear. These linkages may be critical to understand given the health disparities impacting YGBM, which include higher rates of substance use and psychological distress among YGBM populations compared to heterosexual counterparts. The role of parents has been examined mostly in the context of sexual identity disclosure and development among lesbian, gay, and bisexual (LGB) adolescents. Less is known about parental influences on the health of young adults. Despite ethnographic accounts of chosen family networks among LGB populations, the role of the family unit has been examined but mainly with respect to family of origin (biological family). Few researchers have examined the prevalence and the supportive functions of chosen family networks in quantitative studies. More broadly, considerable research gaps exist regarding the role of mentors in the lives of YGBM even as mentoring programs continue to proliferate. In three separate studies, I examine the supportive functions of parents, families, and mentors in the lives of YGBM.

### **Study 1 Abstract**

In the first study, I explored the roles of perceived maternal and paternal social support in YGBM's substance use behaviors (cigarettes, alcohol, marijuana, hard drug) in a sample of young adult gay and bisexual men (N=352). More specifically, I examined the associations

between parental supports and substance use, and I tested a stress-buffering hypothesis by examining if parental supports moderated the associations between sexuality-based victimization and substance use. Results indicated that neither maternal nor paternal supports moderated any of the relationships between victimization and substance use, regardless of victimization severity and type of substance. In main effects models, however, maternal support was associated with abstinence from cigarette smoking (OR=.85) while paternal support was associated with abstinence from marijuana use (OR=.78) among YGBM. Descriptive results indicated that more YGBM were in contact with their mothers than with their fathers. Among those maintaining contact, YGBM reported higher levels of maternal support compared to paternal support. Furthermore, proportions of YGBM reporting cigarette and marijuana use were particularly large compared to previous reports of use among sexual minority and young adult male populations (Halkitis et al., 2014; Johnston et al., 2015; McCabe et al., 2005). Associations between victimization and substance use varied but were strongest with respect to cigarette use. Findings highlight the important and unique roles that mothers and fathers may have on the substance use behaviors, especially cigarette and marijuana use, of young adult sexual minority men.

## **Study 2 Abstract**

In the second study, I explored how YGBM defined their families, and examined whether perceived familial social support and familial social undermining were associated with psychological distress among YGBM within different family types. Analyses also accounted for internalized homophobia and sexuality disclosure. Descriptive findings indicated that YGBM's definitions of family consisted of one or a combination of the following networks: family of origin, friends or roommates, and/or family by romantic partnership. Results also indicated that familial social support and social undermining, respectively, were associated with depression and

anxiety. These associations varied with respect to the type of family that YGBM defined, suggesting that family network content plays a role in shaping perceptions of social support and social undermining. While the vast majority of YGBM included family of origin in their family networks, the majority of YGBM also counted friends and partners among their family networks. Therefore, chosen families appear to play a prominent role in the lives of YGBM (Nardi, 1999; Weston, 1991). Findings also highlight the importance of examining co-occurring social support and social stress processes in the families of origin and chosen families of YGBM.

### **Study 3 Abstract**

In the third study, based on interviews with individuals who work with young Black and Latino men who have sex with men (YBLMSM), I conducted a qualitative analysis to explore the role of mentors in the lives of YBLMSM and to examine the factors influencing development of mentoring relationships. Results indicated that pervasive homophobia, disclosure of sexual identity and HIV status, and representation and visibility of YBLMSM in the community influenced the development of mentoring relationships by creating opportunities for and barriers to social connections. Mentors also served multiples purposes in the lives of YBLMSM. As role models, they were visible examples of achievement, success, and resilience for YBLMSM. Mentors also contributed to YBLMSM's psychological well-being, providing emotional and identity support to increase self-esteem and stimulate hope and visions for the future. They also played a more active role by creating opportunities for social and economic advancement through the provision of informational and instrumental supports related to education and employment. Findings thus highlight the supportive roles of mentors, especially for YBLMSM experiencing challenges related to social and economic disadvantage. These challenges,



however, reflected the urban community and neighborhood conditions that also limited access to and availability of mentors in the first place.

## **CHAPTER I**

### **Introduction**

This dissertation focuses on the social relationships that promote or hinder the health and well-being of sexual minority youth living in the Detroit Metro Area (DMA). The term *sexual minority* has gained traction as a broader and more inclusive term to identify individuals who have same-sex attractions or same-sex sexual experiences and who may or may not claim a specific sexuality-related identity such as lesbian, gay, or bisexual (LGB) (Mohr & Kendra, 2011). The term has also been used to identify groups of people who are stigmatized and share experiences of sexual prejudice because of their same-sex attractions and sexual experiences (Fassinger & Arseneau, 2008). *Sexual minority* may be used throughout this text as a means of remaining inclusive but with the acknowledgement that the term may also obscure within-group heterogeneity with respect to sexual identities, attractions, and behaviors (Moradi et al., 2009). Some discussions of concepts and theory relate to sexual minorities broadly. The use of specific terminology will also vary according to the research being cited, and the sample characteristics of those studies, as well as the characteristics of the participants in the three studies of this dissertation. In Chapter II (Study 1) and Chapter III (Study 2), for example, I focus on self-identified young adult gay and bisexual men (YGBM) while in Chapter IV (Study 3) I focus on young Black and Latino men who have sex with men (YBLMSM).

#### **Sexual Minority Youth (Adolescents and Young Adults)**

Adolescence and young adulthood constitute vulnerable time periods in which individuals are particularly sensitive to social and environmental influences as they progress

through key developmental milestones. Therefore, in discussing the lived experience of sexual minority adolescents and young adults, it is important to understand the developmental transitions that occur during these periods, which include both psychological and social processes (Kertzner, 2007). For sexual minority youth, psychological milestones include those related to the development of an LGB identity. Multiple theories of sexual identity development have been proposed over the last four decades to describe the processes by which individuals become aware of their sexual minority identity and subsequently attempt to integrate this identity into their overall self-concept (Eliason & Schope, 2007). Across these theories, researchers have noted how pervasive homophobia, as documented in national US surveys about attitudes towards homosexuals, may threaten healthy sexual identity development among sexual minority populations (D'Augelli, 1994; Glick & Golden, 2010).

A key concept linking internal psychological processes to external social experiences is internalized homophobia (IH). Defined as “the gay person’s direction of negative social attitudes towards the self,” IH is the process by which external experiences of sexuality-based discrimination lead to internalized states of psychological distress (Herek, 2004; Meyer and Dean, 1998; Ross et al., 2010). In Newcomb and Mustanski’s (2010) meta-analytic review of IH and internalizing health problems among LGB persons, IH had a strong and moderate positive association with depression and anxiety, respectively. Researchers have also highlighted the implications of IH for mental health in the context of sexual identity development among LGB youth, particularly in the process of disclosing an LGB identity (D’Augelli, 1994; Meyer, 1995; Cox et al., 2011; Rosario and Schrimshaw, 2002). Beyond internalized stressors, researchers have also underscored how social stressors (e.g., sexual prejudice, compulsory heteronormativity) may affect the health and development of sexual minorities. The definition

and measurement of these overlapping but distinct concepts has been inconsistent but the goal is ultimately to “locate prejudice within the broader social, cultural, and political context rather than within the individual” (Szymanski et al., 2008).

Social frames included in life course models have an emphasis on the social, cultural, and historical influences that accumulate and continue to shape development over the life course (Cohler & Galatzer-Levy, 2000). By turning the developmental lens outwards to include the social environment, D’Augelli (1994) suggests we can better identify and target one of the most powerful social forces affecting sexual minority development: heterosexism. Heterosexism, defined as “the ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationships, or community,” serves to create hostile social environments that may directly impede healthy development among sexual minorities (Harper & Schneider, 2003; Herek, 1995, p. 321).

Research on the psychosocial health of sexual minority youth remains limited in some important ways. Developmental challenges are often attributed to the adolescent period, for example, yet issues related to sexual identity development and disclosure remain significant throughout adulthood and may vary by across demographic groups. Recent changes in social attitudes toward sexual minority populations likely account for cohort differences in age of disclosure, however, the reasons for disclosure differences by race and ethnicity are not fully understood. Among recent cohorts of male and female youth who eventually self-disclosed (i.e. *come out*) as LGB to a significant family or peer, the average age of disclosure to oneself was 15 to 16 while to a significant family member or peer was around 17 (Groves et al., 2006). In this same study, however, significant difference emerged by race and ethnicity with 77% of Whites overall indicating being out to their parents compared to 62% of Black and 61% of Latino

participants (Groves et al., 2006). Among participants in the youngest cohort (18 to 34 years of age), Groves and colleagues (2006) found that nearly a third of participants had not disclosed their LGB sexual identity to their parents. This type of concealment can have substantial implications for the psychological health of sexual minorities as disclosure to parents at this point in time is likely to coincide with other milestones such as leaving the parents' home, starting college or full-time employment, and pursuing romantic relationships (Dew et al., 2006). Little is known, however, regarding parent influences among young adults in general and specifically among sexual minority young adults compared to what is known about the role of parents among adolescents.

Existing developmental models are limited in their application across diverse populations. The available research examining the transition between adolescence and young adulthood is largely based on the experiences of White, urban, heterosexual, and middle-class young adults (Bynner, 2005; Hendry & Kloep, 2007). Little work has been done with racial/ethnic and sexual minority youth to understand how the changes they experience during this time are shaped by their social identities and vice-versa. For example, as youth pursue new employment and academic opportunities, their social networks potentially increase in size and heterogeneity. These networks become places where youth further develop their particular racial, ethnic, and sexual identities but where they may also encounter experiences of discrimination based on those identities (Longerbeam et al., 2007; Pizer et al., 2012; Renn & Ozaki, 2010). Other important life domains (e.g., family, romantic relationships, employment and school) remain underexplored in the lives of sexual minority youth.

### **Public Health Significance**

In light of these developmental transitions, sexual minority youth face considerable challenges yet they also display tremendous resilience. Public health researchers and practitioners increasingly advocate for greater examination of the factors that are deleterious as well as beneficial to the overall health of sexual minority youth including their psychological, emotional, spiritual, behavioral, physical, and sexual health (D'Augelli & Grossman, 2006; Harper et al., 2012; Herrick et al., 2006; Kubicek et al., 2013; Lerner, 2005; Russell, 2005; Savin-Williams, 2001). The role of psychosocial determinants, which describes the interaction between individual psychological characteristics with those of the social environment, has also gained relevancy for understanding sexual minority health outcomes particularly as they relate to health disparities (Horn et al., 2009; Rutter, 1987).

Through a growing body of literature, researchers continue to provide evidence of the link between the negative effects of heterosexism, as it manifests itself in a variety of ways across various social contexts, on psychological health. Compelling evidence of this includes the mental health disparities that disproportionately affect sexual minority populations in comparison to heterosexual populations. These disparities may begin in childhood and continue through adulthood (Bostwick et al., 2010; Hershberger & D'Augelli, 1995; King et al., 2008). Moreover, these mental health disparities have been implicated in increased rates of maladaptive coping behaviors (e.g., smoking, alcohol use and misuse, substance use) observed among sexual minorities across the life course. Therefore, a major public health concern becomes the elimination of these disparities by reducing psychological distress and improving well-being among LGB youth in order to further prevent long-term psychological and physical morbidity.

*Mental Health Disparities and Young Gay and Bisexual Men*

Sexual minority men experience disproportionately higher rates of mental distress compared to heterosexual men. In a national US sample that included heterosexual and sexual minority men (n=14,564), the prevalence rates of four different types of mood disorders and five different types of anxiety disorders were all significantly higher among gay and bisexual men (GBM) (Bostwick et al., 2010). Compared to heterosexual men, for example, more gay men experienced major depression (42% vs. 27%) and generalized anxiety disorder (17% vs. 5%), and bisexual men were also disproportionately affected with 35% and 12% experiencing major depression and generalized anxiety disorder, respectively (Bostwick et al., 2010). These trends remained true whether making comparisons by sexual identity, sexual attraction, or sexual behavior groups among men. Furthermore, in their meta-analytic review of mental disorders, suicide risk, substance misuse, and deliberate self-harm among LGB populations, King and colleagues (2010) found that gay and bisexual men's risks of depression or anxiety disorders (12-month or lifetime prevalence) were at least nearly twice that of heterosexual men. Similarly, Cochran (2003) found that gay and bisexual men were three and half times more likely to be diagnosed with major depression, however there were no differences with respect to generalized anxiety disorder.

Detailed mental health data for *young* gay and bisexual men (YGBM) is limited and it remains difficult to establish within-group epidemiologic profiles and to make comparisons between them and heterosexual counterparts. Based on community samples, however, there are similar disparities with YGBM reporting more internalizing behavior and scoring higher on the severity of these behaviors, particularly in relation to depression more so than anxiety (D'Augelli, 2002; Elze, 2002). The HIV literature is another source of mental health research on YGBM but findings may not be generalizable to all YGBM given the focus on sexual health and

HIV sexual risk behavior in these studies. Using data from The EXPLORE Study, a national multi-site HIV prevention trial of 4,295 men who have sex with men (MSM), Salomon and colleagues (2009) found that 57% of 16-25 year-olds (n=814) and 46% of 26-35 year-olds (n=1,823), had depressive symptom levels that were above the median depressive symptom level for the entire study sample. Interestingly, prevalence rates continued to decrease with increasing age categories. In a community sample (n=310) of 16-24 year-old MSM, 32% of study participants had a Global Severity Index score that was positive for psychological distress (Mustanski et al., 2007). In another community sample (n=351) of HIV-positive 13-24 year-olds, 50% of study participants scored in the clinically significant range for depression (Hightow-Weidman, 2011). These studies provide evidence that significant proportions of YGBM are experiencing psychological distress but also that more research is needed in developing population-level psychological profiles for YGBM.

#### *Correlates of Psychological Distress*

Depression and anxiety are indicators of psychological distress that are associated with a host of harmful externalizing behaviors among YGBM. In the previously mentioned meta-analytic review, for example, King and colleagues (2010) found significantly higher pooled risk ratios (RR) for adult GBM compared to adult heterosexual men with respect to 12-month suicide attempt (2.52), suicide ideation (1.64), alcohol dependence (1.51), and drug dependence (2.41). The associations between mental distress, externalizing behaviors, and HIV-related sexual risk behavior among GBM have also been documented in the literature (Koblin et al., 2003; Koblin et al., 2006; Lelutiu-Weinberger et al., 2013; Mustanski et al., 2011; Safren et al., 2010; Stall et al., 2010; Yi et al., 2010).



Research on correlates of psychological distress among YGBM largely exists within the HIV/AIDS research literature where a focus has been on examining the mediators and moderators of the relationship between psychological distress and HIV-related sexual risk behavior (Halkitis et al, 2013). For example, Rosario and colleagues (2006) found that anxious symptoms positively predicted substance abuse, which in turn positively predicted condomless receptive anal sex among gay and bisexual 14 to 21 year-old individuals. While it remains critical to directly address the HIV/AIDS epidemic, of which YGBM in particular bear the largest burden in the United States, researchers have begun to examine sexual health more broadly in the context of psychosocial health. However, the public health psychosocial health literature remains limited with respect to YGBM populations.

### **Frameworks and Theories**

In order to effectively address the health of YGBM and other sexual minority populations, YGBM must be understood in the context of their immediate and broader social environments. For this dissertation, I employ a socioecological framework to acknowledge that health behaviors are subject to multiple levels of influence (e.g. individual, interpersonal, community, and structural) (McLeroy et al., 1988). I also apply sexual minority stress theory and social networks theory to further examine how specific experiences (e.g., discrimination and social support) and interactions with certain people (e.g., parents, families, mentors) influence YGBM health.

Among the new topic areas for which health-promotion and disease-prevention goals have been set in Healthy People 2020, *social determinants of health* was recently included, with the goal of creating social and physical environments that promote good health for all among individuals, families, and communities (US Dept. of Health and Human Services, 2010). Social

determinants of health are the social conditions within and across levels of influence that have an impact on health behavior and well-being. Of the five determinant areas reviewed in *Health People 2020*, *social and community context* directly addresses *discrimination* and *social cohesion* as key issues in creating healthy social environments. Similarly, in the CDC's (2006) latest update of *Advancing Nation's Health*, examples of priority research for improving adolescent development included evaluation of parent-based interventions. Public health researchers and practitioners face the challenges of theorizing, examining, and establishing the pathways by which social determinants of health impact individual health. Therefore, a goal is to develop and support policies that promote health by addressing individuals and their behaviors directly and/or by addressing specific features of the social environment that have the most influence on behavior and well-being.

These recommendations fall in line with recent theory and evidence around the importance of considering parents and families, and peers such as friends and mentors, in development of health-related interventions for youth (Arnett, 2000; Drevon et al., 2015; Guilamo-Ramos et al., 2010; Harper & Riplinger, 2013; Hays et al., 2013; Kubicek et al., 2013; Stanton et al., 2004; Turrissi et al., 2001; Zimmerman et al., 2005). However, despite increased interest in the role of parents, families, and peers among YGBM, the social networks of YGBM remain poorly understood in various areas including social support, vulnerability to HIV infection, and friendship. In Bouris' (2010) review of parental influences on the health of LGB youth, for example, most of the 31 quantitative studies examined focused on negative parent-child relationships and did not include racially and ethnically diverse samples of youth.

### *Socioecological Framework*

According to Bronfenbrenner's (1979) socioecological theory of development, multiple systems of influence simultaneously shape human development early in life. This theory provides a useful framework for examining how interpersonal relationships (microsystem), community organizations or institutions and the connections between them (mesosystem), and ideologies, laws, and policies (macrosystem) affect the health and wellbeing of sexual minorities. In other words, human development and behavior is best understood when taking the individual's social environments into account. Researchers have employed socioecological theory to investigate a variety of issues related to YGBM including sexual identity development, mental health, social support, and vulnerability to HIV infection (D'Augelli et al., 1994; Frye et al., 2006; Horn et al., 2009; Mustanski et al., 2011).

Interpersonal relationships with family, peers and romantic partners constitute the microsystem of the socioecological model, the most proximal level of influence with respect to an individual (Bronfenbrenner, 1979). Researchers have underscored the importance of the microsystem (e.g., family and peer social networks) when examining youth well-being (Collins et al., 2000; Helsen et al., 2000; Steinberg, 2000). In his review of conceptual and empirical issues in family research, Parke (2004) highlights the importance of thinking about the family as a unit in order to understand how factors across the socioecological model influence family functioning as a whole. Theoretical and conceptual frameworks on family and peer networks remains limited however with respect to YGBM. One notable exception is D'Augelli's (2005) model of youth sexual and gender identity development, which D'Augelli's situates within the family unit as influenced by factors in the mesosystem (e.g. neighborhoods, schools, work environments, the media, and LGB communities) and macrosystem (e.g. heteronormative conceptualizations of family).

Given sexual minorities' stigmatized identities and marginalized status in society, family and peer networks become potentially significant social determinants of mental and physical health for YGBM (Detrie & Lease, 2007; Helsen et al., 2000; Kawachi & Berkman, 2001; Sheets & Mohr, 2009; Thoits, 2011). Therefore, developing policies and interventions that support YGBM's family and peer networks is one possible approach to addressing the current mental health disparities that disproportionately affect YGBM. Current research on YGBM's family and peer networks, however, remains limited.

#### *Sexual Minority Stress Theory*

Meyer (2003) suggests that increased levels of stress among sexual minorities results from the sexuality-based violence, prejudice, and discrimination that sexual minorities experience in daily life. Repeated exposure to these kinds of experiences leads to expectations around future exposure (e.g., hypervigilance), and individuals may begin to conceal various aspects of themselves (e.g., mannerisms, dress, other gender expression) to decrease vulnerability to victimization. The high effort involved in managing one's identity and the internalization of negative social attitudes, over time, contributes to psychological distress outcomes among sexual minorities. In this context, coping becomes an important process by which sexual minorities deal with stress related to negative social experiences.

#### *Social Networks and Social Support Theory*

Israel (1982) describes social networks in terms of their structural, interactional, and functional characteristics. Structural characteristics include the number of people in a network and number of connections between them, while interactional characteristics further describe the types of interactions and relationships that network members have in relation to each other and to the network as a whole. Examples of interactional characteristics include frequency, which

refers to the amount of contact between individuals, and homogeneity, which refers to the extent that network members are similar or different from each other. Functional characteristics of social networks are the material and psychological resources that pass between network members such as instrumental support (e.g., food and shelter), emotional support (e.g., love and attention), and informational support (e.g., guidance and suggestions).

The functional characteristics of social networks have been the primary focus of research examining the relationship between social networks and physical and psychological health (House et al., 1998). Stress-buffering and direct effects mechanisms have been proposed to explain this relationship (Cohen & Wills, 1985). The stress-buffering hypothesis suggests that social supports moderate the relationship between a stressor and health outcome either by diminishing the stressor or its negative effects. The direct effects model suggests that the availability of social supports is important for health regardless of whether stressors are present or not.

## **Young Gay and Bisexual Men Across Social Contexts**

### *Multiculturalism and Families*

Given the continuously and rapidly changing demographic landscape of the United States, it becomes imperative that researchers consider the role of culture and multiculturalism in the study of families. Health disparities research indicates that Black and Latino families may be particularly vulnerable to poor health outcomes due to structural inequalities that systematically marginalize Black and Latino populations (McLanahan et al., 2008; McLoyd et al., 2000; Gonzales et al., 2002; William & Collins, 2001). Some major limitations affect the generalizability of previous research with Black and Latino families. For example, researchers have often applied a deficits-based approach to studies of Black families, and research on Latino

families has often ignored the heterogeneity that exists within Latino populations (Gadsen, 1999; Parke et al., 2003). Within-group studies have led to research that highlights the variability found within Black and Latino families, including findings around resilient behavior, kinship networks, and family-centered beliefs that are protective against stressors and risks found in surrounding social environments (Gill-Hopple & Brage-Hudson, 2012; Taylor, 2000; Zinn & Wells, 2000; Walsh, 1996). These limitations must continue to be addressed in order to improve understanding around family processes across diverse populations.

A growing area of family-based research is that which focuses on sexual minority youth in the context of their families. Recent changes in social attitudes and policies towards sexual minority populations have created a dynamic social environment that must be considered when conducting contemporary research with families around issues of sexuality and gender (Parke, 2004). Scholars have employed queer theory to examine how families with sexual minority children function in the context of a heterosexist society (Oswald et al., 2009). For example, the extent to which parents adhere to heteronormative beliefs (e.g. traditional gender-based parent roles, gender policing of children, anti-gay marriage sentiment) may cause parent-child relationship strain, which has been associated with poor short and long-term outcomes among youth (Bouris et al., 2010; Ryan et al., 2009; Willoughby et al., 2010). In reaction to this type of within-family discrimination, sexual minority youth have turned to chosen families as sources of support. Chosen families are networks of close friends, including former lovers and other sexual minority individuals, that sexual minority individuals rely on and sometimes claim as their primary family (Weston, 1991). Essentially, these chosen families challenge heteronormative beliefs about family structure. In a recent report, the Institutes of Medicine (IOM, 2011) called for greater research on the “experience and prevalence of ‘chosen families’” (p.235).

### *General Discrimination*

Discrimination and its effects exist across multiple levels of influence from the interpersonal to the organizational and structural levels. The effects of discrimination on the mental health of sexual minority youth depend on the source of the stressor and on the resources available to victimized individuals. For sexual minority youth who also claim other marginalized social identities, an intersectional approach is helpful for identifying the multiple systems of oppression that affect them and their families (Crenshaw, 1989, 1991; Szymanski & Moffitt, 2012; Weber, 1998; Yuval-Davis, 2006).

Racism, classism, genderism, and heterosexism have each played unique roles in shaping living conditions and social urban environments in the United States (William & Collins, 2001). Understanding the experiences of sexual minority youth includes capturing their experiences of having simultaneously occurring racial, ethnic, and sexual identities. In a 2008 national study of attitudes toward homosexuality, 72.3% of Blacks surveyed expressed that homosexuality was “always wrong,” compared to 51.6% of Whites (Glick & Golden, 2010). Several reasons might explain this finding. These attitudes and perceptions of relatively higher levels of homophobia in racial/ethnic communities could reflect the history of exclusion that racial/ethnic sexual minority males have experienced throughout the course of the gay liberation movement (d’Emilio, 2012). On the other hand, Black and Latino communities may not have the resources to cope with sexuality-based stressors when they are already coping with stressors related to identification with a racial or ethnic minority community (Willoughby et al., 2008).

### *Young Gay and Bisexual Men and Discrimination*

Young Black and Latino gay and bisexual men (YBLGBM) contend with heterosexism but also with racial/ethnic discrimination and classism (Diaz, 1998; Glick & Golden, 2010;

Harper & Schneider, 2003; Herek et al., 2010; Kertzner et al., 2009; Kraft et al., 2000; Pizer et al., 2012; Szymanski & Moffitt, 2012; Teunis, 2007; Vega et al., 2011). Among 803 adult Black and Latino sexual minority men, 62% and 68% reported past-year experiences of racism in the general and gay community, respectively, and 54% and 45% reported experiences of homophobia in the general community and among heterosexual friends, respectively (Choi et al., 2013). Despite the lack of descriptive data on the mental health of YBLGBM, a growing body of evidence continues to demonstrate associations between having experiences of racial/ethnic and sexuality-based discrimination and poor mental health. In a sample of gay and bisexual Latino males, 64% and 31% reported ever experiencing homophobia and racism, respectively, and this was associated with poor psychological symptoms (Diaz et al., 2001, 2004). In other studies with diverse samples of sexual minority men, approximately 60% of Black and Latino sexual minority men reported experiences of racism, with half of Black sexual minority men and 60% of Latino sexual minority men also reporting experiences of homophobia; both types of discrimination were associated with depression (Choi et al., 2013; Mizuno et al., 2012).

Few experiences of classism have been documented in the literature. Barrett & Pollack (2005) found that that lower SES predicted less involvement in socially visible gay culture among a large national sample adult sexual minority men, which is consistent with other reports (Mills et al., 2001). Via qualitative interviews, Green (2008) describes a sexual status order that privileges older Caucasian middle class men, and suggests that low-SES racial/ethnic sexual minority men experience poor mental health and engage in HIV sexual risk behavior as a result. These findings highlight the need to consider SES as a social position that becomes intertwined with racial, ethnic, and sexual identities.

#### *Discrimination in the Family*



Recent research on sexual minority youth experiences within their families increasingly highlights the important role of parents in sexual minority youth's mental and behavioral health and long-term well being. Much of the current research on sexual minority youth relates to adolescents and the consequences of disclosing a sexual minority identity to parents including youth's perceptions of parents' reactions. Evidence consistently suggests a strong association between parental rejection and negative psychological and behavioral health outcomes for sexual minority youth (Bregman et al., 2012; Ryan et al., 2009; Willoughby et al., 2010). More specifically, family rejection has been associated with suicide behavior, depressive symptoms, substance use, and condomless sex among sexual minority youth (Ryan et al., 2009). These associations may be contributing to health disparities that disproportionately affect sexual minority youth. For example, Ueno (2005) found that having problems with parents partially explained why sexual minority youth had higher levels of psychological distress compared to heterosexual youth. Little work has been done, however, on examining the factors that predict parental reactions to a child's disclosure of a sexual minority identity. Until recently, the theory of death and dying had been used to explain parent's reactions as a linear progression from rejection to acceptance, but new research suggests that parents may simultaneously express a variety of reactions in a non-linear fashion (Kubler-Ross, 1969; Savin-Williams & Dube, 1998; Willoughby et al., 2006).

Families as single units have unique ways of coping and dealing with stressors that affect the family as a whole. According to family stress theory, a family's ability to cope with stressors depends on three factors: resources, meanings attributed to the stressor, and stressor pileup (Willoughby et al., 2008). A stressor has the potential to change the family system to a state of disequilibrium, and their effect depends in part on the extent to which the stressor is classified as

normative or non-normative (Patterson, 1988; Rossman et al., 1997). Based on this definition and previous research, the disclosure of a son's gay or bisexual identity to his parents may be perceived as a stressor (Willoughby et al., 2006). According to the concept of stress pileup, parents' reactions and ability to cope with the stress of a disclosure may be depend on the presence and accumulation of other stressors (e.g. financial strain, marital discord, etc.). Willoughby and colleagues (2008) also posit that racial and ethnic-based discrimination may contribute to this pileup of stressors, which may explain racial and ethnic differentials in general and parental attitudes towards homosexuality, however, previous evidence has been inconsistent (Glick & Golden, 2010; Morales, 1989; Merighi & Grimes, 2000).

### *Family Social Support*

Researchers have recently begun to apply concepts of social network and social support theory to explain interpersonal processes within families of sexual minority youth. Researchers have found that, among high school sexual minority youth, family connectedness and acceptance was negatively associated with suicide behaviors and that perceptions of family caring predicted lower levels of emotional distress (Eisenberg & Resnick, 2006; Homma & Saewyc, 2007; Ryan et al., 2010). Some evidence indicates that young adult populations still benefit from having parent support even after they leave the home and become more autonomous (Arnett, 2000, 2007; Needham & Austin, 2010; Sheets & Mohr, 2009; Stanton et al., 2004; Turrisi et al., 2001). Doty and colleagues (2010) differentiated between general and sexuality-specific social support, and both were associated with decreased emotional distress but sexuality-specific support was important for sexuality-specific distress. Even among this sample of sexual minority 18-21 year-olds, parental support conferred health benefits (Carpineto et al., 2009; Sheets & Mohr, 2009). Participants, however, perceived the greatest sexuality-specific support as coming from other

sexual minority peers followed by non- sexual minority peers and then parents. A major limitation of this research is the lack of parent perspectives to examine the degree of concordance/discordance between LGB youth perceptions of parental support and parents' own perceptions of support provision.

In order to properly address the health disparities currently affecting sexual minority populations, sexual minorities must be understood in their immediate social context as well as within broader layers of influence. Socioecological theory categorizes the social environment into three distinct levels: micro-, meso-, and macrolevel. Intersectionality theory further situates individuals and their various marginalized social identities within systems of power located throughout these levels. Sexual minorities develop their identities within dynamic social systems. The extent to which these social systems support and sustain healthy psychosocial development, or marginalize and oppress sexual minorities, has an effect on the mental health of sexual minority populations. Currently, little research has been done on family and peer networks as sources of support for young adult sexual minority populations. As sexual minority populations continue to redraw the boundaries that define family and kinship, understanding how these types of families work is important for influencing social policy given that these *chosen families* are beneficial for healthy psychosocial development among sexual minority populations.

## **Current Dissertation**

### **Study Site**

The study site is the Detroit Metropolitan Area (DMA), a combined statistical area (CSA) that includes nine counties comprising Southeast Michigan and includes the city of Detroit, containing 43% of Michigan's overall population. Based on estimates from the U.S. Census Bureau (2016), the majority of residents in the DMA identify as White (70%) followed by

African-American (23%) while 4% identify as Hispanic/Latino of any race. Nearly one-third (32%) of the population is under the age of twenty-five. Among those who are twenty-five and older, 12% have less than a high school degree, 60% have a high school degree or some college experience, and 28% have a college or graduate degree. Furthermore, 12% of the population over fifteen years old is unemployed, and 17% of all individuals and 13% of all families live at or below the federal poverty level. The vast majority of residents (93%) live in urban areas within the DMA.

Socioeconomic conditions in the DMA have been shaped by historical changes in migration patterns and shifts in labor markets that affected major urban areas throughout the United States. As large segments of Black populations began migrating from rural southern areas to northern urban centers beginning in the 1930's, local community groups, land developers, and government representatives began to implement racist housing policies that would limit housing options for Black people. Black populations were relegated to public housing developments in neighborhoods that were isolated and deficient in basic municipal services (Geronimus, 2003; Massey & Denton, 1993). Unemployment within Black communities became a core issue beginning in the 1960's with the increase of manufacturing jobs requiring advanced skills and the relocation of these jobs from urban to suburban areas (Farley et al., 2000; Patillo 2007; Weber, 2010). As affluent Whites left the cities, taking their tax base with them, urban centers became pockets of concentrated poverty occupied primarily by the racial and ethnic minority populations that remained within them. Urban neighborhoods experienced systematic and massive reductions in municipal services (e.g. street and park maintenance, firefighting, law enforcement, etc.), and residents experienced more stress, family separation, isolation, and violence. The effect of these conditions on individual health has become a major focus of

current public health research, specifically in the study of structural and social determinants of health (Acevedo-Garcia et al., 2003; Acevedo-Garcia & Osypuk, 2008; Gee & Payne-Sturges, 2004; Link & Phelan, 2005; Osypuk 2013; Phelan et al., 2010; Williams & Collins, 2001).

### *Description of Studies*

The broad purpose of my dissertation is to examine the social supportive functions of parents, families, and mentors in the lives of young adult gay and bisexual men (YGBM). Using a three paper approach, this dissertation will add to the nascent body of evidence regarding the roles of parents among young adults, the supportive and non-supportive nature of family ties within different family types, and the presence and purpose of mentors among young adult Black and Latino men who have sex with men (YBLMSM). An outline of each dissertation chapter is provided below.

### Chapter II

The purpose of Chapter II is to examine the relationship between perceived maternal and paternal support with substance use behaviors (cigarettes, alcohol, marijuana, hard drug). I will test a stress-buffering hypothesis by examining if maternal and paternal supports moderate the relationship between sexuality-based victimization and substance use. Main effects between support and substance use will also be examined in adjusted multivariate logistic regression models.

Study 1: Among sexual minority youth and young adults, experiencing sexuality-based victimization has been associated with poor psychosocial outcomes including psychological distress and substance use. Social support may play an important role in mitigating the effects of victimization on substance use behavior. While a large body of literature exists regarding the important roles of parents for adolescent health, less is

known about the role of parental support for the psychosocial health of sexual minority young adults. Parent support and rejection has been associated with psychosocial health among sexual minority children although most of this research has focused on negative interactions between parent and child. (Ryan et al., 2009, 2010). Traditional models of youth development also assume that parental influences on child health largely diminish around eighteen years of age. As a result, the direct influence of parental support on substance use behaviors among sexual minority young adults remains largely unexamined. The indirect influence of parental support on mitigating the impact of victimization on substance use, among sexual minority young adults, also remains unexplored. Furthermore, little work has been done to understand the influences of parent support by gender of the parent (i.e., maternal support and paternal support).

**Specific Aim 1:** Describe past 30-day substance use behaviors (alcohol, cigarettes, marijuana, hard drugs) in a community sample of YGBM.

**Specific Aim 2:** Examine the associations between sexuality-based victimization, substance use, and maternal and paternal social support.

**Specific Aim 3:** Examine potential moderation effects of maternal and paternal support on the relationship between victimization and substance use among YGBM.

### Chapter III

The purpose of Chapter III is to explore how YGBM define their families, and to examine how family social support and family social undermining are associated with psychological distress outcomes (depression and anxiety) within different types of families. I will conduct descriptive analyses to generate a family typology of chosen family and family of origin networks. Utilizing multivariate regression, adjusting for measures of sexual identity

development (internalized homophobia and sexual orientation disclosure), I will model depression and anxiety separately for each family type.

Study 2: Sexual minority youth may seek to establish other close supportive social networks when experiencing sexuality-based rejection within the family. Even among supportive families, these youth may establish external networks in order to access support from other sexual minorities that may not be available within their families. Biological families thus become families of origin while these cohesive extra-familial networks have been labeled *chosen families* (Weston, 1991). Thus, families of origin and chosen families may serve distinct and also overlapping functions in the lives of sexual minority youth. For example, chosen families among sexual minority youth may serve specifically as sources of sexuality-based social support and/or other sources of support, possibly depending on the role of the family of origin. Interventions and programming aimed at strengthening the ties between sexual minority youth and their parents have not considered the role of chosen families. The role of these different types of families and their implications in the psychological health of sexual minority populations has also not been well examined quantitatively in a sample of sexual minority youth.

**Specific Aim 1:** Describe a typology of family networks in a community sample of YGBM.

**Specific Aim 2:** Examine the associations between family support and undermining with psychological distress across different family types.

## Chapter IV

The purpose of Chapter IV is to explore the factors that influence development of mentoring relationships, and to examine the purpose of mentors and mentoring relationships in

the lives of YBLMSM. I will conduct a qualitative analysis of interviews completed with community stakeholders who have experience working with YBLMSM or providing services to YBLMSM in some capacity. Salient themes will be presented and described.

Study 3: The significance of mentors for the health and well-being of sexual minorities remain largely unexamined. Research on the social support networks of sexual minority youth and young adults has largely focused on parents and peers. With the exception of a few studies, little is known about the extent to which mentors are available and accessible in the social networks of sexual minority youth and young adults. Researchers have so far examined the significance of natural mentoring relationships (NMRs) and non-parental adults (NPAs) among sexual minorities. Ethnographic studies on the chosen families of LGB populations suggest these networks may be a source of mentors and mentoring relationships. It also remains unclear if there are particular mentor roles or benefits that may be important specifically for sexual minority youth and young adults. Mentors generally have greater knowledge and experience that they draw upon to provide guidance and support for growth among mentees, and the mentoring relationship is one built upon a sense of trust (DuBois & Karcher, 2005). These relationships may form through a program or organization (formal mentoring) or develop organically between two individuals (informal/natural mentoring). The ease by which these relationships form may depend on the opportunities that sexual minorities individuals have to connect with each other in first place. These may be influenced by the social and economic conditions of the immediate environment. Therefore, examining the factors that influence availability and accessibility to mentors may be as important as examining the roles of mentors themselves.



**Specific Aim 1:** What are the factors that influence the development of mentoring relationships among young YBLMSM?

**Specific Aim 2:** What are the roles of mentor and mentoring relationships in the lives of YBLMSM?

### **Public Health Contribution of Proposed Dissertation**

Social networks may serve as sources of support or strain thus potentially contributing to, exacerbating, or protecting against the social stress and subsequent poor psychosocial outcomes impacting YGBM's health. The structural characteristics and functional qualities of YGBM's social networks, however, lack description and remain poorly understood in the social support and sexual minority health literature. This dissertation will address some of these gaps. Findings potentially have implications for clinical care and social work practice with YGBM, particularly in the areas of substance use and mental health. Findings may also inform development of parent or family-based interventions that address substance use issues among YGBM, including identification of key influential individuals in YGBM's social networks. Findings may also inform development of mentoring programs, particularly for vulnerable YBLMSM.

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## CHAPTER II

### **Mothers and Fathers: Do perceptions of parental support matter in the substance use behaviors of young adult gay and bisexual men?**

#### **Introduction**

The majority of sexual minority men do not meet criteria for substance use disorders, however, accumulating evidence suggests there are growing disparities in rates of substance use between heterosexual and sexual minority men (McCabe et al., 2009, 2010). Based on a nationally representative sample, McCabe and colleagues (2010) found a 28% prevalence rate of past-year substance use disorders among lesbian, gay, and bisexual (LGB) adults compared to 11% among heterosexual adults. Men who reported having same-sex attractions or behaviors, including men who identified as gay or bisexual, were more likely than other men to report past-year use or dependence on alcohol, marijuana, and other drugs (McCabe et al., 2009). These sexuality-based disparities, which also apply to cigarette use, have been found among adolescent and adult male populations (Austin & Bozick, 2011; Brewster & Tillman, 2011; Drabble et al., 2005; Mackesy-Amiti et al., 2008; Marshal et al., 2008, 2009; Trocki et al., 2009). Age-specific trends indicate that emerging adulthood, usually defined as occurring between eighteen years of age and lasting through the mid or late twenties, is a particularly vulnerable time for developing substance dependencies (Arnett, 2000; Johnston et al., 2015b). Although the literature on sexual minority emerging adults is limited, recent evidence indicates that substance use levels are generally highest among emerging adult sexual minority men compared to older sexual minority

and heterosexual men (Blosnich & Horn, 2011; Corliss et al., 2010; Greenwood et al., 2005; Goldberg et al., 2013; Mackesy-Amity et al., 2008; Stall et al., 2001).

Substance use increases and peaks throughout young adulthood with use being higher among men compared to women at every age group and for most types of substance (Johnston et al., 2015b). Using nationally representative data from Monitoring The Future (MTF), one of the largest on-going studies of adolescent and adult drug use in the United States, researchers have reported past 30-day prevalence rates for alcohol use (72.5%), cigarette use (20.9%), marijuana use (21.6%), and other illicit drug use (11.4%) among men ages 19 to 30 years old (Johnston et al., 2015b). Findings from Johnston and colleagues (2014, 2015b) further suggest that binge drinking, cigarette use, and other illicit drug use increase during this time, peaking among 21 to 22 year-olds and remaining at higher levels until after 30 years of age when use noticeably begins to drop, especially for binge drinking and other illicit drug use. Marijuana use peaks a couple of years earlier and then steadily dissipates over time through middle adulthood (Johnston et al., 2014).

Trends by race and ethnicity have been observed but they also vary across age groups and by type of substance. In general, alcohol and other illicit drug use is highest among whites followed by Hispanic and then African-American young adult populations (Johnston et al., 2005, 2015a; White & Jackson, 2006). Although more African-American and Hispanic youth initiate cigarette smoking at younger ages, white and Hispanic youth are subsequently more likely to become regular smokers through young adulthood (Ellickson et al., 2004; Johnston et al., 2015a). Similarly, whites are most likely to report marijuana use although racial and ethnic differences in marijuana use are generally less pronounced (Johnston et al., 2005, 2015a).

### **Substance Use and Emerging Adulthood**

Substance use varies within and across various demographic groups but emerging adult sexual minority men carry the burden of this issue. For sexual minorities entering young adulthood, substance use behavior may be impacted by a confluence of social and environmental factors that pertain to normative developmental trajectories common to most youth as well as factors that are directly related to the experiences of LGB youth and young adults (Arnett, 2000, 2007; D'Augelli, 1994; McCabe et al., 2010; Schulenberg et al., 2005). The reasons for these sexuality and gender-based disparities remain unclear and further examination must take into the account social and environmental influences on substance use behavior in relation to young men's experiences as sexual minorities (Grahl & Teague, 2008; Hughes & Eliason, 2002).

Emerging adulthood has been described as a time of exploration and instability, further characterized by transitions that occur across five general social roles: residence (leaving the parent home), higher educational attainment, entering the workforce, romantic involvement including marriage, and having children (Arnett, 2004; Bachman et al., 1997, 2002; Schulenberg et al., 2005). Reporting on 18 to 24 year-old young adults from the MTF study, Schulenberg and colleagues (2005) found that number and type of social role transitions are associated with binge drinking and marijuana use such that experiencing more role transitions was associated with decreased binge drinking and marijuana use over time. When comparing substance use across different groups experiencing different types of transitions, higher levels of alcohol and marijuana use occurred among those who entered college and left home and also among those who entered the workforce but experienced no other social role transitions (Schulenberg et al., 2005). Conversely, the lowest substance use levels were among men who eventually married and lived outside the parent home (Schulenberg et al., 2005).

The assumed universality and health benefits of these social role transitions are problematic given unique structural and social barriers faced by sexual minority populations. For lesbian, gay, bisexual, and transgender (LGBT) youth who experience sexuality-based rejection and violence in the home, leaving the parent's home may be involuntary or necessary to escape violence and abuse, and subsequent discriminatory housing practices can further increase chances for unstable housing and homelessness (Armstrong, 2013; Keuroghlian et al., 2014). Educational attainment and workplace advancement become difficult in light of sexuality-based bullying and discrimination that occurs in these settings, including the absence of policies and procedures to prevent such discrimination (Allan et al., 2015; Kessel Schneider et al., 2015). Opportunities to seek romantic partners and to sustain relationships may be hindered by the lack of spaces for sexual minorities to safely meet and date (Bauermeister et al., 2011). Youth also lack examples of same-sex romantic relationships in the media, and until recently, same-sex marriage remained unrecognized at the federal level but even still remains contested at local levels (Doan et al., 2015; Greene et al., 2015). Inconsistencies in adoption policies across individual states may also pose challenges for same-sex couples wishing to form family through adoption of children (Gates, 2015; Kimberly & Moore, 2015). Among emerging adults, sexuality-based discrimination at structural and interpersonal levels may hinder the transitions in social roles that are associated with decreased substance use.

### **Sexuality-Based Victimization and Parental Support**

The health benefits of social support have been extensively documented across a wide variety of social settings and social relationships (Cobb, 1976; Cohen, 2004; House et al., 1988a; Thoits, 2011). Two broad mechanisms have been proposed to explain how social support influences health: direct effects and stress-buffering hypotheses (Cohen & Willis, 1985; House et

al., 1998b). The direct effects model suggests that the presence of social support, whether enacted or perceived, contributes to psychological health regardless of the presence of stressors. According to the stress buffering hypothesis, individuals may access social support to diminish the source or the negative effects of a stressor on their health.

A significant stressor in the lives of LGB individuals is sexuality-based victimization, which has been associated with a host of health-related issues including substance use, psychological distress, HIV risk, and poor physical health (Andersen et al., 2015; Blosnich & Horn, 2011; Espelage et al., 2008; Grahl & Teague, 2008; Hatzenbuehler et al., 2012, 2014; Hughes, 2005; Hughes et al., 2010; Keyes et al., 2011; Meyer, 1995; Mizuno et al., 2011; Rosario et al., 2014; Ryan et al., 2009). In this context, social support has the potential to reduce vulnerability to substance abuse given the well-established associations between psychological distress and substance-related coping behavior (Foulds et al., 2015; Gage et al., 2015; Ketcherside & Filbey, 2015; Keyes et al., 2011; Roberts et al., 2015). For sexual minorities, social support may buffer the negative psychological impact of sexual minority victimization, thus mitigating the need to use substances to cope with sexual minority stress (Meyer, 2003; Peirce et al., 2000; Rosario et al., 2014).

In light of increasing concerns over the well being of sexual minority youth, the research literature on the role of family members and family-based types of support has grown considerably in recent years (Grafsky, 2014; Goodrich et al., 2009; Maher et al., 2010; Martin et al., 2009; Rupp & Rosenthal, 2007). Given the extensive literature on the parent-child relationships of heterosexual offspring, and the evidence of parental influences on substance use, considerable gaps remain in our understanding of family and parent influences on the health of LGB youth and emerging adults (Groh et al., 2007; Hoeve et al., 2007; Kandel, 1990; Steinberg,

2001; Warren et al., 2007; White et al., 2000; Wood et al., 2004). In her review of parental influence on five key areas of health and well being of LGB youth, Bouris (2010) noted specific gaps with respect to sexual behavior, substance use, and violence and victimization. The author notes that most research has been focused on mental health and suicide with respect to parental rejection, and has not been inclusive of fathers and racial and ethnic minorities. In his discussion of substance use as a function of the five developmental process of emerging adulthood, Arnett (2005) suggests there are potential positive and negative influences of parents on substance abuse among offspring. In other words, despite increasing influences of peer relationships, parental support remains important to the health and well being of offspring even through emerging adulthood (Elkington et al., 2010; Pingel et al., 2012). Precisely because of these changes in their social networks and social roles (e.g., greater exploration, instability, and feelings of in-between), emerging adults may benefit from continued albeit modified parental involvement during this developmental time period (Aquilino, 1997; Bucx & van Wel, 2008; Cohen et al., 2003; Cooney, 2000; Cooney & Uhlenberg, 1992; Knoester, 2003; Thornton et al., 1995; van Wel et al., 2002).

Even as the literature on LGB youth and emerging adults continues to grow, some gaps persist. With a few notable exceptions, the role of fathers has been largely absent from the parenting literature compared to research that includes mothers (Burns & Caldwell, 2015; Hunt et al., 2015; Jadwin-Cakmak et al., 2015). Narrowing down specifically to emerging adult sexual minority men and their fathers, this research gap widens even farther. Longitudinal studies of substance use among emerging adult populations are also limited in their absence of questions to assess any dimensions of sexual orientation (e.g., identity, attraction, and behavior) among young adult populations (Bachman et al., 2014; McCabe et al., 2005, 2011; Midanik &

Drabble, 2007). Some exceptions here include other cohort studies of substance among adolescents through emerging adulthood, however sub-analyses were not always available by gender and sexual orientation (Blosnich & Horn, 2011; Corliss et al., 2010; Halkitis et al., 2014; Hatzenbuehler et al., 2008; Marshal et al., 2009; Rosario et al., 2004, 2014; Ryan et al., 2009, 2010). These studies also highlight the need for different types of study designs that allow measurement of change over time but that also include large enough samples to allow for comparison across important demographic groups. In general, studies that incorporate these two broad developmental frameworks (emerging adulthood and LGB development) will be poised to fill some of these research gaps.

### **Study Aims**

The overall goal of this study is to examine the role of parental support in the substance use behaviors of YGBM. There are three aims to this study. The first aim will consist of a descriptive analysis of alcohol, cigarette, marijuana, and hard drug (ATOD) use in a sample of 18 – 29 year old gay and bisexual men. This includes an examination of substance use prevalence rates across age groups, sexual identity groups, racial and ethnic groups, socioeconomic status (e.g., educational attainment and employment status), and HIV status. These findings will contribute to overall knowledge regarding variations of substance use within emerging adult sexual minority men. As a second aim, the associations between sexuality-based victimization, maternal support, paternal support, and ATOD will be examined. These associations will be examined to explore the relationships between support, stress, and substance use in light social support and sexual minority stress theories. Furthermore, these analyses will also begin to differentiate between maternal and paternal social support. Finally, the last aim consists of further exploration of these associations in multivariate models, controlling for



relevant confounders related to social role transitions. Moderation effects will be tested to examine the potential independent buffering effects of maternal and parental support on the relationship between victimization and substance use. The persistence of the association between maternal and paternal support will be further examined in relation to four types of substances.

## **Methods**

### **Sampling and Data Collection**

Data come from the United for HIV Integration and Policy (UHIP) study, an academic-community partnership conducted by the University of Michigan School of Public Health in collaboration with community partners in the Detroit Metropolitan Area (DMA). The overall study goal of UHIP is to examine the social and structural determinants of vulnerability to HIV infection among young adult men who have sex with men (MSM) living in the DMA.

Participants were eligible if they indicated a male sex assignment at birth, were between 18-29 years old, were currently living in the DMA, and indicated ever having sex with men.

Researchers used a convenience sampling technique, recruiting study participants at LGBTQ-related events and venues, including bars, clubs, health fairs and other community events, and on-line social networks sites, in collaboration with community partners. Potential participants were approached and received an explanation of the study in addition to a palm card outlining the basic eligibility requirements with a link to the on-line survey and mention of the \$30 incentive for completing the survey.

Upon entering the on-line study site, users were asked to provide an e-mail address they could use to return and complete the survey at a later time, if necessary, and receive a \$30 e-gift certificate upon completion. The study site also includes links to and information about other national and local resources for users. If eligible, as determined by responses to screening

questions at the beginning of the survey, users were subsequently invited to participate and complete an on-line informed consent form (ICF). The ICF explained the purpose of the study, study procedures, risks and benefits to participation, compensation, confidentiality including the Certificate of Confidentiality, and contact information for the study's Principal Investigator and the respective institution's Internal Review Board (IRB). Consented participants completed a 30-minute on-line survey that including the following general domains: sociodemographic characteristics, general and physical health and health behavior, sexuality and gender identity and expression, social networks and social support, general and LGBTQ-specific community involvement, sexual health and sexual behavior, substance use, experiences with victimization, and mental health and other psychosocial assessments.

For participant privacy, all study data were protected with a 128-bit SSL encryption and kept within a University of Michigan firewalled server. During data collection, data were reviewed for duplicates and falsified entries were removed by examining participants' e-mail and IP addresses. The researchers obtained a Certificate of Confidentiality to further protect study data. The University of Michigan, Ann Arbor, IRB reviewed and approved all study procedures.

### **Study Participants**

A total of 429 participants completed the on-line survey. Given the few participants who identified as transgender (N=33; 7.7%), these participants were excluded as the sample size did not allow for adequate sub-analyses to explore the unique experiences and challenges of transgender individuals. Similarly, 16 (3.7%) of participants were excluded who indicated a sexual identity other than gay or bisexual. Another 28 participants (6.5%) were excluded because they had missing data on one or more of variables used for the current study. The final

study sample consisted of 352 gay (90%) and bisexual (10%) cisgender participants between the ages of 18 and 29 ( $M = 23.08$ ,  $SD = 2.91$ ).

## Measures

*Demographics.* Participants reported their age, sexual identity (gay or bisexual), race and ethnicity (Black, White, Latino, and Other), highest level of education completed (less than high school, high school, some college or technical school, and college or higher), current employment status (full-time, part-time, unemployed but looking, and other), and HIV status (HIV-positive, HIV-negative, or unknown).

## Dependent Variables

*Substance Use.* From a list of fourteen substances, participants indicated how many times they had used each substance in the past 30 days. Responses were recorded on a 7-point scale ranging from “0 times” to “40+ times.” Based on the distribution of responses, four categories of substance use (cigarettes, alcohol, marijuana, and hard drugs) were created, each as separate dichotomous variables to indicate any use (1) or no use (0) in the previous 30 days. *Cigarette, alcohol, and marijuana use* were assessed individually in the survey while a *hard drug use* variable was created to indicate any past 30-day use of the remaining nine substances listed, excluding viagara and poppers. Based on conceptual justifications and factor loadings from factor analyses, use of viagara and poppers were not included as “hard drugs,” and use was too rare to include as separate outcomes.

## Independent Variables

*Primary and Secondary Caregiver Support.* The main predictors of interest were parental social support, specifically separate measures of maternal and paternal social support. Each participant was asked to identify the two most important people who raised them, choosing

from a list of family members (e.g., mother, father, cousin, brother, grandmother, etc.) or not choosing anyone if no primary or secondary caregiver was present. For the family member selected, the participant then indicated whether or not they were currently in contact with their caregiver including if the caregiver was no longer living. If contact was maintained, participants were then asked to indicate the extent of social support received from that individual using a 5-item scale. Sample items included: *I rely on my [type of family member] for emotional support* and *My [type of family member] is good at helping me solve problems*. Participants responded on a 4-point scale (1=*True*, 2=*Somewhat true*, 3=*Somewhat false*, 4=*False*) and answers were reverse-coded and averaged so that a higher score indicated greater social support.

A maternal and paternal social support score was generated for each participant who indicated their mother or father as a primary or secondary caregiver. If the participant indicated someone other than their mother or father, they received a maternal or paternal social support score of zero. A significant number of participants identified a primary and secondary caregiver but indicated having no contact with this primary (n=64) or secondary (n=50) caregiver. An additional 9 participants did not indicate a primary caregiver, and 93 participants indicated that a primary caregiver alone raised them. These participants were not asked to assess caregiver support thus resulting in a missing value. To recapture these cases in the support measure, they were also assigned a maternal and/or paternal support score of zero.

*Sexuality-Specific Victimization.* Participants received a list of ten items describing different types of verbal or physical violence and were then asked to report how many times they had experienced each one in the previous year as a result of someone presuming them to be gay or bisexual. Based on previously established methods, these ten items were grouped into three attack categories to indicate increasing severity and type of sexuality-based victimization: Attack

Level I (2 items - verbal insults; threats of physical violence), Attack Level II (4 items - personal property damaged/destroyed; objects thrown; chased or followed; spat on), and Attack Level III (4 items - punched, hit, kicked or beaten; assaulted or wounded with a weapon; sexually harassed [without assault], beaten or assaulted by police) (Elze, 2003; Hershberger & D'Augelli, 1995).

In previous studies, participants responded to each item on a 3-point scale (0=*Never*, 1=*Once*, 2=*Two or more times*). In the current study, participants provided a count of how often these incidents had occurred in the past year. Three separate continuous Attack Level variables were generated as sums of the respective items for each attack category. All three attack variables were positively skewed. To achieve an appropriate skewness statistic for each variable ( $\leq 3.00$ ), each variable was transformed using the square root function. Attack 1 and Attack 2 variables maintained an unacceptable skewness statistic even after the square root transformation. The highest value for Attack 1 and highest two values for Attack 2 were reassigned a modified value of the next highest case for Attack 1 ( $x+1$ ) and Attack 2 ( $x+1$ ,  $x+2$ ). This step decreased the skewness statistics to acceptable levels suitable to achieve a normal distribution as a requisite for subsequent multivariate regression analyses.

### **Data Analytic Plan**

Chi-square tests were used to examine the associations between categorical study variables and each of the four substance use outcome variables. A table of bivariate correlations was also generated to examine additional associations between continuous study variables and each of the outcome variables. These associations were examined in univariate logistic regression models as a final step to determine and confirm inclusion of the predictor and control variables in the final logistic regression model. Four final logistic regression models were estimated, one for each substance (cigarettes, alcohol, marijuana, and hard drugs), with

victimization and support variables as continuous predictors and five categorical control variables (race/ethnicity, sexual identity, educational attainment, employment status, and HIV status). To examine if maternal and paternal support moderated the relationship between experiencing sexuality-based violence and substance use, each of the four regression models was estimated with interaction terms between support and victimization variables (Figure 2.1) (Aiken et al., 1991). For the models in which moderation was not detected, each model was estimated without interaction terms to examine the direct effects of victimization and support on substance use.

## **Results**

### **Descriptive Statistics**

*Background Characteristics.* Table 2.1 presents socio-demographic characteristics of the study sample. In terms of race and ethnicity, the majority of participants identified as Black / African-American (48%) followed by White (27%) and Latino / Hispanic (16%) while the remaining participants were grouped under “Other” (9%). The vast majority of participants identified as gay (90%) with the remaining participants indicating they were bisexual. Participants demonstrated high levels of educational attainment. Most participants (43%) had completed some college and 25% had obtained a college or graduate degree. One-quarter (24%) reporting having a high school degree while 8% reported having no high school degree. Most participants were also employed either full-time (40%) or part-time (30%) while 24% indicated they were unemployed but looking for work, and 7% indicated some other occupational status. Overall, the men in this study self-reported being aware of their HIV status with 78% reporting an HIV-negative status and 10% reporting an HIV-positive status. Approximately 1 in 10 of the men in the study (12%) did not know their HIV status.

*Substance Use.* Table 2.1 also presents information on substance use across socio-demographic characteristics. Overall, the prevalence of substance use for the whole sample varied by each of the four types of substances measured. Forty-two (43%) of the men in the study had smoked cigarettes in the past month, 85% had used alcohol, 47% had used marijuana, and 17% indicated using hard drugs (Table 2). One-third (33%) of participants had used at least three of these four types of substances in the past month. With the exception of marijuana, bivariate analyses indicated no significant differences in substance use (cigarette, alcohol, or hard drugs) across race/ethnicity or sexual identity groups. In contrast, higher educational attainment was associated with less reporting marijuana use,  $X^2(3, N=352) = 19.12, p \leq .001$ , and poly drug use,  $X^2(3, N=352) = 14.86, p \leq .01$ , in the previous month. Only alcohol use was associated with higher educational attainment,  $X^2(3, N=352) = 15.30, p \leq .01$ . In some cases, employment status was also associated with substance use. Participants who were unemployed but looking for work were significantly more likely to report past-month cigarette use,  $X^2(3, N=352) = 8.13, p \leq .05$ , marijuana use,  $X^2(3, N=352) = 19.27, p \leq .001$ , and poly drug use,  $X^2(3, N=352) = 14.53, p \leq .01$ . Hard drug use was not associated with educational attainment or employment status. Participant's HIV status was differentially associated with HIV status as well. Participants reporting an HIV-negative status were least likely to report cigarette, marijuana, hard drug, and poly drug use. Those with an unknown status were most likely to report cigarette use,  $X^2(3, N=352) = 9.62, p \leq .05$  while those with a positive status were most likely to report marijuana use,  $X^2(3, N=352) = 16.25, p \leq .001$ , hard drug use,  $X^2(3, N=352) = 13.18, p \leq .001$ , and poly drug use,  $X^2(3, N=352) = 10.39, p \leq .01$ .

*Sexuality-Based Victimization.* Table 2.2 presents bivariate correlations between primary study variables. The average age of study participants was 23.08 years (SD = 2.91), which was

positively associated with past-month alcohol use,  $r(352) = .19, p \leq .01$ . Participant age was not significantly associated with any other substance use, victimization, or social support variable in the study. All correlations between substance use variables were significant at the level of  $p \leq .01$ . In general, reporting more severe sexuality-based victimization was associated with substance use despite experiencing lower frequency of these experiences as severity increased. Attack level 1 was not significantly associated with substance use. Attack level 2 was positively associated with cigarette use,  $r(352) = .20, p \leq .01$ , and hard drug use,  $r(352) = .15, p \leq .05$ , while Attack level 3 was positively associated with cigarette use,  $r(352) = .18, p \leq .01$ , and alcohol use,  $r(352) = .12, p \leq .05$ . Marijuana use was not significantly associated with any level of sexuality-based victimization in bivariate analyses. Despite being moderately correlated, tests of multicollinearity did not indicate collinearity between any of the three attack level variables.

*Parent Social Support.* Participants indicated receiving greater support from their mothers ( $M = 2.27, SD = 1.67$ ) compared to their fathers ( $M = 0.91, SD = 1.40$ ). In part, this difference was due to the greater number of participants who identified their father as a primary caregiver but who were also no longer in contact with their fathers. Maternal support was negatively correlated with Attack 2,  $r(352) = -.12, p \leq .05$ , and Attack 3,  $r(352) = -.13, p \leq .05$ , however paternal support was not correlated with any level of victimization. Furthermore, maternal support was negatively correlated with cigarette use,  $r(352) = -.15, p \leq .01$  and hard drug use,  $r(352) = -.12, p \leq .05$ , while paternal support was negatively correlated with marijuana use only,  $r(352) = -.17, p \leq .01$ .

### **Multivariate Analyses**

Four models were estimated to examine moderation effects of parental support on the relationship between victimization and substance use. Results from these models (not shown)



indicated no moderation effect of either maternal or paternal support on these relationships regardless of victimization severity and type of substance. The following results are from the four estimated models without the interaction terms, examining main effects of parental support on substance use outcomes.

Table 2.3 includes the unadjusted logistic regression models for each of the predictors and each of four substance use types as outcomes. Patterns of association in the unadjusted models reflect the patterns of association found in preliminary analyses in chi-square tests of independence and bivariate correlations. All variables were subsequently included in multivariate models. Age was excluded given results from bivariate analyses and the inclusion of educational attainment, which becomes significantly associated with age given the age range of the study sample,  $r(352) = .36, p \leq .001$  (not shown in Table 2).

To further examine the strength of the association of both sexuality-based victimization and parental social support with substance use, a multivariate logistic regression model was estimated for each of the four substance types. In each model, sexuality-based victimization and parental support variables were entered as predictors. All models were also adjusted for race/ethnicity, sexual identity, educational attainment, employment status, and HIV status. Table 2.4 presents adjusted odds ratios (ORs) for predictors of interest in separate models predicting past-month cigarette, alcohol, marijuana, and hard drug use. In adjusted models, sexuality-based victimization was associated only with alcohol use. Specifically, participants who experienced the most severe type of sexuality-based victimization were nearly three times more likely to report recent alcohol use. The association between parental support and substance use depended on both the parent type and type of substance used. Maternal support was associated with 18% lower odds of cigarette use while paternal social support was associated with 28% lower odds of

marijuana use in the past month. No other associations were significant between victimization, parental support, and substance use.

## **Discussion**

According to sexual minority stress theory, sexual minority individuals may use substances to cope with the psychological distress resulting from victimization (McCabe et al., 2010; Meyer 2003; Weber 2008). A primary goal and objective of the current study was to examine the role of parental support in relation to substance use and sexuality-based victimization experienced by young adult gay and bisexual men. In the current study, an alarming number of young adult men reported recent sexuality-based victimization and substance use, highlighting the need for continued efforts to address homophobia and stigma in society (Hatzenbuehler 2010; Hatzenbuehler et al., 2014). Although parental support did not buffer the relationship between substance use and victimization, parental support played a protective role in substance use behaviors. Specifically, maternal support and paternal support were associated with lower levels of cigarette and marijuana use, respectively, among young adult gay and bisexual men.

### **Substance Use and Prevalence**

Overall, participants reported varying rates of substance use. Prevalence of alcohol use (85%) and hard drug use (17%) in the current study were comparable to rates reported by Halkitis and colleagues (2014) and McCabe and colleagues (2003, 2005) in studies of recent substance use among young adult gay and bisexual men. Marijuana use in the current sample (46%) was also comparable if not slightly elevated compared to figures reported elsewhere in studies of similar populations (Halkitis et al., 2014; Mackesy-Amiti et al., 2008; McCabe et al., 2005). In contrast, recent cigarette use was markedly higher (42%) in comparison to several

other studies of smoking behavior among young adult gay and bisexual men (Blosnich & Horn, 2011; Greenwood et al., 2005; Gruskin, 2007; McCabe et al., 2003, 2005, 2011). Across all four substances, however, prevalence of recent substance use was higher within the current sample compared to figures reported by Johnston and colleagues (2015) for a national sample of similarly aged men, regardless of sexual identity (alcohol, 85% vs. 73%; hard drugs, 17% vs. 11%; marijuana, 46% vs. 22%; cigarettes, 42% vs. 21%). Reports of recent cigarette and marijuana use in the current study were particularly high and double that of national prevalence rates for young adult men. These findings suggest that young adult men in the current sample reported greater substance use than the general population of men.

### **Substance Use, Victimization, and Parental Social Support**

The parent-child relationship undergoes important changes as emerging adults experience social role transitions in the areas of education, employment, sexual and romantic relationships, and housing. These changes, with respect to the quality of the parent-child relationship and the characteristics of the child's broader social network, may impact substance use behavior among emerging adults (Arnett, 2005; Arnett & Schwab, 2013; Bucx & van Wel, 2008; Schulenberg et al., 2005; Staff et al., 2010). Whereas a growing body of literature continues to address the role of family and parents in shaping substance use behaviors among youth and emerging adults (Hernandez et al., 2015; Rossow et al., 2015; Thomas et al., 2016), considerable gaps remain in our understanding of parental influences in the lives of sexual minority youth and emerging adults. In her review of parental influences on the health and well being of LGB youth, Bouris and colleagues (2010) found thirty-one articles of which only five address substance use and just two differentiate between maternal and paternal sources of support. Therefore, the current study is among the first to examine if perceived maternal and paternal social support is associated with

substance use specifically among emerging adult gay and bisexual men. I also examined if support moderated the relationship between sexuality-related victimization and substance use. I detail these relationships by substance category below.

*Cigarette Use.* In previous studies, researchers have examined the relationship between different aspects of sexual orientation (e.g., identity, attraction, behavior) and smoking behavior, including the role of moderators and mediators (Andersen et al., 2015; Cochran et al., 2013; Gruskin et al., 2007; Ortiz-Hernández et al., 2009; Rath et al., 2013; Remafedi et al., 2008; Ryan et al., 2001; Stall et al., 1999; Trocki et al., 2009). In preliminary analyses of the current study, experiencing discriminatory (i.e., based on sexual identity) victimization was associated with recent cigarette use, and the strength of these associations appeared to increase with more severe forms of victimization. However, this association was no longer significant in final analyses after adjusting for demographic characteristics including race/ethnicity, sexual identity, educational attainment, current employment status, and HIV status (although the general trend between increasing victimization severity and smoking remained). According to sexual minority stress theory, experiencing such victimization may contribute to increased psychological levels of distress among sexual minority populations (Meyer, 2003). It remains unclear whether individuals smoke cigarettes as a coping behavior to manage subsequent stress resulting from experiencing victimization. Associations between discrimination or victimization and smoking were reported previously but findings overall have been mixed and inconclusive, and this literature remains limited with respect to young adult sexual minority populations (Bontempo & D'Augelli, 2002; Burgess et al., 2007; Jun et al., 2010; Ortiz-Hernandez, 2009; Rosario et al., 2004; Willoughby et al., 2010). Furthermore, comparisons across studies also become difficult

due to differences in the types of victimization being measured, thus possibly contributing to inconsistencies in findings.

While some researchers have shown that experiences of discrimination and victimization may partially account for increased cigarette use among sexual minorities, few have examined the role of family as a source of support, especially among young adults (for review, see Blosnich et al., 2013). To address these gaps, I tested the stress-buffering hypothesis of social support by examining if maternal and paternal support moderated the relationship between sexuality-based victimization and past-month cigarette use (Cassel, 1976; Cobb, 1976). Although there was no interaction effect between victimization and either source of parental support, maternal support had a significant protective, main effect association with smoking. Rosario and colleagues (2014) reported similar findings between cigarette use and two aspects of attachment, attachment (reported by young adults) and maternal affection (reported by mothers), as both were associated with less lifetime and past-year young adult cigarette use. Scherrer and colleagues (2012) also found significant bivariate associations between smoking and both maternal and paternal closeness among adolescents and young adults, but these associations disappeared in multivariate analyses.

Based on results from the current study, sexual minority young adult men who perceived greater maternal support were less likely to report recent cigarette use. Paternal support, however, was ultimately not associated with cigarette use. In part, these findings run counter to general developmental frameworks that emphasize the dwindling effects or lack of parental influences on young adult offspring. It remains unclear why mothers but not fathers would continue to influence smoking behavior among participants in the current study. Rosario and colleagues (2014) have posited alternative pathways to explain the relationship between cigarette

use and parental attachment. Specifically, maternal discomfort with homosexuality was associated with increased cigarette use among offspring, with attachment and discomfort variables partially explaining differences in cigarette use by sexual orientation (Rosario et al., 2014). Given the dearth of research in this area, and the historical exclusion of fathers in family-based research, future studies would benefit from inclusion of separate parent support measures as well as sexuality-specific measures (e.g., discomfort with homosexuality).

*Marijuana Use.* Recent marijuana use was not associated with any type of sexuality-based victimization or victimization. Researches have previously examined and reported positive associations between victimization or discrimination and substance use, although marijuana has rarely been considered on its own in this context. Instead, it has been excluded or captured as part of a larger construct of *substance use* or *illicit drug use*, often in relation to mental health or disparities by sexual orientation (Blosnich & Horn, 2011; Espelage et al., 2008; Hatzenbuehler et al., 2008; Jun et al., 2010; Marshal et al., 2008; McCabe et al., 2010; Ryan et al., 2009, 2010; Weber, 2008). Given a few notable exceptions, researchers have less frequently considered the role of family or parental social support on marijuana use among young adults in general and specifically among sexual minority young adults (Book et al., 1999; Morojele & Brook, 2001; Needham & Austin, 2010; Rosario et al., 2014 von Sydow et al., 2002)

An important finding in the current study was the persistent relationship between paternal support and marijuana use. Paternal support was associated with less marijuana use while maternal support remained unassociated with marijuana use. Therefore, perceived father support may be playing a role that is uniquely protective for young adult men in the current study. In perhaps one of the only other studies to examine these associations among young adult men (18 to 26 years old), Needham and Austin (2010) reported this same parental protective effect in

relation to marijuana use. However, no sub-analyses were conducted by sexual orientation, and they utilized a composite parental social support score when they found that results did not differ when using separate maternal and paternal social support measures (Needham & Austin, 2010). In contrast, von Sydow and colleagues (2002) found differential effects based on parent gender such that having a *very good* maternal relationship was associated with lower incident use while a *very good* paternal relationship decreased likelihood of abuse. Age moderated these associations with maternal support having this protective among adolescents but increased likelihood of abuse in the older subgroup (18 to 24 years old) while paternal support decreased likelihood in this older group (von Sydow et al., 2002). Given the cross-sectional data utilized for the current study, it is impossible to ascertain incidence. Nevertheless, it is possible that among participants who did not report any past 30-day use, some may have never used marijuana. At present, however, it is unknown whether maternal or paternal support protects against, or delays, the onset of marijuana use. Future longitudinal research in this area may be warranted.

*Alcohol Use.* There was an enduring association between experiencing the most severe type of sexuality-based victimization (e.g., physical or sexual assault, assault with a weapon) and recent alcohol use. Participants reporting this type of victimization were three times more likely to report recent alcohol use, even after taking into account demographic characteristics and experiences with other types of sexuality-based victimization. Positive associations between victimization and alcohol use have been reported across several studies although researchers often examined this only with respect to general and not sexuality-related victimization across sexual identity groups (Andersen et al., 2015; Bontempo & D'Augelli, 2002; Hughes et al., 2010). In several cases, however, no associations were found between global measures of

sexuality-related discrimination and alcohol use (McLaughlin et al., 2010; Rosario et al., 2004), nor between specific types of attacks during victimization and alcohol use (Hughes et al., 2010). In general, studies of discrimination or victimization with respect to alcohol use have focused on describing differences in general experiences of discrimination and victimization between sexual identity groups, or have focused on global experiences of sexuality-related discrimination or stress among sexual minority populations. The current study, however, addresses sexuality-related victimization by asking participants to report on different types of attacks they experienced in relation to their specific sexual identity (i.e., gay or bisexual). Whereas Hughes and colleagues (2010) found no associations between different types of attacks and alcohol use, participants in the current study who reported the most severe types of sexuality-related victimization were more likely to report recent alcohol use. Therefore, severity of victimization may be especially important to consider given that only high-severity victimization was associated with alcohol use despite fewer participants reporting this degree of victimization. Therefore, more severe types of victimization, which are also the most physical forms of victimization measured in the current study, may exact a greater psychological toll on victims. Since these experiences are related to participants' sexual identities, they may contribute to excess psychological distress (Meyer, 2003). As a result, these individuals may turn to substances as means of coping with this psychological distress (Cochran et al., 2007; Keyes et al., 2011; King et al., 2008; Link et al., 1997; Stockdale et al., 2007).

Within the larger adolescent literature, White and colleagues (2000) conducted a literature review and noted inconsistent findings with respect to the relative influences between maternal and paternal support on adolescent and young adult drinking behaviors. In the current study of young adult gay and bisexual men, alcohol use was not related to participant's



perceptions of maternal or paternal support. These findings are consistent with prior findings reported by Needham and Austin (2010) as well as Rosario and colleagues (2014). The limited attention placed to the relationship between alcohol use and parental support among sexual minority populations merits further investigation given previous evidence of parental influences on drinking behavior on general populations of youth.

*Hard Drug Use.* The prevalence of recent hard drug use was comparable, if not higher, than that reported in recent studies (Needham & Austin, 2010; Traube et al., 2013). In the current study, however, no associations were found between sexuality-related victimization, maternal or paternal support, and hard drug use. These findings counter previous studies with young adults where greater perception of parental social support (combined or separate maternal and paternal measures) was associated with less hard drug use (Morjorel & Brook, 2001; Needham & Austin, 2010; Piko, 2000; Traube et al., 2013). Traube and colleagues (2013), for example, found that baseline social support played a mediating role between victimization/discrimination and psychological distress, and psychological distress was directly associated with hard drug use, in a longitudinal study of young adult men who have sex with men. This study differs from the current study, however, in that a single victimization/discrimination latent factor was used to capture experiences across multiple social identities and situations (race and sexuality; witnessing and experiencing), and social support was a latent factor characterized by separate measures of family and friend support (Traube et al., 2013). Therefore, future research examining important dynamics linked to hard drug use, including type of victimization experienced and type and source of social support, are warranted.

### **Maternal and Paternal Influences on Substance Use**

Taken together, my study results suggest that parent gender may play an important role in how perceived paternal and maternal support is related to substance use behavior among emerging adult sexual minority men. Gender-specific roles may shape the kinds of support that mothers and fathers provide or how this support is expressed. According to role theory, maternal roles are characterized by the provision of emotional support through the expression of warmth and care while the paternal role is characterized as that of disciplinarian and provider of instrumental support, primarily as a financial provider (Hosley & Montemayor, 1997; McKinney & Renk, 2007). Role theory may thus explain differences in the types of support that mothers and fathers provide as well as differences in how sons and daughters seek support or perceive support from their parents. This theory may explain why, on average, the young adult male participants in the current study rated their fathers lower on social support compared to ratings for social support from mothers. Laible and Carlo (2004) also state that *support* is just one of two important dimensions of parenting style, and they suggest that measuring *control* may aid in understanding the role of parent gender when examining parental influences on child health.

Despite the lower rating of perceived social support from fathers, paternal support appears to play a unique role in marijuana use behavior while maternal support has a unique role with respect to cigarette smoking behavior. Perceptions of support reflect an individual's belief that support is or would be available through their social network or from specific people in their network in times of need. Therefore, perceived support is important for subsequent stress appraisal and stress-related coping, thus having an important role in psychological health and distress (Cohen & Wills, 1985; Heller et al., 1986; Procidano & Heller, 1983). Given the association between psychological distress and substance use reported in previous studies, perceived parental support may be operating through psychological status to impact substance

use behaviors in the current study (Cochran et al., 2007; Keyes; et al., 2011; Maslowsky et al., 2016). In a study of stress and substance use among adolescents, Wills (2000) reports that major life events and negative daily experiences predicted cigarette use. Current findings reflect this trend given the enduring association between sexuality-related victimization and recent cigarette use. Given that only maternal support was associated with abstention from cigarette use, however, role expectations may be influencing sex-specific perceptions of parental support. In other words, social support from the mother perceived as more characteristic of emotional support may be particularly important for youth who engage in smoking as a stress-based coping behavior.

Further studies are needed to examine how fathers might influence substance use behaviors among youth and young adults and among sexual minority youth in general. Until recently, the roles of fathers have remained largely unexamined or have been studied primarily in relation to father absence (residential status) without regard to the type or quality of parent-child interactions (Pleck, 2012). This knowledge gap further widens in the context of parental influences and the health of young adults. At present, conceptual frameworks are needed that allow for broader and more complex considerations of paternal involvement and paternal influences on the health and well being of youth and young adults. This should also take into account changing social norms regarding the presumed responsibilities of mothers and fathers, including structural barriers (e.g., workplace paternal/maternal leave policies) and the increasingly diverse structures of family networks.

The current study offers a novel finding in which perceived paternal support was associated with decreased marijuana use. This finding highlights not only the potential benefits of paternal support for young adults but also the benefits for young adult gay and bisexual men.

Researchers have focused on describing the experiences of sexual minorities within their families, particular around the issues of sexual identity disclosure, noting greater experiences of paternal rejection and less paternal support among sexual minority men compared to heterosexual counterparts (Corliss et al., 2002; D'Augelli et al., 1998; Ryan et al., 2009; Willoughby et al., 2010). More recently, however, researchers have offered more nuanced depictions of relationships between fathers and gay or bisexual sons (Carpineto et al., 2008; Gonzalez et al., 2013; Grafsky, 2014; Jadwin-Cakmak et al., 2015). Based on findings from recent studies, including the results described here for example, the influence of paternal social support merits further investigation with a focus on illuminating the range and diversity of experiences that occur within populations of sexual minority men and their fathers (Caldwell et al., 2004; Goodrich, 2009; Pleck, 2011; Stolz et al., 2005; Young et al., 1995).

### **Limitations**

Some limitations are important to consider in the interpretation of current findings. Causality is not possible to establish given the cross-sectional nature of the study. Participants were asked to report on their experiences of sexuality-related victimization within the past year and their substance use behaviors within the past thirty days. Participants may have used substances to cope with psychological distress resulting from experiences of victimization. Mediation analyses were beyond the scope of the current study but future studies of support, victimization, and substance abuse among sexual minorities should examine this mediational hypothesis (Lehavot & Simoni, 2011; Maslowsky et al., 2016). On the other hand, the social contexts of substance use may also place individuals in situations where they are more vulnerable to such victimization. Gay bars and clubs, as well as LGBT Pride events, provide opportunities for sexual minority individuals to meet and socialize (Buttram & Kurtz, 2012;

D'Emilio, 1983; Kipke et al., 2007; Trocki et al., 2005; Wagenaar et al., 2004; Youatt et al., 2015). Increased visibility, particularly around other individuals who are intoxicated, also potentially increases the risk of experiencing any of the types of victimization and violence asked about in the study.

The study sample is a convenience-based community sample from the Detroit Metro Area, thus generalizability of findings beyond this population may not be possible. Although collaborations with community partners helped diversify the recruitment strategy in terms of locations for recruitment, participants who frequent gay bars and clubs may have been oversampled. Given the associations between substance use and gay-venue attendance previously discussed, increased rates of substance use in the current study may be an artifact of oversampling from gay venues. Unfortunately, it was not possible to account for this in the analyses.

While a strength of the study was the possibility of examining the independent effects of paternal and maternal social support, there were several limitations to the study that prevented a more complete network analysis with respect to social support and substance use behaviors. Groh and colleagues (2008) offer a review of structural and functional characteristics of social networks that are relevant to studies of substance use, specifically alcohol use. Based on the matching theory of social support, for example, the benefits of social support for addressing problematic substance use may depend on the extent to which social support is tailored to address a particular substance (Beattie & Longabaugh, 1999; Cutrona, 1990; Flynn et al., 2006; Groh et al., 2007). Similarly, perhaps certain types of support may be more relevant at specific developmental time periods. The current study utilizes a global measure of social support that is akin to emotional support (Procidano & Heller, 1983). Other types of support (e.g., instrumental,

informational, sexuality/identity-specific) should be considered in future studies of young adult sexual minority men and psychosocial health.

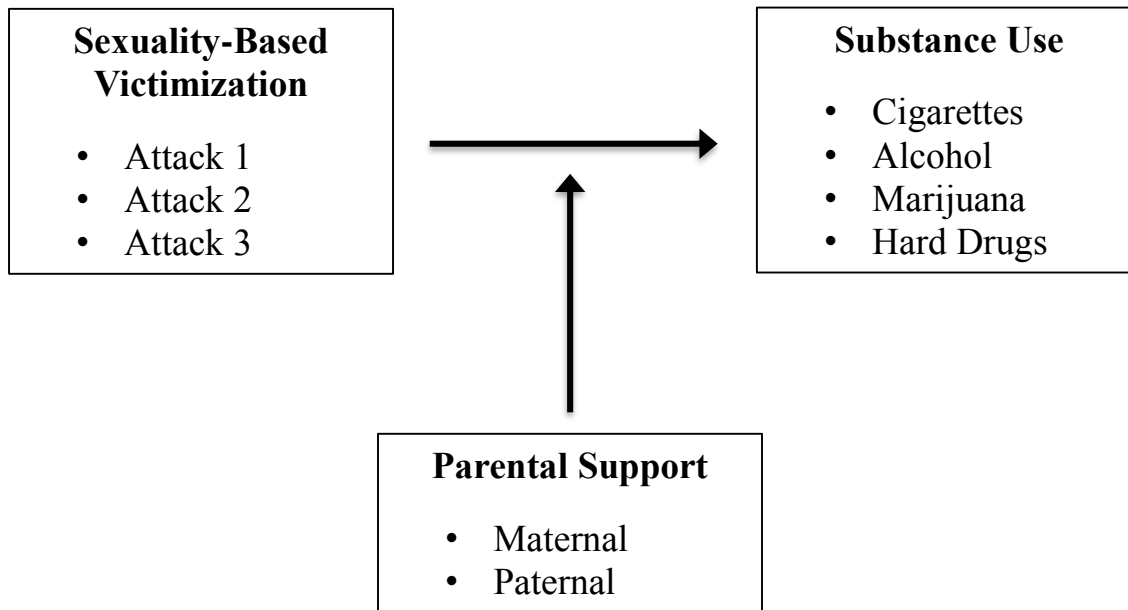
Sample size also limited the ability to conduct more nuanced analyses with respect to parental social support. In the current study, participants received a maternal or paternal support score of zero under two circumstance: (1) If the participant indicated someone other than a parent as a primary/secondary caregiver (2) If a parent was indicated but there was no current contact with the parent. In both of these situations, participants did not receive a social support scale and thus had no data for this measure. Excluding these participants would have resulted in a dramatic reduction in sample size especially given the significant proportion of participants indicating no paternal caregiver or no contact with their father. As a result, the assignment of a zero paternal support score to these cases decreased the overall sample mean score for paternal social support. This procedure also conflates the experiences of participants who never had a paternal caregiver, had a paternal caregiver but no longer maintains contact, and participants who have contact but report very low perceptions of paternal support. It would be important to distinguish between these two types of participants, however, my approach reflects similar methods that have been previously used to account for absence of data due to no contact (Zimmerman et al., 2005). Although this method resulted in a suppressed mean paternal support score, I compared mean maternal and paternal scores among participants who had contact with both mothers and fathers, and found that the average paternal support score was still significantly lower than the average maternal support score.

## **Conclusion**

This study contributes to a limited but growing body of literature demonstrating the influence of parents on the health and well being of their children beyond adolescence and into

young adulthood. The current study extends these findings to sexual minority young adults, specifically in the role of maternal and paternal support in substance use behaviors. While a handful of family-based interventions have been developed to address sexual health communication between parents and their adolescent children, further research is needed to inform the development of parent-based interventions that address other areas of sexual minority health and are inclusive of fathers (Akers et al., 2011; Atienzo et al., 20011; Hutchinson & Wood, 2007). In acknowledging the unique contributions of mothers and fathers, however, the role of parents must also be considered in the context of increasing diversity in the structure and function of family networks.

**Figure 2.1** Analytic Model Depicting Proposed Moderation Effects of Parental Support on the Relationship Between Victimization and Substance Use





**Table 2.1** Descriptive statistics by type of substance used in the past 30 days (N=352)†

	Total		Cigarettes		Alcohol		Marijuana		Hard Drugs		Poly Drug Use	
	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
<b>Race / Ethnicity</b>												
Black	170	48.3%	71	41.8%	138	81.2%	86	50.6%	28	16.5%	59	34.7%
White	95	27.0%	43	45.3%	84	88.4%	34	35.8%	13	13.7%	23	24.2%
Latino	56	15.9%	27	48.2%	50	89.3%	25	44.6%	14	25.0%	22	39.3%
Other	31	8.8%	11	35.5%	27	87.1%	19	61.3%	6	19.4%	11	35.5%
			$X^2=1.634, p=.65$		$X^2=3.722, p=.29$		<b><math>X^2=8.323, p\leq.05</math></b>		$X^2=3.357, p=.34$		$X^2=4.637, p=.20$	
<b>Sexual Identity</b>												
Gay	318	90.3%	136	42.8%	273	85.8%	145	45.6%	56	17.6%	103	32.4%
Bisexual	34	9.7%	16	47.1%	26	76.5%	19	55.9%	5	14.7%	12	35.3%
			$X^2=0.231, p=.63$		$X^2=2.112, p=.15$		$X^2=1.306, p=.25$		$X^2=0.181, p=.67$		$X^2=0.118, p=.73$	
<b>Educational Attainment</b>												
< High School	28	8.0%	17	60.7%	21	75.0%	19	67.9%	8	28.6%	17	60.7%
High School	86	24.4%	40	46.5%	64	74.4%	53	61.6%	15	17.4%	32	37.2%
Some College	151	42.9%	65	43.0%	133	88.1%	60	39.7%	26	17.2%	46	30.5%
College+	87	24.7%	30	34.5%	81	93.1%	32	36.8%	12	13.8%	20	23.0%
			$X^2=6.581, p=.09$		<b><math>X^2=15.304, p\leq.01</math></b>		<b><math>X^2=19.120, p\leq.001</math></b>		$X^2=3.232, p=.36$		<b><math>X^2=14.858, p\leq.01</math></b>	
<b>Employment Status</b>												
Full-time	139	39.5%	53	38.1%	125	89.9%	52	37.4%	22	15.8%	35	25.2%
Part-time	106	30.1%	42	39.6%	89	84.0%	44	41.5%	16	15.1%	32	30.2%
Unemployed; looking	83	23.6%	47	56.6%	67	80.7%	55	66.3%	21	25.3%	41	49.4%
Other	24	6.8%	10	41.7%	18	75.0%	13	54.2%	2	8.3%	7	29.2%
			<b><math>X^2=8.131, p\leq.05</math></b>		$X^2=5.791, p=.12$		<b><math>X^2=19.273, p\leq.001</math></b>		$X^2=5.626, p=.13$		<b><math>X^2=14.534, p\leq.01</math></b>	
<b>HIV Status</b>												
HIV-negative	274	77.8%	107	39.1%	229	83.6%	113	41.2%	37	13.5%	78	28.5%
HIV-positive	35	9.9%	18	51.4%	33	94.3%	26	74.3%	12	34.3%	18	51.4%
Unknown	43	12.2%	27	62.8%	37	86.0%	25	58.1%	12	27.9%	19	44.2%
			<b><math>X^2=9.615, p\leq.05</math></b>		$X^2=2.830, p\leq.24$		<b><math>X^2=16.245, p\leq.001</math></b>		<b><math>X^2=13.182, p\leq.001</math></b>		<b><math>X^2=10.392, p\leq.01</math></b>	

† Significant associations are in bold

**Table 2.2** Correlations among primary study variables (N=352)

	M	SD	Range	1	2	3	4	5	6	7	8	9
<b>1</b> Age	23.08	2.91	18-29									
<b>2</b> <sup>a</sup> Cigarette use	0.43	0.50	0-1	0.05								
<b>3</b> <sup>a</sup> Alcohol use	0.85	0.36	0-1	0.19 **	0.24 **							
<b>4</b> <sup>a</sup> Marijuana use	0.47	0.50	0-1	-0.04	0.35 **	0.23 **						
<b>5</b> <sup>a</sup> Hard drugs use	0.17	0.38	0-1	0.04	0.31 **	0.19 **	0.23 **					
<b>6</b> <sup>b</sup> Attack Level 1	4.23	14.46	0-126	0.00	0.08	0.01	0.01	0.06				
<b>7</b> <sup>b</sup> Attack Level 2	0.93	3.03	0-26	-0.04	0.20 **	0.08	0.06	0.15 **	0.55 **			
<b>8</b> <sup>b</sup> Attack Level 3	0.68	2.28	0-20	-0.02	0.18 **	0.12 *	0.09	0.09	0.47 **	0.63 **		
<b>9</b> Mother Support	2.27	1.67	0-4	0.01	-0.15 **	-0.01	-0.10	-0.12 *	-0.05	-0.12 *	-0.13 *	
<b>10</b> Father Support	0.91	1.40	0-4	-0.07	-0.10	0.01	-0.17 **	-0.08	-0.02	-0.08	0.00	0.20 **

\*  $p \leq .05$ ; \*\*  $p \leq .01$ <sup>a</sup>Point biserial  $r$ ; dichotomous variable (Yes/No)<sup>b</sup>Continuous variable before log transformation (M, SD, and Range)

**Table 2.3** Unadjusted Logistic Regression Models Predicting Substance Use In The Past 30 Days

	<u>Cigarettes</u>		<u>Alcohol</u>		<u>Marijuana</u>		<u>Hard Drugs</u>	
	UOR	95% CI	UOR	95% CI	UOR	95% CI	UOR	95% CI
<b>Race/Ethnicity</b>								
Black	0.87	0.52 , 1.44	0.57	0.27 , 1.18	1.84 *	1.10 , 3.08	1.24	0.61 , 2.53
Latino	1.13	0.58 , 2.18	1.09	0.38 , 3.13	1.45	0.74 , 2.84	2.10	0.91 , 4.88
Other	0.67	0.29 , 1.54	0.88	0.26 , 3.01	2.84 **	1.23 , 6.55	1.51	0.52 , 4.40
<i>White</i>	1.00				1.00		1.00	
<b>Sexual Identity</b>								
Bisexual	1.19	0.59 , 2.42	0.54	0.23 , 1.26	1.51	0.74 , 3.08	0.81	0.30 , 2.18
<i>Gay</i>	1.00		1.00		1.00		1.00	
<b>Education Completed</b>								
< High School	2.94 *	1.22 , 7.06	0.22 **	0.07 , 0.73	3.63 *	1.47 , 8.97	2.50	0.90 , 6.94
High School	1.65	0.90 , 3.05	0.22 **	0.08 , 0.56	2.76 ***	1.49 , 5.11	1.32	0.58 , 3.02
Some College	1.44	0.83 , 2.48	0.55	0.21 , 1.44	1.13	0.66 , 1.95	1.30	0.62 , 2.73
<i>College</i>	1.00		1.00		1.00		1.00	
<b>Employment Status</b>								
Other	1.16	0.48 , 2.80	0.34 *	0.12 , 0.99	1.98	0.83 , 4.74	0.48	0.11 , 2.21
Unemployed, looking	2.23 **	1.22 , 3.68	0.47	0.22 , 1.02	3.29 ***	1.86 , 5.81	1.80	0.92 , 3.53
Part-time	1.07	0.63 , 1.79	0.59	0.28 , 1.25	1.19	0.71 , 1.99	0.95	0.47 , 1.90
<i>Full-time</i>	1.00		1.00		1.00		1.00	
<b>HIV Status</b>								
Unknown	2.63 **	1.36 , 5.12	1.21	0.48 , 3.04	1.98 *	1.03 , 3.80	2.48 *	1.17 , 5.26
Positive	1.65	0.82 , 3.35	3.24	0.75 , 14.00	4.12 ***	1.86 , 9.12	3.34 **	1.53 , 7.29
<i>Negative</i>	1.00		1.00		1.00		1.00	
<b>Discrimination</b>								
Attack 1	1.10	0.97 , 1.24	1.10	0.85 , 1.20	1.01	0.89 , 1.14	1.08	0.93 , 1.24
Attack 2	1.63 ***	1.24 , 2.14	1.39	0.89 , 2.16	1.15	0.91 , 1.47	1.45 **	1.11 , 1.90
Attack 3	1.65 ***	1.21 , 2.25	2.34 *	1.07 , 5.12	1.26	0.95 , 1.68	1.31	0.95 , 1.79
<b>Caregiver Support</b>								
Mother	0.83 **	0.73 , 0.95	0.98	0.82 , 1.17	0.89	0.78 , 1.01	0.84 *	0.71 , 0.98
Father	0.87	0.74 , 1.01	1.01	0.82 , 1.25	0.77 ***	0.66 , 0.91	0.86	0.69 , 1.06

\* p ≤ .05; \*\* p ≤ .01; \*\*\* p ≤ .001

**Table 2.4** Adjusted Logistic Regression Models Predicting Substance Use In The Past 30 Days

	<u>Cigarettes</u>		<u>Alcohol</u>		<u>Marijuana</u>		<u>Hard Drugs</u>	
	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI
<b>Race/Ethnicity</b>								
Black	0.55	0.30 , 1.01	0.77	0.32 , 1.86	0.98	0.53 , 1.81	0.92	0.40 , 2.08
Latino	0.71	0.33 , 1.51	1.14	0.36 , 3.65	0.87	0.41 , 1.86	1.63	0.65 , 4.12
Other	0.42	0.17 , 1.06	0.73	0.20 , 2.74	2.21	0.90 , 5.42	1.27	0.42 , 3.87
White	1.00				1.00		1.00	
<b>Sexual Identity</b>								
Bisexual	1.38	0.63 , 3.02	0.77	0.30 , 2.01	1.35	0.61 , 2.99	0.90	0.31 , 2.60
Gay	1.00		1.00		1.00		1.00	
<b>Education Completed</b>								
< High School	2.09	0.77 , 5.72	0.19 *	0.05 , 0.72	2.35	0.85 , 6.51	1.39	0.42 , 4.61
High School	1.10	0.53 , 2.28	0.18 **	0.06 , 0.54	1.64	0.80 , 3.38	0.86	0.33 , 2.26
Some College	1.16	0.63 , 2.11	0.49	0.18 , 1.32	0.79	0.43 , 1.44	0.94	0.42 , 2.11
College	1.00		1.00		1.00		1.00	
<b>Employment Status</b>								
Other	0.87	0.34 , 2.26	0.39	0.12 , 1.32	1.56	0.58 , 4.19	0.37	0.08 , 1.83
Unemployed, looking for work	1.72	0.90 , 3.26	0.83	0.33 , 2.04	2.28 **	1.19 , 4.37	1.38	0.63 , 3.04
Part-time	0.91	0.52 , 1.61	0.74	0.32 , 1.69	1.05	0.59 , 1.85	0.82	0.39 , 1.75
Full-time	1.00		1.00		1.00		1.00	
<b>HIV Status</b>								
Unknown	2.64 **	1.27 , 5.49	1.64	0.58 , 4.61	1.93	0.94 , 3.97	2.67 *	1.17 , 6.10
Positive	1.41	0.66 , 3.02	4.68 *	1.01 , 21.74	3.51 **	1.51 , 8.20	3.41 **	1.47 , 7.91
Negative	1.00		1.00		1.00		1.00	
<b>Discrimination</b>								
Attack 1	0.91	0.77 , 1.08	0.82	0.67 , 1.01	0.95	0.80 , 1.12	0.93	0.76 , 1.15
Attack 2	1.40	0.96 , 2.05	1.28	0.73 , 2.25	0.94	0.65 , 1.36	1.52	0.99 , 2.34
Attack 3	1.45	0.95 , 2.22	2.85 *	1.16 , 6.98	1.37	0.90 , 2.07	0.94	0.59 , 1.50
<b>Caregiver Support</b>								
Mother	0.85 *	0.74 , 0.98	0.94	0.77 , 1.15	0.95	0.82 , 1.10	0.85	0.71 , 1.02
Father	0.85	0.71 , 1.02	1.03	0.81 , 1.30	0.78 **	0.65 , 0.94	0.93	0.74 , 1.19

\* p ≤ .05; \*\* p ≤ .01

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## CHAPTER III

### **Families of Origin and Chosen Families: Who counts as family, and how is family support and family undermining related to psychological distress among young adult gay and bisexual men?**

#### **Introduction**

Accumulating evidence indicates that mental health problems are more prevalent among sexual minorities compared to heterosexual populations (Balsam et al., 2005; Bostwick et al., 2010; Cochran & Mays, 2001; Cochran et al., 2003; Gilman et al., 2001; King et al., 2008). In a nationally representative sample of adults, Bostwick and colleagues (2010) found that lesbian, gay, and bisexual (LGB) populations were more likely to have experienced a variety of mood and anxiety disorders in the past year or at any point in their lifetime. Findings from smaller community samples, consisting of adolescents and young adults, demonstrated similar trends (Hatzenbuehler et al., 2008; Spencer and Patrick, 2009; Ueno, 2010). In a longitudinal study of 11 to 14 year-olds, Hatzenbuehler and colleagues (2008) found that same-sex attracted youth had more depression, anxiety, and emotion dysregulation compared to heterosexual youth. In a sample of 18 to 30 year-olds, LG individuals reported more depressive symptoms and had lower self-esteem compared to heterosexual individuals (Spencer & Patrick, 2009). Psychological distress is an important risk factor and correlate of externalizing behavior such as substance abuse as well as suicide attempt, which may also explain the higher prevalence of these behaviors among LGB populations (King et al., 2008). These disparities appear to exist across various stages of life, thus posing particular challenges for the health and well-being of sexual minorities from childhood and adolescence through young and older adulthood.

The family as a source of both stress and support is an important yet understudied area of research with respect to the mental health of sexual minority youth and young adults (Carpineto et al., 2008; Goldfried & Goldfried, 2001; Ryan et al., 2009, 2010; Willoughby et al., 2010). The primary focus of this research has been on parents' reactions to an adolescent child's initial disclosure of an LGB identity and the subsequent strain on the parent-child relationship, often characterized as the rejection or loss of social support experienced and reported by LGB youth (Bouris et al., 2010; D'Augelli et al., 2005; Dew et al., 2006; Willoughby et al., 2006). Recent evidence suggests that parental influences extend beyond adolescence to play an important and unique role in an LGB child's transition to young adulthood and in adjustment during young adulthood (Barker et al., 2006; Needham & Austin, 2010; Mustanski et al., 2010; Sheets & Mohr, 2009). Parental roles, however, may be difficult to define as young adults gain autonomy and begin to develop and expand their own social networks within and outside the family. Lesbian, gay, and bisexual populations may form *chosen families* or *families of choice*, which include people who may have no biological or legal ties to the LGB individual yet the LGB individual defines them as family (Nardi, 1992; Oswald, 2002; Weston, 1991).

While some researchers have included separate parent, family, and peer/friend social support constructs in quantitative studies of LGB psychological health and distress, very few have examined how LGB individuals themselves define family and subsequently how support or non-support from these families is associated with psychological status (Detrie & Lease, 2007; Doty et al., 2010; Sheets & Mohr, 2009; Shilo & Sava, 2011; Torres & Harper, 2012).

Therefore, I sought to develop a typology of families based on a sample of young adult gay and bisexual men (YGBM) who were asked to define their families with respect to their family of origin, relationships formed via romantic partnerships, and roommate or friendship relationships.

I then examined the associations of family social support and family social undermining, as perceived by YGBM, with psychological distress.

### **Social Support and Social Undermining**

Despite the vast body of research and evidence linking social support to physical and mental health, the mechanisms by which this occurs remains relatively less understood with respect to sexual minority populations (Cohen, 2004). Social support may be particularly advantageous for LGB individuals given their marginalized status in society and the related physical and psychological effects of sexuality-based discrimination (Hatzenbuehler, 2009; Hatzenbuehler et al, 2011). In this context, various types and sources of social support are important for maintaining health as well as for mitigating the negative effects of various stressors (Cohen & Wills, 1985). Emotional support, for example, becomes critical for LGB people living in a homophobic society that devalues their very identity, while instrumental support in the form of monetary aid and shelter is paramount for youth who face ejection from the home upon disclosing an LGB identity (Shilo & Savaya, 2011; Thoits, 2011; Wong et al, 2013).

A challenge in understanding the influence of social support on health is that relationships often consist of supportive and non-supportive social exchanges, a dynamic often overlooked in social network and social support research (Abbey et al., 1985; Rook, 1984). These non-supportive exchanges (also called social undermining, social strain, social conflict, and negative social support) consist of attitudes or behaviors, directed from one person to another, that serve to intimidate, criticize and devalue, or create obstacles (Vinokur & van Ryn, 1993). They may be subtle and occur over prolonged periods of time rather than as short bursts of overt aggression. Evidence generally suggests that social undermining (term used herein) is associated with psychological distress and decreased well-being whereas social support is

primarily associated with well-being (Newsom et al., 2005; Vinokur & van Ryn, 1993). The relative strength of these associations, however, varies across relationship conditions (e.g. type and closeness) such that support and undermining may both correlate strongly with distress under one set of conditions while either support or undermining alone is the more significant predictor of distress under other conditions, for example (Abbey et al., 1985; Grant et al., 1993; Walen & Lachman, 2000).

A family social network framework that incorporates support and undermining may facilitate better understanding of LGB youth's experiences with their families during emerging adulthood. Emerging adulthood is a developmental period that encompasses youth's transition from adolescence to young adulthood and consists of continued identity exploration and exploration in the areas of education, vocation, friendships, and romantic relationships (Arnett, 2000). For vulnerable populations that experience multiple forms of marginalization, however, emerging adulthood may present more challenges than opportunities (Osgood et al., 2005). Among LGB youth, sexual identity exploration across these areas becomes an important component of identity formation and identity integration during this time (Mohr and Kendra, 2011; Rosario et al., 2008). As youth's social networks expand and peers become increasingly influential, the relationships with family of origin also undergo important changes marked by periods of growth and tension.

When LGB youth disclose their sexual identity to family of origin disclosure may lead to increased support and closeness between family members or it may cause conflict and even lead to abuse or complete rejection of an LGB child (Carpineto et al., 2008; D'Augelli et al., 2010; Gonzalez et al., 2013; Savin-Williams and Ream, 2003; Willoughby et al., 2006). Therefore, LGB youth must carefully weigh the risks and benefits of disclosure. They must decide whether



or not to disclose but also when, where, and to which parent or family members. The initial reactions from family members may have prolonged effects on the quality of the relationships and the physical and mental health of LGB individuals (Ryan et al., 2009; 2010). While disclosure to family of origin is an important milestone for many youth, considerably less attention has been given to family dynamics post-disclosure as LGB youth and family address issues related to dating and romantic partners, faith and spirituality, and disclosure to non-parental family (D'Augelli, 2005; Phillips & Ancis, 2008; Rothblum et al., 2005). Families remain an important influence on LGB young adults well being yet social support and social undermining functions of family networks remain largely undefined in the literature.

### **Family Networks Among Sexual Minority Youth**

At the societal level, biological and legal (i.e., biolegal) recognition of family ties remains the predominant manner by which these relationships are defined, yet evidence suggests that individuals construct and define meaningful family networks outside of this paradigm. A significant body of literature captures this practice as it occurs within specific populations, referred to as *fictive kinship* among African-Americans and *compadrazgo* among Mexican-American populations (Chatters et al., 1994; Gill-Hopple and Brage-Hudson, 2012). Scholars have also extended this concept to LGBT populations, demonstrating how LGBT individuals form *chosen family* networks consisting of biolegal (i.e., *family of origin*) and non-biolegal family ties that include friends as well as current and former romantic partners (Moore and Stambolis-Ruhstorfer, 2013; Nardi, 1992; Weston, 1991).

The positioning of the biolegal family as the dominant family structure type is a feature of a heteronormative society that privileges “the heterosexual couple as the social and sexual ideal” (Fields, 2001, pg. 166). In their processes of self-discovery, identity disclosure, and

construction of personal networks, including networks for exploring sexual and romantic relationships, LGB individuals must confront these dominant heteronormative social scripts both internally and in their everyday social lives. Heterosexism thus becomes the process by which LGB people and their families are systematically discriminated against across multiple settings ranging from interpersonal exchanges between individuals, and individual experiences of isolation from personal communities, to anti-LGBT legislation and policy at the national level. Clear examples of this includes rejection from parents after a youth discloses an LGB identity, religious condemnation of same-sex partnerships, legislation that prevented same-sex marriage and adoption of children by same-sex couples, as well as the lack of sexuality-based anti-discrimination policy in work and educational environments (Hatzenbuehler, 2010; Szymanski and Moffit, 2012). Therefore, formation of chosen family networks is one manner by which LGB people directly challenge heteronormative conceptualizations of family.

The variation in family network structure and function within and across LGBT communities remains a rich area for descriptive exploration and examination of family influences in the lives LGBT people. This area of research includes understanding the role of family at different developmental stages across the lifespan, particularly as a person transitions between stages. Among younger cohorts, for example, self-acceptance and disclosure of an LGBT identity to family members and friends often coincides with the transition from adolescence to young adulthood (Groo, 2006). The quality of reactions to disclosure may subsequently have profound impacts on the short and long-term psychological and psychosocial well-being of the LGBT individual. The very structure of the family network, as defined by the individual, may change as a result of these reactions and thus shape the individual's overall experience in their transition to young adulthood.

While some scholars argue that non-biological family networks are not specific to any particular sociocultural group, others suggest that populations such as racial and ethnic minorities, immigrants, and those who identify as LGBT form these networks to access material and psychological resources where access has been diminished as a result of group members' marginalized status (Dewaele et al., 2012; Ebaugh and Curry, 2000; Nelson, 2014; Riggle et al., 2008). For LGBT youth who experience sexuality-based rejection from their families-of-origin, for example, friends may take on the role of family in providing various types of support (Weston, 1991). Even among LGBT youth in supportive families, finding other LGBT peers may be important if there are no other LGBT family members to serve as role models or sources of sexuality-specific support. There remains, however, the lack of conceptual clarity around who counts as family and the need for further investigation of the mechanisms by which family social support and family social undermining impacts health.

### **Study Aims and Hypotheses**

Based on the concept of chosen families and on theories of social networks and social support, the current study focuses on the role of social support and social undermining from family, as defined by YGBM, with psychological distress. In previous quantitative studies of LGBT mental health, social support from family and friends, definitions of family networks have rarely been explored and have often been seen as mutually exclusive from friendship networks. According to previous research, particularly ethnographic and qualitative studies, sexual minorities form chosen families consisting of relationships between people not necessarily related by biology (i.e., family of origin) nor through legally-recognized partnerships. Therefore, the first aim of this study is to describe a typology of families based on the definitions of young adult GBM themselves, and then to examine the levels of social support and social undermining

across family types. I hypothesize that young adult GBM will define their families in a variety of ways, leading to a typology of families consisting of six different types of family formed by a single network or any combination of the following networks: family of origin, family by partnership, and family as roommates or friends. Furthermore, levels of social support and social undermining will vary across family types.

The second aim of the current study is to examine the relationships between family social support and family social undermining with psychological distress while accounting for internalized homophobia and degree of sexual identity disclosure. Findings from previous research suggest that these two latter variables represent markers of sexual identity development that reflect real or perceived experiences of rejection and affect access to social support. To further understand the relationship between social support, social undermining, and sexual identity development with psychological distress, I will examine these relationships within each family type. I hypothesize that these relationships will vary across family types given the differences in the composition of family types.

## **Methods**

### **Sampling and Data Collection**

Data come from the United for HIV Integration and Policy (UHIP) study, an academic-community partnership conducted by the University of Michigan School of Public Health in collaboration with community partners in the Detroit Metropolitan Area (DMA). The overall study goal of UHIP is to examine the social and structural determinants of vulnerability to HIV infection among young adult men who have sex with men (MSM) living in the DMA. Participants were eligible if they indicated a male sex assignment at birth, were between 18-29 years old, were currently living in the DMA, and indicated ever having sex with men.

Researchers used a convenience sampling technique, recruiting study participants at LGBTQ-related events and venues, including bars, clubs, health fairs and other community events, and on-line social networking sites in collaboration with community partners. Potential participants were approached and received an explanation of the study in addition to a palm card outlining the basic eligibility requirements with a link to the on-line survey and mention of the \$30 incentive for completing the survey.

Upon entering the on-line study site, users were asked to provide an e-mail address they could use to return and complete the survey at a later time, if necessary, and receive a \$30 e-gift certificate upon completion. The study site also includes links and information about other national and local resources for users. If eligible, as determined by responses to screening questions at the beginning of the survey, users were subsequently invited to participate and complete an on-line informed consent form (ICF). The ICF explained the purpose of the study, study procedures, risks and benefits to participation, compensation, confidentiality including the Certificate of Confidentiality, and contact information for the study's Principal Investigator and the respective institution's Internal Review Board (IRB). Consented participants completed a 30-minute on-line survey that including the following general domains: sociodemographic characteristics, general and physical health and health behavior, sexuality and gender identity and expression, social networks and social support, general and LGBTQ-specific community involvement, sexual health and sexual behavior, substance use, experiences with discrimination, and mental health and other psychosocial assessments.

For participant confidentiality, all study data were protected with a 128-bit SSL encryption and kept within a University of Michigan firewalled server. During data collection, data were reviewed for duplicates and falsified entries were removed by examining participants'

e-mail and IP addresses. The researchers obtained a Certificate of Confidentiality to further protect study data. The University of Michigan, Ann Arbor, IRB reviewed and approved all study procedures.

### **Study Participants**

A total of 429 participants completed the on-line survey. Given the few participants who identified as transgender (N=33; 8%), these participants were excluded as the sample size did not allow for adequate sub-analyses to explore the unique experiences and challenges of transgender individuals. Similarly, 16 (3.7%) of participants were excluded who indicated a sexual identity other than gay or bisexual. Another 30 participants (7%) were excluded because they had missing data on one or more variables used for the current study. The final study sample consisted of 350 gay (89%) and bisexual (11%) cisgender male participants between the ages of 18 and 29 ( $M = 23.0$ ,  $SD = 2.9$ ).

### **Measures**

#### *Psychological Distress*

Depressive symptoms were assessed using a 10-item scale adapted from the Center for Epidemiologic Studies Depression (CES-D) Scale, a validated survey of clinically significant distress as a marker for clinical depression (Radloff, 1977). Sample items include, “*I felt that everything I did was an effort,*” “*I felt hopeful about the future,*” and “*I felt lonely.*” Participants responded on a 4-point scale (1=*Rarely or none*, 2=*Occasionally*, 3=*Some or a little time*, 4=*All of the time*). Two of the ten items were reverse-coded to match the remaining items in valence. A depression score was calculated by averaging the responses to the ten items, where a higher mean score was indicative of depressive symptoms ( $\alpha = .80$ ).

Anxiety symptoms were assessed using a 6-item scale adapted from the Brief Symptom Inventory (BSI) (Derogatis & Melisarato, 1983). Participants responded to 6 statements to indicate how they had felt or what they had thought in the past week. Sample items include “*Nervousness or shakiness inside*” and “*Feeling so restless you couldn’t sit still.*” Participants responded on a 5-point Likert scale where 1 = *Never*, 2 = *Almost never*, 3 = *Sometimes*, 4 = *Fairly often*, and 5 = *Very often*. An anxiety score was calculated by averaging the responses to the 6 items, where a higher mean score was indicative of anxiety symptoms ( $\alpha = .92$ ).

#### *Family Social Support and Social Undermining*

Participants were asked to indicate the extent to which they received social support from their families. A 10-item scale was used to capture the four functional domains of social support proposed by House (1981): appraisal, emotional, informational, and instrumental. Together, these items represent an underlying factor of universal social support (Vinokur and Vinokur-Kaplan, 1990; Vinokur et al., 1987). Participants indicated how often their families behaved in a certain way or made certain comments. Sample items include “*Say things that raise your self confidence*,” “*Show that they care about you as a person*,” “*Give you useful informational or advice when you need it*,” and “*Provide you with direct help ... how much they do things for you.*” Participants responded on a 4-point scale (1=*Never*, 2=*Rarely*, 3=*Sometimes*, 4=*Often*). A family social support (FSS) score was calculated by averaging the responses to the ten items, where a higher score was indicative of greater perceived social support from family ( $\alpha = .94$ ).

Social undermining from the family was assessed using a 7-item scale. Social undermining consists of behaviors that diminish a person’s self-worth and counteracts the benefits of supportive behaviors (Abbey et al., 1985; Vinokur and van Ryn, 1993; Vinokur and Vinokur-Kaplan, 1990). Participants indicated how often their families behaved in a certain way

or made certain comments. Sample items include “*Act in an unpleasant or angry manner toward you,*” “*Criticize you,*” and “*Get on your nerves.*” Participants responded on a 4-point scale (1=*Never*, 2=*Rarely*, 3=*Sometimes*, 4=*Often*). A family social undermining (FSU) score was calculated by averaging the responses to the seven items, where a higher score was indicative of greater social undermining from family ( $\alpha = .91$ ).

#### *Comfort With Sexual Identity and Disclosure of Same-Sex Attractions*

Discomfort with one’s sexual identity was measured as internalized homophobia using a 9-item scale adapted from the Internalized Homophobia Scale (Meyer, 1995). Participants were asked to indicate the extent to which they agreed with statements about the level of comfort with their gay/bisexual identity or attraction towards men. Sample items include “*I wish I weren’t [gay or bisexual],*” “*I have tried to stop being attracted to men in general,*” and “*I feel alienated from myself because of being [gay or bisexual].*” The survey was programmed to substitute the bracket in each statement with the participant’s previously selected sexual identity. Participants responded on a 4-point scale (1=*Strongly disagree*, 2=*Disagree*, 3=*Agree*, 4=*Strongly Agree*). An internalized homophobia score (IH) was calculated by averaging the responses to the nine items, where a higher mean score was indicative of internalized homophobia ( $\alpha = .92$ ).

Degree of disclosure (i.e., *outness*) about same-sex attractions was measured by asking participants whether they had disclosed this information to specific social network members represented by the following categories: mother, father, siblings, other family members, friends, and co-workers (Waldo, 1999). Participants had the options of responding *Yes*, *No*, or *Not Applicable* for each category for a total of six responses. A proportion was calculated by dividing the number categories in which disclosure had occurred by the total number of possible categories, excluding categories from the denominator where a participant responded *Not*



*Applicable.* This proportion indicates the extent to which a participant was out about their feelings of same-sex attractions given their specific social network. On average, participants were out to 75% of their social network.

### **Data Analytic Plan**

Descriptive statistics are provided to elaborate on the demographic and social network characteristics (e.g, household composition, relationship status, peer network homogeneity) of study participants. Bivariate correlations were used to initially examine general associations between study variables. Three sets of regression analyses were conducted to examine (1) general associations, and main effects of support and undermining in the whole sample, (2) general associations, and interaction effects between support and undermining in the whole sample, (3) general associations within family types.

In the first set of regression analyses, anxiety and depression were modeled separately in multivariate regressions with age and race/ethnicity as covariates and support, undermining, IH, and SOD as predictors. To examine the role of family type in relation to psychological distress, family type was also included as five dummy variables with family-of-origin serving as the excluded reference category. In the second set of analyses, I was interested in further examining the relationship between support and undermining in relation to the outcomes. The previous regressions models were repeated with the inclusion of an interaction term between support and undermining in the final step. Significant interactions were plotted to gain better understanding of the roles that support and undermining have when they occur simultaneously. In the third set of analyses, I examined how the relationships between predictors and outcomes varied across family types. Depression and anxiety were modeled separately for each of the six family types defined by participants, which represented six different participant sub-samples.

## Results

### *Preliminary Analyses*

Table 3.1 displays the sociodemographic characteristics of the study participants as well as some structural characteristics of their social networks. Considering the age eligibility criteria, participants tended to be younger with the largest group (36%) consisting of 21 to 23 year-olds. The vast majority of participants identified as gay (89%) while nearly half the sample identified their race/ethnicity as Black or African-American (48%) followed by White (29%), Hispanic or Latino (15%), and Multi-racial/ethnic (9%). In general, the sample was highly educated with 58% having had at least some college education and approximately 45% indicated they were currently a full or part-time student. The majority of participants had full or part-time employment (69%) while a significant proportion indicated they were unemployed but looking for a job (25%).

When asked to describe their families, participants constructed their family networks in a variety of ways. The largest group of participants (37%) stated that their family consisted only of their family of origin such as parents and siblings. The second largest group (29%) said it was both their family of origin and their friends or roommates. The third largest group (15%) was those who indicated all three family type options: family of origin, friends or roommates, and family by partnership. Smaller proportions chose only their friends/roommates (9%), their family of origin and partners (7%), or their family by partnership only (3%) to represent their families. A single individual defined his family as family by partnership and friends/roommates (0.3%). There were also eight individuals who indicated that their families were not defined by any of the three given family type categories (2%). These latter two groups were excluded from further analyses.

Among the 249 participants (71%) who said that they lived with other people, 29% indicated living with one other person, 28% with two other people, 23% with three other people, and 21% with four or more other people. When asked to describe who these household members were, most participants identified them as their friends or roommates (43%) and their mother (41%). About one-quarter (26%) stated they lived with a sibling and 23% stated they lived with their father. A smaller proportion said they lived with another relative (10%) and their partners (8%). In general, 42% of the entire sample also indicated they currently had a partner. When participants were asked how many of their friends share the same sexual orientation as the themselves, 22% said “almost all of them,” while 40% said “some of them,” 33% said “a few of them,” and only 4% said “none of them.”

Table 3.2 displays the Pearson correlations, means, and standard deviations for the primary study variables. The means suggest that, overall, participants experience high levels of family social support (Family-SS) and sexual identity disclosure, low levels of internalized homophobia, and moderate levels of family social undermining (Family-SU). Both depression and anxiety symptoms were each significantly associated with Family-SS ( $r = -.30, p < .01$ ;  $r = -.12, p < .05$ ) and Family-SU ( $r = .32, p < .01$ ;  $r = .35, p < .01$ ) as well as with IH ( $r = .22, p < .01$ ;  $r = .26, p < .01$ ) in the expected directions, although the associations were generally more significant with respect to depressive symptoms. The strength of the association between depressive symptoms and Family-SS, however, was more than twice that between anxiety symptoms and Family-SS. Also as expected, Family-SS and Family-SU were negatively and moderately correlated ( $r = -.21, p < .01$ ). Family-SS was positively but weakly associated with sexual orientation disclosure ( $r = .13, p < .05$ ) but not IH, while Family-SU was not significantly associated with sexual orientation disclosure but positively and moderately associated with IH ( $r = .20, p < .01$ ). The

strength of the negative association between IH and sexual orientation disclosure was significant and moderate ( $r = -.33, p < .01$ ). Age was not significantly associated with any of the other primary study variables.

### *Associations of Support and Undermining with Psychological Distress*

To address the second study aim, hierarchical multivariate linear regressions were modeled to examine the association of family social support and family social undermining with depression and anxiety symptom levels for the entire sample. I modeled each regression in three steps to test the main (Step 1 and 2) and stress buffering (Step 3) effects of support on undermining. Age and race/ethnicity were included as covariates in both models (Step 1) along with family type, internalized homophobia (IH) and sexual orientation disclosure (SOD). Family type was included as a categorical variable with family of origin as the referent. Support and undermining were subsequently entered (Step 2) followed by their interaction term (Step 3).

Table 3.3 includes the results from multivariate regression analyses modeling depression and anxiety symptoms, utilizing the whole sample. In all three steps, neither age nor race/ethnicity were significantly associated with depressive symptoms. In Step 1, IH ( $\beta = .20, p < .001$ ) was associated with increased depressive symptom levels but no other associations were significant. With the addition of family social support and social undermining in Step 2, IH ( $\beta = .17, p < .001$ ) and undermining ( $\beta = .18, p < .001$ ) were both positively associated with depressive symptoms while support ( $\beta = -.22, p < .001$ ) was negatively associated with depressive symptoms. Compared to those who defined family as family of origin, assigning friends as family ( $\beta = .22, p < .05$ ) was also positively associated with depressive symptoms. The addition of support and undermining in Step 2 significantly increased the variance explained by the model ( $R^2\Delta = .14, p < .001$ ). Addition of the support x undermining interaction term in

Step 3 maintained the previous associations, with the interaction term being significant and negatively associated with depressive symptoms ( $\beta = -.13, p < .01$ ). The interaction term further increased the variance explained by the model ( $R^2\Delta = .02, p < .01$ ). The relationship between depressive symptoms and undermining was conditioned by support; the association between depressive symptoms and undermining was attenuated at higher levels of support (Figure 3.1). Results indicate that this full model explained 20.2% of the variance in depressive symptoms ( $R^2 = .20, F(13, 336) = 7.20, P < .001$ ).

The previous steps were repeated to model anxiety symptom (Table 3.3). In all three steps, neither age, race/ethnicity, nor family type were significantly associated with anxiety symptoms. In Step 1, IH ( $\beta = .42, p < .001$ ) had the only significant relationship with anxiety symptoms and was associated with greater anxiety symptoms. This association persisted for IH ( $\beta = .33, p < .001$ ) in Step 2 with the addition of family social support and social undermining, however only undermining had a significant relationship with anxiety symptoms ( $\beta = .38, p < .001$ ) and was associated with greater anxiety symptoms. Overall, addition of these family relationship process measures significantly increased the model variance ( $R^2\Delta = .10, p < .001$ ). These associations remained consistent with the addition of the support x undermining interaction term in Step 3. The interaction term had a negative relationship with anxiety symptoms and further increased the variance explained in anxiety symptoms ( $R^2\Delta = .01, p < .05$ ). The relationship between anxiety symptoms and undermining was conditioned by support; the association between anxiety symptoms and undermining was attenuated at higher levels of support (Figure 3.2). The full model explained 17.4% of the variance in anxiety ( $R^2 = .17, F(13, 336) = 6.24, P < .001$ ).

#### *Stratified Analyses by Family Type*

Preliminary analyses resulted in a family typology consisting of six different family types based on YGBM's reporting of family relationships across family of origin, romantic partnerships, and friends. To better understand how support and undermining were associated with psychological distress symptoms, I performed a stratified analysis by examining these associations within different family types. As with the previous regression, I modeled depression and anxiety symptoms separately for each of the six family types for a total of twelve regressions. The sample size for each regression model thus reflects the number of YGBM that defined their family as such. Results indicated that the omnibus F-test for model significance was significant for only three of the six family types. The same three family type models were significant when depression and anxiety symptoms were modeled, for a total of six valid regression models (Table 3.4 and Table 3.5).

Table 3.4 includes the results from multivariate regressions modeling depressive symptoms for each of three family types: family of origin,  $F(8,121) = 5.60, p < .001$ ; family of origin and friends,  $F(8,92) = 3.90, p < .01$ ; and family of origin, partners, and friends,  $F(8,43) = 2.47, p < .05$ . Within the family of origin group, both IH ( $\beta = .22, p < .01$ ) and SOD ( $\beta = .32, p < .05$ ) were positively associated with depressive symptoms as was family social undermining ( $\beta = .12, p < .05$ ). In contrast, family social support ( $\beta = -.27, p < .001$ ) was strongly associated with fewer depressive symptoms. This model accounted for 22.2% of the variance in depressive symptoms among YBGM with families of origin ( $R^2 = .22, F(8, 121) = 5.60, P < .001$ ). Among participants who indicated family of origin and friends as their family, age ( $\beta = .04, p < .05$ ) and social undermining ( $\beta = .25, p < .01$ ) were both associated with greater depressive symptoms. No other associations in this group were significant. The amount of variance explained in this group was 18.8% ( $R^2 = .19, F(8, 92) = 3.90, P < .01$ ) Finally, results for the family type defined

by family of origin, partners, and friends indicated that social support ( $\beta = -.38, p < .01$ ) was negatively associated with depressive symptoms. No other associations were significant in this group. The model explained 18.7% of the variance in depressive symptoms for this family type ( $R^2 = .19, F(8, 43) = 2.47, P < .05$ ). The regression model explained a slightly greater percentage of the variance in depressive symptoms in the family of origin group compared to the other two family types.

Table 3.5 includes the results from multivariate regressions modeling anxiety symptoms, repeated in the same manner as they were for depressive symptoms, among three family types: family of origin,  $F(8,121) = 4.00, p < .001$ ; family of origin and friends,  $F(8,92) = 3.40, p < .01$ ; and family of origin, partners, and friends,  $F(8,43) = 5.63, p < .001$ . Among YGBM with family of origin only, IH ( $\beta = .28, p < .05$ ) and family social undermining ( $\beta = .42, p < .001$ ) were both associated with anxiety symptoms. With no other significant associations, this model explained 15.4% of the variance in anxiety symptoms ( $R^2 = .15, F(8, 121) = 3.94, P < .001$ ). Similarly, social undermining was negatively associated with anxiety symptoms ( $\beta = .48, p < .001$ ) in the family of origin and friends group. In this group, identifying as Black ( $\beta = -.36, p < .05$ ) was negatively associated with anxiety symptoms as compared to White individuals. This model explained 16.1% of the variance in anxiety symptoms ( $R^2 = .16, F(8, 92) = 3.40, P < .01$ ). In the last group, family of origin, partners, and friends, both IH ( $\beta = .79, p < .001$ ) and SOD ( $\beta = 1.48, p < .001$ ) were associated with greater anxiety symptoms. Social support ( $\beta = -.60, p < .001$ ) was negatively associated with anxiety symptoms while there was no significant association between social undermining and anxiety symptoms. Lastly, this model accounted for 42.1% of the variance in anxiety symptoms ( $R^2 = .42, F(8, 43) = 5.63, P < .001$ ), which is nearly three times the variance explained by the model in the previous two family type groups.

## Discussion

This study is among the first quantitative studies to examine how family relationship processes (family social support and family social undermining) are associated with YGBM mental health with respect to the type of family networks that they define for themselves. Based on findings from previous ethnographic studies of gay and lesbian familial and friendship networks, participants in the current study were asked to define their family as family of origin (e.g., parents and siblings), family formed by marriage or partnering, or family of friends or roommates, including any combination of these family types (Nardi, 1992; Weston, 1990). I then created a family network typology that allowed me to further examine the relationship between family social support and undermining and psychological distress across the whole sample and subsequently within each family type. Furthermore, I examined if sexual identity development characteristics also varied by family type. This approach provided a more nuanced and current understanding of family networks among YGBM, including the ways in which YGBM simultaneously experience support and conflict within more personally defined family networks.

My results support Weston's (1990) observations that gays and lesbians form chosen family networks in addition to or in place of family of origin networks. The current study builds upon previous work by further characterizing the structure and function of these chosen family networks. I found that the associations between family relationship processes and psychological distress in the overall sample varied by family type. Family social support was protective against anxiety symptoms but not depressive symptoms whereas family social undermining was associated with greater symptoms of both depression and anxiety, however, these relationships differed when the sample was stratified by family type. Similarly, IH and SOD were



differentially associated with depressive and anxiety symptoms across family types. These findings highlight dynamic social processes occurring within YGBM's families that may also reflect the structure of their family networks.

### *Structural Characteristics of Family Networks*

Results indicate partial support for the study hypothesis that YGBM form family networks that include relationships outside of family of origin. On the one hand, YGBM's responses resulted in a family typology consisting of six different family types comprised of single networks or combinations of networks based on family of origin, family as friends/roommates, and family by partnering/marriage. The most common types of family were family of origin, family of origin and friends, and family of origin with friends and partners, which all accounted for 81% of family types. Family as friends, family of origin with partners, and family as partners constituted the remaining family types. Overall, 53% of YGBM included friends in their family network while 25% included partners although just over half of those who included partners were currently partnered. The diversity of these family types and inclusion of non-biolegal ties supports the theory that LGB populations form chosen family networks (Dewaele et al., 2011; Muraco, 2006; Weston, 1990). Nonetheless, the vast majority (88%) of YGBM still incorporated family of origin into their definitions of family whether it was family of origin alone or in combination with other networks. Therefore, family of origin, which includes parents, remains an important network for this sample YGBM (Goldfried & Goldfried, 2001; Needham & Austin, 2010).

It is noteworthy that the YGBM in this study are generally embedded in rich social networks. The majority of participants indicated living with multiple people who they mostly identified as friends/roommates and mothers but also to a lesser extent as siblings and fathers.

Participants had also disclosed their sexual orientation to most of their social network; the vast majority had disclosed to their friends and mothers yet only half had disclosed to their fathers. Consistent with prior research, an average of about five years had passed since participants first disclosed their sexual identity to someone, which had occurred in the late teenage years (Groves, 2006). These findings are consistent with previous studies in which LGB youth were more likely to first disclose their sexual identity to mothers (D'Augelli et al., 1998; Savin-Williams & Dube, 1998). More recent evidence suggests that LGB youth are increasingly disclosing to fathers and that fathers may also react positively (D'Augelli et al., 2005; Grafsky, 2014; Savin-Williams and Ream, 2003).

With respect to peers, about half of participants said they knew either more or less than fifty other 18 – 29 year old individuals. Peer networks were also diverse with respect to sexual identity as most YGBM indicated that only some of their friends were also bisexual or gay, and very few stated having friends that didn't identify as bisexual or gay. Among nearly half of YGBM who had partners at the time of the survey, most indicated that it was a "serious relationship" with an average relationship length of two years. In other words, most YGBM in the current study are likely not experiencing the type of extreme social isolation that has been characterized in previous research with sexual minority populations (Gonzalez et al., 2013; Goodrich, 2009; Grossman, 1997; Meyer, 1995).

A few trends, albeit non-significant, emerged when comparing participant demographic and network characteristics across the six family types identified. Due to sample size however, comparisons were possible only between the three most common family types: family of origin, family origin with friends, and family of origin with friends and partners. Conceptually, the latter two groups could also be combined into a *chosen family* category as a contrast to family of

origin, however, a strength of the current study remains in its ability to examine nuances even across different chosen family types (Weston, 1990).

The proportion of bisexual participants tended to increase as the family network diversified. Bisexual populations carry a high burden of psychological distress stemming from discrimination experienced from heterosexual as well as lesbian and gay individuals (Bostwick et al., 2010; Friedman et al., 2014; Herek, 2002; Mulick and Wright, 2002). In response, bisexual individuals may open up and diversify their family networks to access various types of social support including coping resources like emotional support, which may explain the 17% of participants who were bisexual in the family as origin/friends/partner group compared to just 9% in the family of origin group (Muñoz-Plaza et al., 2002; Sheets and Mohr, 2009).

The proportion of Black participants was consistent across the three family types. This finding somewhat contradicts previous findings that Black/African-American individuals tend to form extended fictive kinship networks by assigning close family-like roles to individuals not necessarily related by biology or marriage (Chatters et al., 1994). These studies have produced mixed findings, however, and the intersection of race/ethnicity and sexuality has often been overlooked (Demo and Allen, 1996; Nelson, 2013).

Other researchers argue that socioeconomic status (SES) is a significant factor in shaping family networks (Sarkisian et al., 2006). In the current study, SES is difficult to assess in relation to family network type given the small sample size and the age range of the population. The question regarding employment status, however, includes the answer “unemployed but looking for a job,” which provides some indication of economic strain that study participants may be experiencing. When comparing this answer across family types, those who were unemployed but looking were concentrated more in more diversified family networks. For these

individuals, a broader network may serve multiple purposes, providing resources necessary for survival as well as avenues for job searching.

### *Correlates of Psychological Distress in the General Sample*

In previous studies of LGB youth and family, family support was associated with decreased psychological distress whether support was defined as “family” or more specifically as “parent” support (Needham & Austin, 2010; Sheets & Mohr, 2009; Shilo & Savaya, 2011). In the current study, this relationship held true with respect to depressive symptoms. In the overall sample, family social undermining was associated with greater symptoms of depression and anxiety while family social support was associated with fewer symptoms of depression only. Previous researchers have documented this more consistent and robust relationship between undermining and psychological distress (Abbey et al., 1985; Taylor, 1991; Vinokur & van Ryn, 1993). My findings, however, suggest that support remained an important protective factor as effect sizes were comparable to those of undermining in relation to depressive symptoms.

The significant independent and interactive effects of support and undermining on psychological distress suggest there are dynamic social processes occurring within the families of YGBM. While most family studies of LGB youth and their parents have focused on negative social exchanges or on supportive behaviors separately, the current study is among the few to examine family-related social support and conflict concurrently (Bouris et al., 2010; Bregman et al., 2012). My findings highlight the importance of examining both positive and negative dimensions of YGBM’s social relationships with their families. The weak but significant negative bivariate correlation between support and undermining (-.21), and their significant interaction terms, further suggests that YGBM may simultaneously perceive support and strain

coming from the same family network although it's more likely that high support corresponds with low undermining and vice-versa in the current sample (Schuster et al., 1990).

Participants in the current study generally had low levels of IH and were generally out about their same-sex attractions yet IH remained strongly associated with depressive and anxiety symptoms even after accounting for family support and stress. According to the sexual minority stress model, sexuality-based victimization leads individuals to become fearful and hyper-vigilant of subsequent discrimination, and repeated exposure leads to an internalization of anti-LGB societal beliefs (Meyer, 2003). Shedding these beliefs is an integral process of sexual identity development among LGB individuals, and the current findings highlight the importance of continuing to address IH even among young adult men who self identify as gay or bisexual. (Meyer, 1995; Troiden, 1988). On the other hand, degree of disclosure had no association with either psychological distress outcome. A limitation of the disclosure measure is that it does not take into account the size of the network nor the types of relationships YGBM have to those network members. Nonetheless, the current findings are consistent with previous research, which indicates the saliency of IH across mental health outcomes and the absence of a disclosure effect (Newcomb & Mustanski, 2010; Shilo & Savaya, 2012). Contrary to Newcomb and Mustanski's (2010) findings from their meta-analysis, however, results from the current study yielded larger effect sizes for the association between IH and anxiety compared to the relationship between IH and depression. Therefore, internalized homophobia appears to play a larger role in YGBM's feelings related to social avoidance and discomfort over feelings related to negative self-perceptions.

*Correlates of Psychological Distress Within Different Family Types*

Previous researchers have presented rich ethnographic narratives on the family lives of LGB individuals (Nardi, 1992; Schulman, 2009; Westin, 1991). However, the structure and function of these family networks has not been adequately described in quantitative research, and the influence of family networks on the health of LGB individuals remains understudied. Findings from the current study indicated that family social processes were related to the psychological well being of YGBM but that some associations varied by type of mental health outcome and family network content. Comparisons were made between families of origin and chosen families, with chosen families further classified into two types: family of origin and friends, and family of origin, friends, and partners.

Support and undermining, along with IH and disclosure, were differentially associated with depressive and anxiety symptoms across the three family types examined. When associations were significant, support was always associated with decreased depressive and anxiety symptoms while family undermining, IH, and disclosure were always associated with increased symptoms. Collectively, these factors explained similar levels of variance in depressive symptoms across the three family types but explained a great deal more variance in anxiety symptoms for the family of origin, friends, and partners group. Undermining but not support was associated with psychological distress within the family of origin and friends group; the reverse was true within the family of origin, friends, and partners group. Lastly, IH and disclosure had no association to psychological distress only within the family of origin and friends group.

Several important patterns emerged upon closer inspection of the associations between support and undermining with depression and anxiety outcomes, across the three family types. First, the associations between support and either outcome were significant for every family type

except the family of origin and friends group. Second, family of origin, partner, and friends was the only group in which support was associated with both outcomes and where undermining was not associated with either outcome. Third, family of origin was the only family type in which both support and undermining were associated with the outcome (depressive symptoms). Fourth, undermining was associated with depressive and anxiety symptoms in every family type except family of origin, friends and partner. An important overall finding here is that associations varied not only across different family subtypes but they also varied with respect to the associations found for the sample as a whole. In other words, when family social processes are examined and the *content* of the family network is not taken into account, the analysis may mask some of the relationships being examined. Possible explanations for the patterns of associations found in the current study are described below.

Early research conducted by Abbey and colleagues (1985) suggests that the protective effects of perceived support may depend on the specificity of the support source such that the support received from a specific person will confer greater psychological benefits than support received from a group of people. Support was associated with decreased psychological distress, specifically depressive symptoms. Whereas study participants in the current study likely referenced their immediate biological family when they selected family of origin, adding friends to this choice may result in a reference group that is not specific enough or where the perception of support becomes too diffused to capture when asking follow-up questions about family support. The addition of “partners” to a family of origin and friends network may restore the specificity needed to assess support. It’s also possible that YGBM who include partners in this type of family network are individuals with a highly integrated network of support. Previous researchers have documented the challenges that some LGBs experience when first introducing

romantic partners to their family of origin even if they experienced initial support after first disclosing their LGB identity (LaSala, 2000; Kurdek, 2005). Overcoming these challenges requires that the family of origin reach new levels of understanding thus resulting in a highly supportive network of family of origin, friends, and partners, which may explain why this was the only family type where support was associated decreased levels of both outcomes and undermining was not associated with either outcome (Grafsky, 2014; Huston, 2000; McConnell et al., 2015). Furthermore, romantic partners themselves are also important sources of support (Doty et al., 2010).

Current findings partially support previous studies demonstrating consistent and robust relationships between undermining and distress compared to support and distress (Rook, 1984; Newsom et al., 2005; Schuster et al., 1990). In general, undermining was more often associated with increased psychological distress than support was with decreased distress across the different family types and outcomes. On the other hand, support remained significant for some family types, and there were no clear patterns with respect to differences in effect sizes between undermining and support coefficients. In fact, in family of origin, the only group where support and undermining were both associated with the outcome, the support coefficient (-.27) was twice the magnitude of the undermining coefficient (.12). This finding suggests there may be unique family social processes that are specific to family of origin even though all three networks examined have been designated a family status by YGBM. It highlights the family of origin's unique supportive role among YGBM but perhaps reflects the dual nature of close relationship with family of origin, characterized by the presence of support and conflict within the same social ties (Abbey et al., 1985; Walen & Lachman, 2000).



I also compared the associations between IH and disclosure with psychological distress outcomes, across the three family types. As expected, IH was associated with greater psychological distress however this association was only significant within the family of origin and within the family of origin, friends, and partners groups. Disclosure followed a similar pattern. In the family of origin group, the positive association of IH and disclosure with distress may reflect the experiences of individuals who are in the earlier stages of sexual identity development, and this could reflect a lack of GB friends and sexuality-specific support to deal with sexuality-related stress (Bregman et al, 2012; Meyer, 2003; Szymanski et al., 2008). The finding that IH and undermining were positively correlated in bivariate analyses, and that both were associated with greater depressive and anxiety symptoms within the family of origin group in multivariate analyses, further supports this reasoning. Disclosure has been linked to psychological well-being as it may increase access to more or greater types of support, and it relieves the individual of the stress related to identity management (Cox et al., 2011; Goffman, 1963; Rosario et al., 2009). Indeed, disclosure was positively correlated with support and negatively correlated with IH in bivariate analyses but, unexpectedly, associated with increased psychological distress in multivariate models. Although researchers have suggested the benefits of disclosure, unique characteristics of the social environment may determine the benefits and risks involved in disclosing (Floyd and Bakeman, 2006; Legate et al., 2011). Current study findings suggest that among YGBM who only consider family of origin in their family network, disclosure might involve more risk and reap fewer benefits.

Interestingly, IH and disclosure were also associated with psychological distress in the family of origin, friends, and partners group. More specifically, support, IH, and disclosure accounted for nearly 40% of the variance in anxiety symptoms within this family type. The

inclusion of multiple networks in this family type may be providing YGBM with multiple sources and types of support. The strong association between IH and disclosure with anxiety symptoms may be related to the inclusion of “partner” in this family type. Researchers have suggested that same-sex couples experience more stigma and discrimination than heterosexual couples because of the visibility gained as a couple. For example, whereas two gender-conforming individuals may individually pass as heterosexual, their presentation as a couple and displays of affection may present non-heterosexual identities that then makes them targets for discrimination, which in turn triggers a stress response that contributes to greater anxiety (Igartua et al., 2003; Meyer, 2003; Otis, 2006).

### *Implications*

While the body of literature on social support continues to grow, research on social undermining remains limited and is particularly scant as it pertains to LGB young adults and their families. Research on family conflict among LGB youth mostly addresses psychological distress following disclosure of an LGB identity and subsequent experiences with overt sexuality-based discrimination and rejection from parents (Bouris et al., 2010). Therefore, the current study is among the first to examine the effects of more subtle forms of perceived negative social exchanges between YGBM and their families. Furthermore, I simultaneously examined the role of support and undermining on mental health across diverse types of family networks.

Taken together, these findings illustrate how family network composition may be related to YGBM’s perceptions of family support and social undermining in relation to psychological distress. Sexual identity development milestones such as shedding of IH and disclosure of sexual orientation also appear to have some relationship to family network structure. Within quantitative studies, researchers have only recently begun to examine the roles of family and

friend support, and rarely partner support, as they intricately play out in the lives and social networks of LGB individuals. To-date, much of this work has been conducted based on heteronormative assumptions that privilege “biological and legal ties as ‘genuine’ family and designates other forms of relations as ‘pseudo’ (Oswald, 2006, pg.146). This begs a basic question: *Who counts as family?* As the current study findings indicate, when YGBM were asked to define their families based on any single or combination of networks, only 37% of them indicated their family of origin as their only family network, and 19% of them didn’t include their family of origin at all. The remaining participants described their families based on various combinations of networks that included family of origin, family of friends, and family of partners. Subsequent questions about family social support and family social undermining were then based on the family networks that YGBM defined for themselves.

The approach of the current study takes into account the *content* of YGBMs’ relationships, which is an interactional characteristic of a network that describes “the meaning that a person in an network give their relationships,” and a relationship may consist of one or multiple content areas (Israel, 1982). Weston (1991) captured these layered dimensions of family relationships in her ethnography of LGB individuals living in San Francisco, evoking a distinction between *families of origin* and *chosen families*. Nardi (1992) also observed and chronicled how gay men incorporated current and former lovers into their family networks. Therefore, by employing a method in which the researcher and participant co-construct definitions of family, researchers may produce findings that more accurately reflect how LGBT individuals actually perceive their family networks and the family social processes that occur within them.

## **Limitations**

Several limitations must be considered when interpreting the results from the current study. Findings are limited to a community sample of young adult men from the Detroit Metropolitan Area (DMA) who self-identify as gay or bisexual. The sample is also a non-random and cross-sectional sample with recruitment largely taking place at LGBT establishments as well as LGBT events in the DMA. Therefore, relationships between constructs can only be discussed in terms of associations. The study sample itself is diverse with respect to the inclusion of participants from racial and ethnic minority groups (71% identified as Black/African-American, Latino/Hispanic, or Multi-racial/ethnic), however the overall sample size was a limitation to conducting any subgroup analyses. In general, the current findings are a unique contribution to the literature given that many studies of LGBT health in the United States include samples of LGBT populations primarily drawn from large coastal cities.

The current study is also unique in that participants first provided some description of the different kinds of relationships (e.g., network content) within their family networks before answering questions about their experiences of social support and social undermining (e.g., functional characteristics) within their particular family. To conduct a more complete family network analysis, however, additional information is needed. This would include further details about the structural, interactional, and functional characteristics of their family networks, including the number of family members and the frequency of contact among them and with the participant, the homogeneity across family members, and the different types of support (e.g., affective, instrumental, cognitive) given and received (i.e., reciprocity) (Israel, 1982). The overall sample size may have also limited the power to detect some associations between the predictors and outcome variables. Also due to sample size, it was not possible to conduct within group analyses for four of the seven different family types that participants described, including

participants who indicated that their family did not consist of any of the given options (origin, friends/roommates, or partners/boyfriends).

An important consideration for future research on the influence of family on the health of LGB young adults is determining the precise role of family in the lives of young adults. Much of the existing literature on LGB populations and their families is specific to the experiences of adolescents and the impact of homophobia and rejection within the family. As a result, current measures of support may be inadequate for examining the role of family support in the lives of LGB young adults. Futures studies should also include additional measure of family network characteristics in order to examine what aspects of family networks, including any unique characteristics of origin and chosen families, may be associated with the psychological well-being or associated with specific health behaviors among LGB young adults.

**Table 3.1** Sample Demographics (N=350)

	N	%		N	%
Age category (years)			Group(s) identified as family		
18 - 20	74	21.1	(1) Family of origin	130	37.1
21 - 23	127	36.3	(2) Family by partnership	10	2.9
24 - 26	106	30.3	(3) Friends/roommates	32	9.1
27 - 29	43	12.3	(1) - (2)	25	7.1
			(1) - (3)	101	28.9
Sexual Identity			(1) - (2) - (3)	52	14.9
Gay	313	89.4			
Bisexual	37	10.6	Lives with others	249	71.1
Race / Ethnicity			Average number of people	3.06	6.68
Black or African-American	168	48.0	in household (n=249)		
White	101	28.9			
Hispanic or Latino	51	14.6	Household members (n=249)		
Multi-racial/ethnic	30	8.6	Mother	102	41.0
			Father	57	22.9
Education Reached			Sibling(s)	65	26.1
Some HS	27	7.7	Children	2	0.8
HS/GED	87	24.9	Other relatives	31	12.4
Technical/Associates	32	9.1	Friend(s)/roommate(s)	106	42.6
Some college	118	33.7	Partner(s)	19	7.6
College	53	15.1	Other	7	2.8
Graduate school	33	9.4			
			Has a partner/boyfriend	145	41.4
Current Student			Partner type (n=145)		
Full-time	104	29.7	Serious	108	74.5
Part-time	52	14.9	Casual	33	22.8
No	194	55.4	Other	4	2.8
Current Employment			Friends who share the		
Full-time	136	38.9	same sexual orientation		
Part-time	104	29.7	Almost all of them	78	22.3
Unemployed - looking	88	25.1	Some of them	140	40.0
Other	22	6.3	A few of them	117	33.4
			None of them	15	4.3

**Table 2.2** Pearson Correlations Among Primary Study Variables

	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. Depression	1.94	0.03						
2. Anxiety	1.75	0.05	0.66 **					
3. Family Social Support	3.18	0.04	-0.30 **	-0.12 *				
4. Family Social Undermining	2.14	0.04	0.32 **	0.35 **	-0.21 **			
5. Age	23.07	0.15	0.06	0.04	0.04	-0.01		
6. Internalized Homophobia	1.61	0.04	0.22 **	0.26 **	-0.06	0.20 **	-0.05	
7. Sexual Orientation Disclosure	0.75	0.02	-0.03	-0.03	0.13 *	-0.04	0.03	-0.33 **

\* $p < .05$ , \*\* $p < .01$

**Table 3.3** Multivariate Regressions by Psychological Distress Outcomes (N=350)

	Depression			Anxiety		
	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3
Age	0.01	0.01	0.02	0.01	0.01	0.01
Race/Ethnicity (White)						
Black/A-A	0.08	0.00	0.02	-0.15	-0.22	-0.21
Latino	0.02	0.01	0.03	0.00	0.01	0.02
Other	0.04	-0.02	-0.05	0.00	-0.11	-0.13
Family Type (1 - Origin)						
(2) Partner	0.06	0.02	-0.03	0.18	0.14	0.09
(3) Friends	0.18	0.22 *	0.42 *	0.21	0.22	0.27
(1) - (2)	-0.12	-0.11	-0.17	-0.03	-0.05	-0.04
(1) - (3)	-0.07	-0.02	-0.04	-0.13	-0.10	-0.11
(1) - (2) - (3)	0.07	0.11	0.20	0.17	0.19	0.21
IH <sup>a</sup>	0.20 ***	0.17 ***	0.29 ***	0.42 ***	0.33 ***	0.36 ***
SOD <sup>b</sup>	0.12	0.15	0.24	0.16	0.15	0.14
Family-SS <sup>c</sup>		-0.22 ***	-0.28 ***		-0.11	-0.10
Family-SU <sup>d</sup>		0.18 ***	0.22 ***		0.38 ***	0.29 ***
Family-SS x Family SU <sup>e</sup>			-0.13 **			-0.12 ***
(Constant)	1.18 ***	1.54 ***	-1.22 **	0.71	0.42	-0.92 *
F	2.74 **	7.17 ***	7.17 ***	3.23 ***	6.17 ***	6.24 ***
Adjusted R <sup>2</sup>	0.05	0.19	0.20	0.07	0.16	0.17

\*p &lt; .05, \*\*p &lt; .01, \*\*\*p &lt; .001

a = internalized homophobia, b = sexual orientation disclosure, c = family social support, d = family social undermining, e = interaction term



**Table 3.4** Multivariate Regressions by Family Type, Predicting Depression

	Origin ( <i>n</i> =130)			Origin and Friends ( <i>n</i> =101)			Origin, Partner, & Friends ( <i>n</i> =52)		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Age	0.02	0.44	0.12	0.04 *	0.02	0.21	-0.01	0.03	-0.05
Race/Ethnicity (White)									
Black/A-A	0.03	0.11	0.02	-0.14	0.12	-0.13	0.09	0.22	0.07
Latino	0.13	0.14	0.09	-0.17	0.19	-0.09	-0.44	0.28	-0.25
Other	0.30	0.20	0.13	-0.12	0.19	-0.06	-0.49	0.34	-0.22
IH <sup>a</sup>	0.22 **	0.07	0.29	0.15	0.10	-0.16	0.22	0.14	0.21
SOD <sup>b</sup>	0.32 *	0.14	0.18	-0.13	0.19	-0.07	0.43	0.30	0.21
Family-SS <sup>c</sup>	-0.27 ***	0.06	-0.36	-0.17	0.09	-0.20	-0.38 **	0.14	-0.38
Family-SU <sup>d</sup>	0.12 *	0.06	0.18	0.25 **	0.09	0.29	-0.27	0.13	0.03
(Constant)	1.36 **	0.45		0.88	0.66		2.88 **	0.95	
F	5.60 ***			3.90 **			2.47 *		
Adjusted R <sup>2</sup>	0.22			0.19			0.19		

\**p* < .05, \*\**p* < .01, \*\*\**p* < .001

a = internalized homophobia, b = sexual orientation disclosure, c = family social support, d = family social undermining

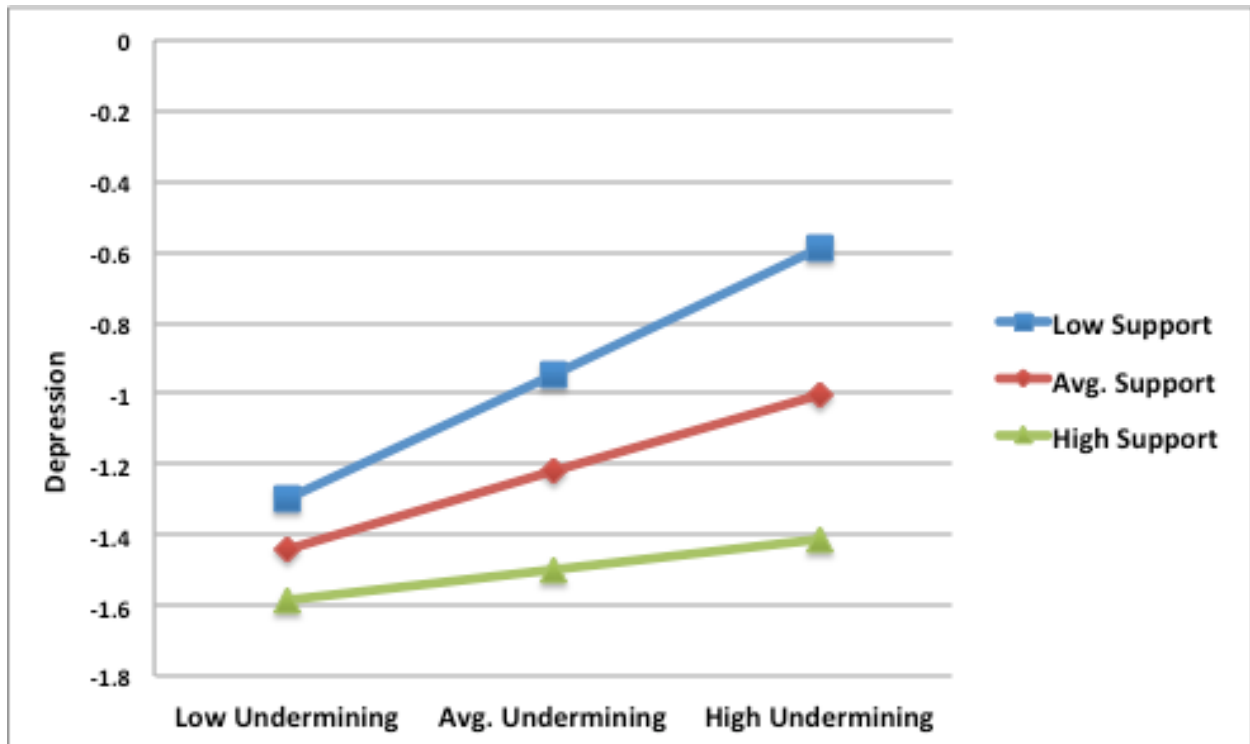
**Table 3.5** Multivariate Regressions by Family Type, Predicting Anxiety

	Origin ( <i>n</i> =130)			Origin and Friends ( <i>n</i> =101)			Origin, Partner, & Friends ( <i>n</i> =52)		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Age	0.00	0.03	0.00	0.05	0.03	0.17	-0.02	0.04	-0.05
Race/Ethnicity (White)									
Black/A-A	-0.17	0.20	-0.09	-0.36 *	0.17	-0.24	-0.18	0.28	-0.10
Latino	0.11	0.25	0.04	-0.38	0.27	-0.14	-0.54	0.35	-0.21
Other	0.13	0.36	0.03	-0.30	0.28	-0.11	-0.73	0.42	-0.22
IH <sup>a</sup>	0.28 *	0.12	0.20	0.08	0.15	0.06	0.79 ***	0.17	0.51
SOD <sup>b</sup>	0.29	0.26	0.10	-0.44	0.27	-0.16	1.48 ***	0.37	0.50
Family-SS <sup>c</sup>	-0.14	0.11	-0.10	-0.10	0.13	-0.08	-0.60 ***	0.17	-0.40
Family-SU <sup>d</sup>	0.42 ***	0.10	0.35	0.48 ***	0.13	0.38	0.16	0.16	0.11
(Constant)	0.65	0.82		0.22	0.96		1.76	1.17	
F	4.00 ***			3.40 **			5.63 ***		
Adjusted R <sup>2</sup>	0.15			0.16			0.42		

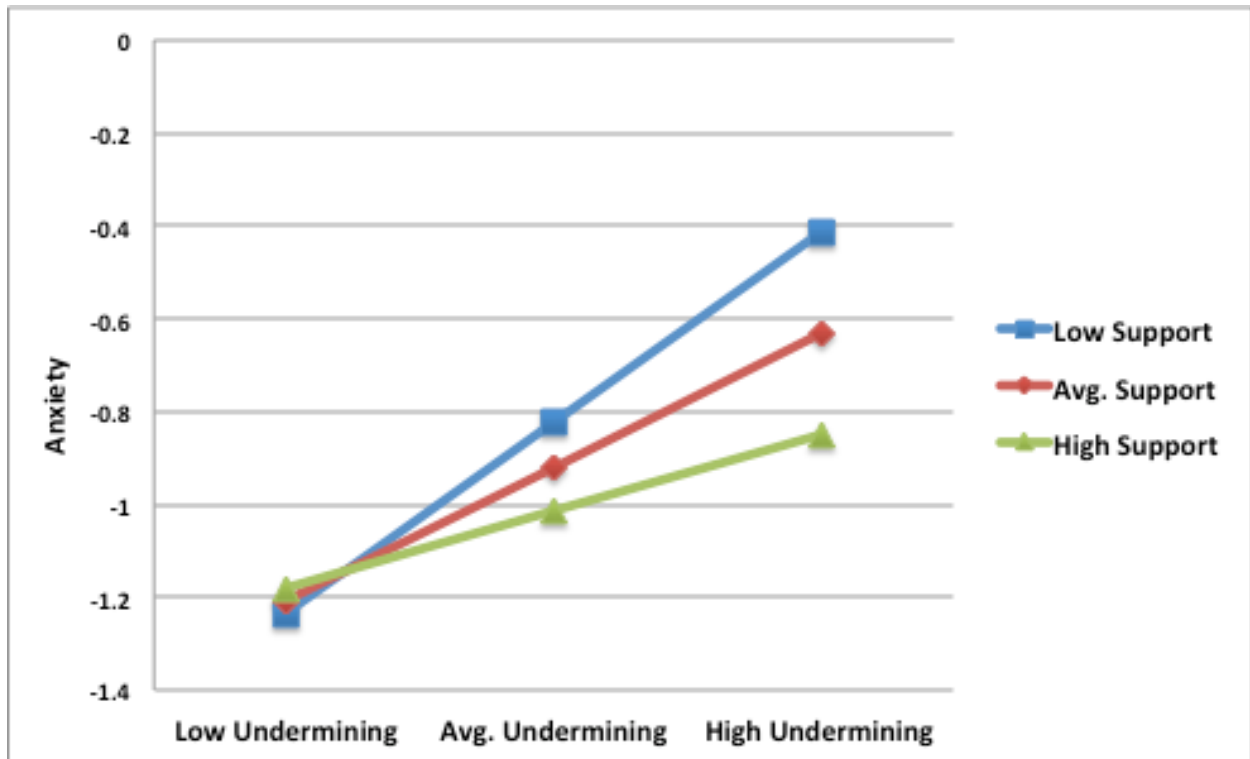
\**p* < .05, \*\**p* < .01, \*\*\**p* < .001

a = internalized homophobia, b = sexual orientation disclosure, c = family social support, d = family social undermining

**Figure 3.1** Relationship Between Depression and Family Social Undermining, as Conditioned by Family Social Support



**Figure 3.2** Relationship Between Anxiety and Family Social Undermining, as Conditioned by Family Social Support



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## CHAPTER IV

### **Mentors and Mentoring Relationships: What are the roles of mentors in the lives of vulnerable young adult Black and Latino men who have sex with men?**

#### **Introduction**

Men who have sex with men (MSM) are particularly vulnerable to experiencing comorbid psychosocial outcomes, including substance use, psychological distress, and HIV infection (Halkitis et al., 2013; King et al., 2008; Stall et al., 2003). Based on a nationally representative sample of adults, gay and bisexual men were more likely than heterosexual men to report past-year alcohol, marijuana, and other substance use or dependence, and report psychological distress, across various dimensions of sexual orientation (identity, attraction, and behavior) (Bostwick and colleagues, 2010; McCabe et al., 2009). Researchers have also reported poor psychological well-being among sexual minorities in relation to self-esteem, perceived social support, and feelings of hopelessness and loneliness (Halpin & Allen, 2004; Hatzenbuehler, 2009; Spencer & Patrick, 2009; Ueno, 2010). Given these findings, Stall and colleagues (2008) describe this phenomenon as a syndemic or co-occurrence of epidemics that individually compromise the health status of MSM but that also mutually reinforce each other and accumulate across the life course to create further vulnerability to poor physical and mental health outcomes. Recent findings support syndemics as a possible explanation for the increasing HIV rates and HIV-related health disparities disproportionately impacting young adult Black and Latino MSM (YBLMSM), particularly those living in urban areas throughout the United States (Bruce & Harper, 2011; CDC, 2014; Diaz et al., 2001, 2004; Egan et al., 2011; Halkitis et al.,

2013; Mizuno et al., 2011; Mustanski et al., 2007, 2011; Stall et al., 2003, 2008). As a result, researchers have advocated for greater attention to the structural factors that contextualize and enable these syndemics.

### *Structural Contributors to Syndemics*

Structural heterosexism and sexual prejudice are structural factors that foster hostile social environments towards sexual minorities in different areas of life including work, school, and the family. Through frequent exposure to anti-LGBT beliefs, attitudes, and behaviors, sexual minorities may experience a negative impact on their psychological health, predisposing them to enact in negative and maladaptive coping behaviors (Armstrong, 2013; Hatzenbuehler et al., 2010, 2014; Keyes et al., 2011; Meyer, 2003; Pachankis et al., 2014; Pizer et al., 2012; Szymanski & Moffitt, 2012). Among racial/ethnic sexual minorities, discrimination and victimization on the basis of race and ethnicity further contribute to YBLMSM's marginalized status at the intersections of race, ethnicity, gender, and sexuality (Della et al., 2002; Meyer & Ouellette, 2009; Mizuno et al., 2011; Sandfort et al., 2007). This dual minority status among young Black and Latino MSM has been associated with poor health outcomes. Mustanski and colleagues (2007), for example, found that likelihood of condomless sex increased with increasing number of psychosocial problems (e.g., substance use, psychological distress, sexual assault) experienced in a sample of 16-24 year-old urban YMSM. In a sample of adult Latino MSM from two major urban areas, Mizuno and colleagues (2011) found that men who reported experiencing both homophobia and racism were 42% and 92% more likely to report binge drinking and condomless sex, respectively, compared to men reporting only one type of discrimination. Finally, in a mostly young adult and immigrant sample of Latino MSM from three cities, men reporting more experiences of social discrimination and financial hardship were

also more likely to report having been in a sexual situation where it was difficult to use condoms (Diaz et al., 2004). Taken together, these studies suggest a link between social stress and health risk behavior. Further research is needed to examine the mechanism by which YBLMSM's social environments influence these behaviors.

### *The Role of Social Networks in Addressing Syndemics*

Earlier theoretical writing on syndemics focused on a broad range of intertwining epidemics that included socioeconomic factors such as poverty and unemployment but also factors that more directly impacted social networks such as residential overcrowding, forced geographic mobility, and family break up (Singer, 1994). Stall and colleagues (2008) have adapted this theory, for example to describe the benefits and risks that YGBM experience when they migrate from rural to urban areas, losing or leaving family, and adapting to a new environment (Egan et al., 2011). This highlights a broader issue and tension, however, about the benefits of connection but also exposure to risk behaviors, and the threat to psychological well-being related to isolation.

Social network and social support theories provide a framework for exploring the structural, interactional, and functional characteristics of YBLMSMs social networks. Structural features are the number of people and connections while interactional characteristics describe the connections themselves such as the frequency (amount of interactions), content (meaning or roles assigned), and homogeneity (degree of shared attributes) (Israel, 1982). The transfer of social support, including its loss, and the subsequent impact on health is one of the most studied functional dimensions of social networks. Examples of support range from the provision of money or shelter (instrumental) to less tangible forms such as offerings of advice (informational) and expressions of love (emotional) (Heaney & Israel, 2008).



A growing body of literature highlights the ways in which YBLMSM's social networks function as sources of support as well as sources of stress across various social contexts. In their review of the quantitative literature, Bouris and colleagues (2010) note that research on parents and LGB youth have largely excluded parent perspectives, with existing research primarily focused on LGB youth perspectives and their experiences of rejection following LGB identity disclosure to parents. In the only literature review currently available regarding MSM's social networks in relation to their health status (HIV risk), Amirkhanian (2014) reported finding high homogeneity with respect to HIV-related norms, attitudes, and risk behaviors within MSM social networks. Furthermore, social networks served as primary sources of social support for MSM, especially for MSM living with HIV (Amirkhanian, 2014). Researchers have also increasingly focused on examining how support influences sexual minority mental health in relation to source (e.g., parent, peer, MSM, non-MSM) and type (e.g., general, sexuality-specific, emotional, instrumental) of social support (Doty et al., 2010; Harkless & Fowers, 2005; McConnell et al., 2015; Muraco, 2006; Nardi, 1999; Sheets & Mohr, 2009; Shilo & Savaya, 2011; Wong et al., 2013). Although increasing in scope, research on the characteristics of YBLMSM's social networks remains limited and uneven. Despite the focus on social support, researchers have largely employed a deficits-based approach, examining the relationship between low levels of social support and psychological distress, primarily anxiety and depression, and HIV-related sexual risk behavior among MSM especially. In response, researchers have also called for more holistic frameworks that capture both risk and strengths-based approaches to studying sexual minority health across multiple social contexts (Halkitis, 2010; Harper, 2007; Harper et al., 2004; Herrick et al., 2011; Horn et al., 2009; Russell, 2005).

#### *Mentoring as a Structural Resource*

Developmentally, researchers have highlighted the importance of mentors in the lives of adolescents and young adults. Mentors have typically been defined as older non-parental adults characterized by their knowledge and experience and their willingness to offer guidance to a mentee through a mutual connection based on trust (Dubois & Karcher, 2005). Furthermore, mentoring may occur formally through mentoring programs where an organization is responsible for matching mentors and mentees, or mentoring may occur through relationships that have formed and developed naturally between a mentee and an individual already present in their social network (Zimmerman et al., 2005).

Evidence suggests the health promoting and health protective effects of natural mentoring relationships across several domains including physical and behavioral health (e.g., physical activity, birth control use, substance use), psychological health (e.g., depression, self-esteem, life-satisfaction, suicidal ideation, anxiety), and socioeconomic opportunity (eg., high school completion, college attendance, job hours worked) (Dubois & Silverthorn, 2005a, 2005b; Hurd et al., 2014; Hurd & Zimmerman, 2014; Whitney et al., 2011). Interactional characteristics of mentoring dyads appear to influence mentorship effects. In general, benefits of mentoring relationships were greater with non-kin (versus family) and older adult (versus peer) mentors, and better outcomes were evident among mentees who reported greater frequency and duration of contact with their mentors (Dubois & Silverthorn, 2005a; Hurd et al., 2014; Hurd & Zimmerman, 2014; Whitney et al., 2011). In terms of functional characteristics of mentoring relationships, Hurd & Zimmerman (2014) found that social support mediated the association between having a natural mentoring relationship (NMR) and psychological outcomes, while Hurd and colleagues (2014) reported that NMR presence was associated with decreased substance use and psychological distress through mediational pathways related to youths'

perceived coping ability and sense of purpose. Thus, there are both individual and relational qualities that influence and are influenced by the dynamics of the mentoring relationship between mentor and mentee. Applying social network and social support theory to Rhode's (2005) model of youth mentoring may further elucidate the mechanisms by which mentors and mentoring relationships influence youth outcomes in the context of youth's broader social networks and social environments.

Based on mixed-methods studies examining the characteristics of mentors and mentoring relationships in a nationally representative sample of young adults (ages 18 to 21), researchers found that two-thirds of young adults reported ever having a mentor, with the majority (77%) reporting NMRs (Bruce & Bridgeland, 2014). Beyond the presence of a mentor, the characteristics of the mentoring relationship seem to vary. Across studies, the proportion of participants who reported having NMRs ranged from 44% to 57%, with mentors being identified as non-parental family members (38% to 57%), professionals such as teachers and coaches (10% to 35%), or other community members (22% to 52%). (Dubois & Silverthorn, 2005a, 2005b; Greeson et al., 2010; Haddad et al., 2011; Hurd et al., 2014; Hurd & Zimmerman, 2014; Zimmerman et al., 2002). The majority of mentoring relationships began in adolescence and had lasted approximately nine years, on average, by the time of interview (Dubois & Silverthorn, 2005a, 2005b; Greeson et al., 2010). Hurd and colleagues (2014) noted a high propensity for gender matching (73%) within mentorship pairs and for race/ethnicity matching among white young adults (94%) compared to Asian (79%), African-American (66%), and Latino (58%) young adults. It remains unclear the extent to which homogeneity (e.g., by sexual identity) within mentorship dyads influences the quality of the mentoring relationship among sexual minorities.

At present, however, the role of mentors in the lives of BLYMSM remains greatly understudied within the social support literature.

### *Mentoring and Well-being Among Sexual Minorities*

Researchers have only recently employed population-based studies to examine the presence and characteristics of mentors in the social networks of sexual minority youth and young adults. Among sexual minority and heterosexual 18 to 28 year-olds, for example, Johnson & Gastic (2015) found that sexual minorities overall were more likely to report mentors (81% vs. 76%), and sexual minority men were more likely than heterosexual counterparts to report women and school adults as mentors and were less likely to identify family members as mentors. The average age at which participants met their mentor was higher among sexual minority than heterosexual youth (14.4 vs. 13.3 years old) and was highest among sexual minority men (15.7 years old) (Johnson & Gastic, 2015). This delay in mentorship identification may be especially concerning given the marginalized social status of YBLMSM and the related rejection and discrimination they may experience early at home and in school (Andersen et al., 2015; Espelage et al., 2008; Pizer et al., 2012; Ryan et al., 2009). Therefore, YBLMSM may be primed to reap the greatest benefits from mentoring relationships earlier in adolescence. Evidence from two quantitative studies indicates the importance of mentors in helping sexual minority youth achieve educational and employment milestones, and two other qualitative studies describe the unique role of mentors in the process of identity development among emerging adult GBQ men (Drevon et al., 2015; Gastic & Johnson, 2009; Sheran & Arnold, 2012; Torres et al., 2012).

Similar to the larger mentoring literature among heterosexual youth, the characteristics of mentor-mentee relationships may also vary and may result in differential health outcomes. Sterrett and colleagues (2015) provide further insight into the structural, interactional, and

functional social network characteristics of 16 to 20 year-old sexual minority male youth (SMMY) specifically. Compared to white SMMY, racial/ethnic minority SMMY reported more non-parental adults (NPAs) in their networks, and SMMY overall generally reported higher levels of closeness with female NPAs and heterosexual NPAs; matching for both gender *and* sexual orientation made no difference in closeness (Sterrett et al., 2015). Comparing levels of closeness across NPAs types, Sterrett and colleagues (2015) also found that SMMYs reported feeling least close to NPAs they had sex and used substances with compared to NPAs they also socialized with or NPAs they only socialized with (Sterrett et al., 2015). These findings, some of which are unexpected and contradictory to previous research on mentoring relationships, highlight the critical need for research that describes the rich complexities of these networks.

#### *Current Study*

Given that the links between structural factors, mentorship, and psychosocial health and well-being among sexual minorities remain vastly unexplored, the goal of the current study is to contribute towards a greater understanding of roles and impact of mentors and mentor-like individuals in the lives and well-being of YBLMSM. This population continues to experience increasing rates of HIV infection in the context of urban syndemics fueled by the social, political, and economic marginalization of racial/ethnic and sexual minorities. Therefore, the current study will also consider the factors that influence the development of mentoring relationships among YBLMSM, taking into account youths' unique characteristics as well as the influences coming from the social and built environments they inhabit. To this end, the following research questions guide the current study:

- 1) What is the role and function of mentors in the lives of young adult Black and Latino men who have sex with men (YBLMSM)?

- 2) What are the factors that influence the development of mentoring relationships between mentors and YBLMSM?

Building this area of research may give a more complete picture of YBLMSM social networks and thus help inform development of public health interventions for addressing the multiple epidemics that continue to threaten the health YBLMSM and other sexual minority populations. Study questions will be explored through the perspectives of forty-eight individuals who work closely with or provide services to YBLMSM in many different capacities and across different types of agencies and organizations. In some cases, study participants themselves identify as YBLMSM. Collectively, their history with local communities and their connections to each other and to the larger network of service providers and advocates for LGBT issues, offers a unique opportunity to explore their perspectives as well as their own roles in the social support networks of YBLMSM.

### **Methods**

Data from the current study come from a multi-phase study investigating structural vulnerability to HIV infection among YMSM (18 to 29 year-old) in the Detroit Metropolitan Area (DMA). This study was an academic-community partnership conducted by the University of Michigan School of Public Health in collaboration with several community-based organizations located throughout the DMA. These organizations comprised the study's Stakeholder Committee (SC), which provided review and feedback of study documents and procedures throughout the course of the study. Phase I of the study consisted of fifty qualitative semi-structured in-depth interviews with key community stakeholders followed by a Phase II quantitative structured survey administered to YMSM. The current study is a qualitative analysis utilizing a subset of Phase I interview data. All interviews were completed over a period of six months between November 2011 and April 2012.

## **Instrument**

The research study team developed a preliminary semi-structured interview guide that included a broad range of questions based on a theoretical framework encompassing correlates of HIV infection among YMSM. The interview guide was further refined over several iterative discussions between the research study team and the SC, and included multiple rounds of mock interviews with research staff and pilot interviews with community partners to test clarity of individual questions, overall interview flow across questions, and approximate length of time to conduct a full interview. Based on three pilot interviews, questions were eliminated, clarified, re-structured, and re-arranged, taking into account the feedback from community partners. Once changes were made, a final pilot interview was conducted before commencing study interviews.

The final interview guide consisted of five discussion areas. Introductory questions covered participants' professional roles and perspectives on the HIV/AIDS epidemic in the DMA. The next area focused on the participants' views on BLYMSM in the DMA and her/his experiences working with them, including questions regarding their sexual identities, socioeconomic status, and places of residence. Participants were then asked to speak about HIV/AIDS in relation to BLYMSM and the resources that they have to keep safe from HIV infection. For the section on structural factors, participants received a list of potentially relevant issues faced by BLYMSM in the DMA and then checked the five issues they deemed most important. Follow-up questions addressed the reasons for their selections and how these were related to risk of and protection from HIV infection and related to HIV/AIDS care and treatment among BLYMSM. The policy assessment section pertained to participants' opinions about existing services in the DMA that contributed to the general and social well being of BLYMSM,

and those that were missing and needed. Participants also had the opportunity to suggest ideas for engaging youth, organizations, and city or state officials in enacting policy changes.

## **Procedure**

### *Sampling and Participants*

A non-probability sampling technique was used to recruit study participants. Individuals were eligible if they met any of the following criteria: (1) worked with Black, Latino, or LGBT youth, (2) worked in HIV prevention or care, (3) worked for foundations that fund HIV and/or LGBT work, and/or (4) identified as a community advocate for HIV/AIDS issues, LGBT issues, or youth. Study participants engaging in any of these activities in the DMA were considered to be key community stakeholders and thus eligible to participate.

In collaboration with the SC, the research team generated an initial list of sixty-five potential community stakeholders to contact. These contacts either agreed to participate or recommended a more appropriate person at their agency, and in some cases also nominated potential study participants at other agencies. The final contact list consisted of ninety-one individuals. The original study proposal called for twenty key stakeholder interviews; however, the protocol was amended to accommodate additional interviews in order to reach the point of saturation where no new information surfaced from the interviews.

The final sample size consisted of fifty (N=50) individual interviews with participants from across forty-five different agencies, organizations, and institutions located throughout the DMA. Participants worked in various capacities including direct provision of social services or medical care at community-based health clinics or within large hospital systems. Among these health service providers, the focus was on LGBT health broadly or HIV/AIDS-related services primarily. Participants also worked in community-based agencies and organizations that



addressed these issues in the context of overall LGBT health and well-being, which included programming related to family, peer, and romantic relationships, mental health and substance use, and skill building for educational and job-related advancement. Some participants worked in the capacity of program administrators and directors in local agencies and organizations and within state-level and government institutions. Across these different settings, participants also worked as allies and advocates for development of initiatives such as LGBT healthcare access and anti-bullying policies (e.g., support of Gay Straight Alliances in schools). Based on overall responses during their interviews, participants described a range of work and personal histories in the DMA; some participants were born and raised and have only resided in the DMA, or they left and returned after some time, while others had only recently starting living and working in the DMA. Furthermore, some participants also identified with the study population of interest, identifying as Black or Latino, gay or bisexual, and/or transgender.

### *Recruitment*

Representatives from the study's SC contacted the potential study participants they had recommended. Via e-mail, study recruits were initially given an overview of the study and informed they would receive a follow-up e-mail and formal invitation to participate from the study Project Director. The Project Director subsequently contacted them to provide further details, answer any questions, and schedule a time and location for their interview that was most convenient for the participant. For study recruits that were more difficult to reach, they were contacted multiple times by e-mail and telephone. Dates, times, and methods of all outreach efforts were carefully recorded in a spreadsheet to keep track of communication and avoid re-contacting recruits who did not wish to participate or had already scheduled an interview. Participants did not receive an incentive for enrolling in the study.

### *Data Collection*

Based on participants' preferences, interviews occurred in private at the participant's office, at the University of Michigan School of Public Health, or in an office at a community partner's organization. Six trained members of the study team conducted the interviews. Each participant received time to review the informed consent form (ICF) and ask questions prior to providing consent and commencing the interview. The ICF included an overview of the study, outlined the interview procedure, covered risks and benefits of participation including measures taken to protect confidentiality, and provided contact information for the study Principal Investigator and the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board (IRB). Participants were given the option of having their interview audio recorded. All but one participant consented to audio recording; in this single case, the interviewer was permitted to take hand-written notes during the interview. Participants were encouraged to use only first names or aliases when talking about other people, organizations, or locations. The majority of interviews lasted between sixty and ninety minutes. Following the interview, the Project Director sent a thank-you note to each interviewee for their participation in the study.

Shortly after completion of each interview, the digital audio recording was downloaded onto a password-protected computer at the University of Michigan School of Public Health. Members of the research team then transcribed all interviews verbatim. To further protect confidentiality, each file received a unique identification number, and all identifying information in the interviews was masked during transcription. Throughout the interview period of the study, three members from the research team read all transcribed interviews and met regularly to

discuss the study's progress and assess if point of saturation had been reached with respect to the interview content.

## **Data Analysis**

### *Meta Codes and Codebook*

After transcription of all interviews was complete, a codebook was created based on the themes addressed in the interviews and the underlying theoretical model (Crabtree and Miller, 1992). The final codebook consisted of nineteen different codes and included definitions, inclusion and exclusion criteria, and examples for each code. Study data underwent two rounds of coding by four member of the research study team. At the time of data analysis, these four coders were Master of Public Health students at the University of Michigan School of Public Health. Two coders identified as men and two as women; all were cis-gender. Furthermore, two coders identified as racial/ethnic minorities and three coders identified as sexual minorities.

During the first round of coding, the four research team members individually coded a single interview transcript and then met to compare coding. This step helped ensure there was collective understanding of the study codes and the coding process and to ensure that the codebook would be a reliable tool throughout the analytic process. During the second round of coding, the four research team members were divided into two pairs with each pair assigned a given set of transcripts for review. Members from each pair separately reviewed and coded the same transcripts and then met to compare results and reconcile any differences in coding. Each pair of coders discussed their coding strategies and provided explications for their interpretations of the data, including how their individual experiences and perspectives influenced these interpretations. This step, in which the researcher's role is explicitly acknowledged as part of the investigation, is a key feature of phenomenology (Langdrige, 2007). Throughout this process,

the research team also had general meetings to discuss any broad issues and make any adjustments deemed necessary to the codebook. Upon completion of this initial review and coding process, forty-eight interviews were imported into NVivo, a software program used to facilitate qualitative analyses. Two interviews were excluded because one was not recorded and the other was lost due to an audio recorder malfunction. The codes were divided among the study team members who then applied them across all forty-eight interviews to conduct preliminary analyses and synthesis of data for each code. Research team members prepared written reports that were presented to the SC and made available to community partners upon request.

#### *Analytic Approach and Procedures*

The current study consisted of a phenomenological approach to inquiry to explore the factors that influence the development of mentoring relationships, and to explore the function of mentoring relationships in the lives of YBLMSM living in the DMA. Defining features of phenomenology include an emphasis on exploring a particular phenomenon among a group of individuals. Inherent to the approach is a focus not only the subjective individual experiences of study participants but also on the objective shared experience with other study participants (Moustakas, 1994). Accordingly, at the beginning of the interview, all participants were asked about their relationships with YBLMSM and the capacities in which they provided services or advocated for this population. These questions naturally lead participants to discuss the ways in which they related to the physical and social environment of the DMA as well as the extent to which they identified with YBLMSM populations in this area. In many cases, this allowed for better understanding of how study participants viewed and thought about mentoring relationships

in the lives of YBLMSM, including how they viewed and described themselves in the social networks of YBLMSM (Frost et al., 2014).

As previously described, nineteen meta codes were initially developed during the open coding process of the analysis. The meta code labeled “social network characteristics” was selected as the representative code to explore the core phenomenon of social network construction among young adult MSM. This meta code was the most logical choice given the focus of the current study on the mentors and mentoring relationships of YMSM. Using NVivo, all interview data coded under “social network characteristics” was extracted from across forty-eight interviews, and this became the primary text for further the current analyses.

A phenomenological analysis is a structured method of analysis that is appropriate when attempting to make specific comparisons between elements of individuals’ experiences. To this end, I read all forty-eight interviews once in their entirety followed by a second reading only of the text originally coded under the larger “social networks and social support” meta-code. Through an iterative process, I developed an initial list of codes that were then grouped or collapsed into themes and sub-codes that reflected patterns in significant statements appearing throughout the text. Portions of the text were read multiple times and re-coded to reflect changes in the coding scheme and thematic structure. Significant statements were then used to provide textural and structural descriptions of the final group of themes, highlighting which aspects of the phenomenon were experienced and how the phenomenon was experienced (Creswell, 2011). Phenomenological analysis was facilitated by the creation of thematic maps through which the thematic structure was developed during the coding process (Braun & Clark, 2006). Figure 4.1 and Figure 4.2 are the thematic maps pertaining to the first and second research questions,

respectively. These maps provide further insight into the process of theme development, sub-code grouping, and establishing links between themes and sub-codes.

Table 4.1 provides the list of sub-codes that I generated and used to further code data, which were then grouped into themes that comprised two larger domains pertaining to the two original research questions. For each sub-code, I also provide the number of interviews (sources) and number of statements (references) made by participants. Single sub-codes possibly contributed to multiple themes; however, I grouped sub-codes under the single theme they represented the most. The text marked by sub-codes became the significant statements used as examples in the presentation of results.

Participants talked about the social networks of YBLMSM throughout their interviews although only one area of the discussion guide specifically asked about social networks. The section of the discussion on structural factors, located towards the end of the interview, yielded large amounts of data as participants selected “weak social networks/social support” as one of the most important issues facing YBLMSM in the DMA. Participants then received follow-up questions about their selections. It is noteworthy that conversations about mentors, mentoring, and mentoring-like relationships arose spontaneously across all sections of the discussion guide.

## **Results**

Across their responses, participants discussed the various roles that mentors and role models play in the lives of YBLMSM. Generally, mentors were older adults characterized as having greater life experience and knowledge about local resources, and who also demonstrated some degree of social and economic stability. Their degree of involvement with YBLMSM mentees also varied from direct to indirect provisions of social supports. These conversations often occurred in the context of social and economic disadvantage as participants discussed the

challenges that YBLMSM faced with respect to their intersecting social identities (e.g., sexuality, gender, race, ethnicity) and the social and economic conditions of the DMA. The following results are thus an account of the challenges that YBLMSM experience in the DMA and how these challenges shape availability of and access to mentors. This is followed by an exploration of the purpose and place that mentors have in the social networks of YBLMSM in light of these challenges.

### **Opportunities for and Barriers to Connection**

Interviews were examined to explore participants' perspectives on factors that influenced the development of mentoring relationships between mentors and YBLMSM. Although participants were not explicitly asked to comment on this topic, they spoke to the larger need of eliminating barriers and creating opportunities for connection among YBLMSM and between YBLMSM and older or more experienced MSM. Three primary themes emerged around this central phenomenon: *pervasive homophobia*, *disclosure of sexual identity and HIV status*, and *YBLMSM representation*. Themes are presented below with interview excerpts that illustrate how each theme impacted or could potentially impact the availability of and access to mentors.

***Pervasive homophobia.*** Participants discussed the impact of homophobia at multiple levels by describing its effect on YBLMSM and their individual relationships as well as on the ways they relate and interact with larger communities. Ultimately, pervasive homophobia created barriers to social connections between YBLMSM and other supportive peers, adults, and networks from which mentors and mentoring relationships would emerge. At an individual and interpersonal level, homophobia hindered YBLMSM development by limiting the connections that were possible with people outside of the family:

During adolescence you're supposed to mature and, and part of your maturation is that you're supposed to learn about yourself by having relationships outside of

your family of origin, but if you're in a homophobic world and you're a gay person, you can't do that openly. (*Anthony, Clinical Social Worker*)

These extra-familial connections, which are important for the personal and social development of YBLMSM, were limited due to the fear of rejection. This next participant expands upon this issue by describing the different areas in which YBLMSM may miss opportunities to connect with others:

A: When I talk to young Black men about the, being gay Black men, people don't get it. From the church, from the family, family— close family members and cousins and all that, homophobia exists in all that. When they goes the street [sic], it exists in the school, on the street. When I go there in gay community, it's also there like, "Ok I'm gay man, Black man," I go there, they're not accepted because their, their race is in play ... as well, so.

Q: Ok. So they're kinda rejected in various communities.

A: Reject in all ways. (*Andre, Program Coordinator*)

This passage illustrates the extent to which homophobia permeates the various physical spaces that YBLMSM occupy. These spaces range from specific places (home, school, and church environments) to general spaces that YBLMSM occupy in everyday life (the street). The passage also demonstrates the function of homophobia at the intersections of race, sexuality, and gender in causing further marginalization of Black gay men specifically. As another participant highlights, the rejection and subsequent disruption of social networks caused by homophobia directly impacts the social support that YBLMSM have access to:

I think that kinda correlates with the whole idea of homophobia and really not being aware of how to access certain services. If you're a youth, and if you're having these feelings, and if you feel like you're going toward this direction, then who do you go to? Who do you turn to? If you don't know anyone that's already engaged in these behaviors, or if you don't have anyone that you can look at for that support, it's kinda difficult to try to find out who you can talk to about this. (*Donald, Disease Intervention Specialist*)

Together, the two participants above provide examples of how homophobia affects availability but also access to or awareness of social support networks by YBLMSM. Furthermore, Donald



alludes to the potential benefits of having a specific person or mentor-like individual who can provide support to YBLMSM.

Participants discussed the important role of religion and the church in connecting YBLMSM to their families and communities; however, homophobia interrupted those connections. When asked what policies they would implement to improve the well-being of YBLMSM, one participant suggested investing in education to create more inclusive faith-based institutions:

Also use that money to kinda, like, broadly educate the community everywhere, including faith-based institution too so these young men can feel like they can go to their church and get the support that they need. Right now they're, a lot of them are like, "I'm not going to that church." So and see one of the things about the denomination I belong to is that we are, we are a welcoming church because it was founded by people who cared about people who were dying of AIDS and HIV. (*Paula, Clinical Psychologist*)

According to this participant, rejection from the church results in YBLMSM feeling disconnected from faith-based institutions, which leads to loss of support. The participant also provides a personal example of a church with a history of inclusion and provision of support that began in response to the HIV/AIDS epidemic. Therefore, while the majority of references to religion and the church were negative across interviews, a few participants provided examples of churches and church leaders who were striving to be inclusive of LGBT youth:

Umm, so there's a pastor in the neighborhood who's developing a church. He's, like, a Lutheran pastor developing a church plan in Southwest Detroit ... a church that's more inclusive for LGBT teens and people in general.

...

It's funny 'cause religion's such, like, barrier. This pastor's been awesome and he gave us his information. And what's exciting is, it is one of the only opportunities our kids have to connect with other LGBT teens – and also young adults are going to be a part of this group too, like LGBT adults between the ages of 20 and 30, which I think – another thing missing for our kids is, like, adult mentors that are LGBT. (*Teesha, Social Worker*)

This participant, who provides support to the Gay-Straight Alliance (GSA) at the school where she is employed, expressed excitement at the possibility of linking GSA members to mentors through a church program. The reference to Southwest Detroit is also important because it refers to a predominately Latino community in Detroit. Therefore, participants in the current study have also provided examples that support an alternative narrative in which religion and churches can be free of homophobia and are inclusive of YBLMSM populations.

*Disclosure of sexual identity and HIV status.* According to participants, YBLMSM connected with other supportive individuals when they were able to disclose their gay/bi identity and/or their positive HIV status. By focusing on disclosure as a separate theme from homophobia, it was possible to explore the dimensions of disclosure and non-disclosure in relation to social connections. Participants juxtaposed the potential risks involved with the potential benefits received when YBLMSM disclosed their sexual identity to their families and friends. Stories of disclosure to family were often followed by descriptions of hardship as YBLMSM faced homelessness, losing both emotional and instrumental support from parents, after being ejected from their family's home. At the same time, disclosure was also seen as beneficial for expanding one's social network and increasing access to different resources including other supportive peers:

They the ones that are out and proud they've gotten out. They either now live in one of the houses of the house and ball community, or they're staying with friends. They have a network of friends, the ones that we haven't gotten that are still not out and proud or that are still hidden, are the ones that are still probably livin' at home still you know so they can't, they have to sneak out, they have to go. They don't have their resources, the opportunities, they haven't connected out yet. (*Roberto, Program Director*)

While this participant suggests that disclosure results in greater extra-familial connections, others suggest that the support from these external connections facilitate disclosure to family in the first place.

A older MSM took him under his wing, and again they came to me wanting some information, and I sat down with them, went through it, the whole, what we do, directed them to case management, they got the information they needed, and he is on his way to living again, and from that he has gotten the courage to talk to his family, and I don't know but I'm sure there are some family members now who are supporters of him now. But it was really in his own mind that was helping to kill himself, because he remained silent and closeted. (*Teresa, Executive Director*)

In this example, the mentor helped a YBLMSM mentee access additional support through an agency-network. Having a mentor was a precursor to disclosure, which lead to more rather than less family support. Conversations around disclosure were not limited to sexual identity, however, as participants also discussed the challenges but also the benefits for YBLMSM who disclosed their positive HIV status:

A lot of them aren't really out about their sexuality or don't have kind of a, a sense of belonging to a community that's supportive and that's, um, and that is uh, uhh kind of open to you know whether it be their HIV status or the fact that they have sex with other men, umm, so I think part of it is, it's, it's their own sometimes uhh not wanting to be very out, umm that keeps them sort of from, from being more visible to us. (*Cynthia, Executive Director*)

Therefore, HIV-positive YBLMSM who have not disclosed their sexual identity or HIV status are less connected to supportive networks and they are more difficult to reach by the agencies that provide supportive services. The result is that YBLMSM miss out on opportunities to meet potential mentors through peer and agency-based networks.

***YBLMSM representation.*** Participants discussed the importance of creating opportunities to develop leadership among YBLMSM and to have YBLMSM represented in positions of influence and authority. In these positions, YBLMSM served as mentors and leaders

who created opportunities for other YBLMSM to connect with each other. Mentors were YBLMSM who had overcome major challenges and now held leadership positions in community-based organizations (CBO). Participants often described themselves as these leaders or they spoke about other youth who were clients at their organizations. Although participants in the study were prompted to provide examples of YBLMSM who had faced and overcome challenges in their lives, an important finding was the extent to which YBLMSM naturally emerged as mentors and leaders:

A: He works for one of the organizations and has for some time, because of his status, because of all that, all that negativity that I spoke of, and he has formed several groups that are made up of young MSMs. As far as having come through a lot himself. And one of the things that he did was he actually made himself available to other MSMs day or night. Um, would go to jail, to see about them, would go into any other negative area where they were to see about that.

Q: And this was outside his employment at the organization?

A: Oh yeah, and that lead him into this type of work and employment. So, you know, because he overcame a lot in his own, in his own life, and finding out at a very young age that he was HIV positive. (*Carla, Pastor*)

Based on his own experiences of hardship, the YBLMSM in the passage above recognizes the importance of connection and responds accordingly by creating peer-based support groups. He also dedicates his time to supporting jailed and incarcerated individuals, a population that is physically separated from their networks of support. Participants shared similar stories of leadership among youth in Gay-Straight Alliances (GSAs):

They'll have agencies and speakers and pastors come in and talk to them about, you know, how can they connect more, and newspapers are coming in to interview them on what they do. They are developing alliances with other non-profits to help develop the LGBTQ community here, in the neighborhood, and so they also have talked about wanting to do, like, a bullying awareness day here. One passion our leaders have is not wanting to just address GSA issues or LGBTQ issues but wanting to address issues in the entire school. (*Teesha, Social Worker*)

These narratives exemplify a cycle of leadership development in which YBLMSM seek support from an organization, subsequently become volunteers or employees at the same organization, and create programs or reach out to YBLMSM from their own communities. Participants stressed the general idea of having peer-led initiatives, believing that peer leaders were in the best position to connect with youth, provide support, and influence behavior.

Participants also discussed barriers to developing YBLMSM representation, which resulted primarily from the absence of older adult male figures in families and communities. When asked to name services that were missing and important for keeping YBLMSM safe, one participant responded “mentors” because there were so many “fatherless families.” She was less sure, however, about how to make mentoring services more available:

Good question. In this economy and with this government, um, you know, I don't know. I think that, I think there needs to be a huge push for volunteers from the community to step up. Um, because there's not gonna be funding for it. I mean, you aren't gonna be able to pay people to be mentors.

...

I think a lot people might do that privately, try and help someone they know, but I think that it's not necessarily a, you know, I mean it's, I got to believe it's hard to find people in the community, Black men who are willing to take on this kind of thing or Hispanic men who may be fathers and whatever willing to step outside of themselves and help somebody who's you know, where is that gonna come from? And our men who are, you know, are gay men gonna step up and do this? I mean that's where, personally I think they will 'cause they tend to rise to every occasion I think, but you know, I don't think HIV would be anywhere if they hadn't made it happen. (*Nicky, HIV Nurse*)

The participant believes there is little economic and political support for mentoring services but also wonders whether there are enough Black and Latino men left in communities to subsume mentoring responsibilities left unfulfilled by missing fathers. When it come to gay men, however, she believes they will ultimately rise to the occasion as they have before in increasing awareness of HIV. Other participants echoed these sentiments, citing incarceration as a major

reason for the lack of male figures. One participant, who managed an after-school chess program for high school kids, noted:

I don't know any of them that have older brothers that have not been incarcerated at some point or another because there is no employment, there's no money, and they'll do things like sell weed or run drugs or hijack cars or whatever, just to make a little bit of money. I – do I know a single family out of – I probably know well over a hundred families, and I don't know a single one of them that does not have an immediate family member that is selling drugs or doing something else illegal. Usually it's an uncle or maybe the dad. (*Natalia, Nurse and Program Coordinator*)

Incarceration may account for the absence of older male figures in Latino and Black communities, which would result in a smaller pool of potential candidates to fill mentor roles. Another participant emphasized the need to both develop and retain YBLMSM mentors, suggesting that lack of retention may also explain the absence of older male figures in these communities:

A: I can think of one in particular who's in the medical field. He's young; he's in his early 20s approaching his mid-20s. But he has his own house, his own car. And his, I think his friends look at him as a model. So I think it's a matter of cultivating those leaders, and then once they make it, the thing that our community hasn't been very strong in, is once you make it, coming back to help others make it.

Q: So it's like once you make it, a lot of people get out?

A: Umm hmm. (*Darius, Program Chair*)

What remains unclear is whether YBLMSM who succeed either leave the geographic area or perhaps are not involved in the community to the extent that participants would like. In some cases, therefore, the main priority of YBLMSM may be to achieve some degree of economic stability or independence and not necessarily to mentor others.

Through their discussions around homophobia, disclosure, and lack of representation, participants spoke about the issue of social connections and social support among YBLMSM. The narratives provided insight into the challenges that YBLMSM experienced in finding,

forming, and expanding their networks of support and thus tapping into sources for mentorship. Given that mentors are embedded across many different kinds of supportive networks, homophobia, disclosure, and representation potentially have direct consequences on YBLMSM's opportunities to develop mentoring relationships and to benefit from those relationships.

### **Mentor Models**

Participants were asked broadly about the social networks of YBLMSM but they spontaneously spoke about the roles of mentors and mentoring relationships in the lives of YBLMSM. Three general themes emerged regarding this phenomenon: *mentors as role models*, *social and economic advancement*, and *psychological well-being*. Mentors were directly addressed in the narratives by approximately one-third of participants, with a greater number of participants linking mentors with role models. Mentors served as examples of resilience and success for YBLMSM. They provided informational and instrumental support to assist other YBLMSM in achieving their own personal and financial milestones, and they contributed to the self-esteem of YBLMSM by providing emotional and identity support. These different types of support were grouped together to capture the themes of *social and economic advancement* and *psychological well-being* as the primary functions of mentoring relationships.

***Mentors as role models.*** To an extent, participants used the terms mentor and role model interchangeably but mentoring relationships involved greater interactions leading to direct provision of support whereas role models had little or no contact with YBLMSM often resulting in indirect provision of support. The majority of participants described a hybrid role in which they placed equal emphasis on the benefits of direct support and the benefits of having visible examples of older YBLMSM who were embedded although not necessarily involved in the social networks of YBLMSM.

The type of mentoring relationships described ranged from informal/natural to formal mentoring approaches. Natural mentors engaged with YBLMSM outside of a program or organization while formal mentors engaged via mentorship programs or peer-based programs housed within LGBT-serving or AIDS service organization (ASOs). Many mentoring approaches fell somewhere along this range with participants describing mentors who provided mentorship to YBLMSM as a member, volunteer, or employee of an organization while also providing mentorship beyond this capacity. Participants often described their own involvement as mentors:

I also think, mentors, you know, some of these kids have been able to, through this [LGBT Center in Detroit] and other places, to establish mentorships. You know, like I'm a mentor to a lot of some of these young men so... They have some role models that they can kinda look up to. And they know that someone cares and someone cares about their safety. (*Paula, Clinical Psychologist*)

This participant, who also serves in leadership positions at an LGBT center, an African-American LGBT center, her church, and an agency for Black lesbians, highlights the importance of her visibility as a role model and her contributions of emotional support as a mentor to YBLMSM. Mentors also came from the family networks that YBLMSM construct (or choose), particularly chosen families from the house and ball communities. These families, comprised of young adult MSM who assume familial titles and roles with each other, live together and compete with other houses through performance in events called balls. One participant describes the social structure of houses:

Maybe hierarchy isn't the word but it would be similar to a frat, you have, or a social club. You know, there's either what's called a house den mother or den mother, which would be like a parent. Someone who has been in the community, that is now not maybe 13-24 but maybe in their 30s, a little bit more secure, stable and secure, and so can mentor the younger ones. (*Roberto, Program Director*)



This passage highlights both the mentoring and role model aspects of the den mother in addition to the semi-formal nature of the mentoring relationship. Although house and ball communities are not formal organizations, they are highly organized. House mothers are symbolic parent figures who provide support and enforce rules that govern how the rest of the house members (i.e., *children*) interact with each other and how responsibilities are distributed.

***Social and economic advancement.*** The lack of social and economic opportunities was often the backdrop for conversations about the function of mentor role models in the lives of YBLMSM. Participants discussed the limited opportunity structure for youth in general and for YBLMSM in the DMA. Therefore, mentors provided informational and appraisal support to fill some of these gaps, particularly gaps in educational and employment opportunities. One participant gave practical advice to YBLMSM on how to manage personal finances, including some personal advice on doing this in the context of family relationships:

I feel like sharing that story with young people. That was important. I wasn't taught to budget or credit. But after I learned, I know better, and I know what to encourage... Do not let anyone run your credit! People will just, "Oh, put my gas bill in your name." You know, you don't think about that. Historically, I mean, in the African American community, if your parents ran up their gas bill, "Oh, let's put it in the child's name." Nooo! That's important. (*Desean, Project Coordinator*)

According to the participant, this type of informational support seems particularly valuable for African-American youth and young adults. Another participant also describes her own role in providing informational and appraisal support to a group of transgender women regarding the reasons and steps involved for legally changing one's name:

I was telling a bunch of young trans women that, um, they call me their big sister, and you know they look up to me, and I'm like, "Okay, well, if you've been living your life for a girl for three years, why didn't you go and get your name changed?" Most of them don't even know that that's an option, that they can go do that and it's not gonna cost a ridiculous amount of money, and then some of them were just like, "Oh, well, it doesn't bother me," and I'm like, "Okay it

doesn't bother you, but at the same time you're 'Oh my gosh I can never find a job and everybody is, you know, discriminating against me.'" (*Karina, Project Coordinator*)

Karina highlights the issue of discrimination that transgender individuals face when they are unable to present gender-appropriate identity documents during the job interview and hiring process. Therefore, the suggestions and advice she provides may potentially have an immediate impact on the social and economic advancement of these women by decreasing their experiences of discrimination and increasing their opportunities for employment.

A primary function of mentors is to provide instrumental support to YBLMSM. Mentors provided instrumental support in the form of assistance with college financial aid forms and job applications, including direct referrals to potential employers and job opportunities:

And so um, got him in to work here, and we, we watched him grow. And like now he's a case manager [laugh] over at [Medical Agency], and you can't even tell it's the same young man from five years ago. (Dwayne, ASO Employee)

Mentors also played a critical role in providing housing for YBLMSM who faced homelessness after being ejected from their family homes:

I have friends who have adopted young men who have sex with men who've been thrown out of their, kicked out of their houses, kicked out of their homes, got no family, who take them into their homes, treat them as their own and give them that foundation, that support, and so it's been great sitting down and having these conversations with these young men, who because they have these two fathers, who have made it an expectation that you will go to high school, that you will go to college, that you will get a job. (Sheila, Program Director)

Housing and shelter thus become one of the most important types of instrumental support that mentors provided to YBLMSM who are forced to leave home after disclosing they are gay or bisexual, or who leave home to avoid abuse. House and ball communities also provided shelter for YBLMSM experiencing these same challenges. As the passage above suggests, social and

economic advancement is not possible without the physical and social foundation that stable housing can provide.

*Psychological well-being.* Through supportive functions, mentors contributed to the psychological well-being of YBLMSM in terms of their self-esteem and their feelings of hope and vision for the future. Social and economic disadvantage contributed to psychological distress among YBLMSM as a result of the discrimination and limited local opportunity structure they experienced:

Our students who don't value education as much and come from sometimes lower economic backgrounds, they tend to just see the fore—the here and now. They can't see, you know, like, the future like how LGBT rights can be developed. They just see: "I got pushed in the hall. I got called a faggot". And they just, they have more of a sense of hopelessness because of it. (*Teesha, Social Worker*)

As discussed in the previous theme, mentors served to fill some of the opportunity gaps shaped by the social and economic environment. Participants, however, extrapolated this effect to discuss the psychological benefits of mentoring. As a result, participants discussed their concerns about the availability as much as they discussed the absence of mentor role models and the subsequent psychological impact on YBLMSM. These concerns largely corresponded with participants' discussions about the importance of social support from mentor role models to YBLMSM

Feelings of hope and vision for the future were closely linked with perceptions of opportunities for employment and educational attainment. Across multiple interviews, participants repeatedly spoke about the lack of educational aspirations and narrow range of occupations that characterized youths' visions for their own futures. This this lack of hope and inability to envision a future full of opportunities and choices was indicative of psychological

distress. One participant described her attempt to broaden students' perspectives by taking them on tours of college campuses and providing education-related informational support:

I think most of the people that live in my area of Detroit have not much hope for a future. The young people I know have no real understanding of what it is to go to college. I take them to look at what a college is 'cause they don't know. I was mostly at schools just right here north of [University X]. Those kids did not know what [University X] was, and when I took 'em there they wanted to know where the college was. And I said, "You're in it. These buildings are the college." And they're, they don't understand, you know, because they don't know. Um, I also think that the education system here has just totally broken down. So you have parents who can't read or write very well. (*Natalia, Nurse and Program Coordinator*)

According to Natalia, a hopeful future is one that includes visions of going to college; however, she also acknowledges her limitations to influence these students in light of larger structural barriers to educational attainment. Other participants also positioned themselves as mentors in similar capacities:

Working with the community, I mean, it allowed me to be a mentor, a big brother, to, um—I feel as though it was necessary to see an individual moving forward in life but that doesn't fall into the stereotypical young African American male, um—it may have took me longer to get my bachelor's degree but I also got an associate's degree, and I also purchased two homes. I purchased my first home at the age of 20. (*Desean, Project Coordinator*)

I don't mean mentor in terms of being a father. I'm, but more like, more of a role model, like you can choose this lifestyle or you can choose this lifestyle. You know, you can choose to do nothing with your life or you can choose to try and do something with your life. (*Nicky, HIV Nurse*)

Both of these participants stress the importance of presenting examples of achievement and choices for a better or different future, which are also framed as alternative examples to existing models (e.g., "stereotypical" and "this lifestyle"). Self-esteem was another key element of psychological well-being that participants frequently discussed. When asked about their general perceptions of YBLMSM in the DMA, for example, one participant stated:

Low self-esteem. Very talented. Very talented and educated. But also low self-esteem. And not enough role models and not enough—hmm, the lack of self-efficacy. (*Desean, Project Coordinator*)

Other participants also made this link between low self-esteem and lack of motivation despite YBLMSM possessing other valuable qualities (e.g., *talent, intelligence, experience, charisma*).

Low self-esteem was tied to not loving oneself, resulting from experiencing homophobic rejection by parents, family, peers, communities, and/or the larger society. In some cases, participants talked about YBLMSM's feelings of self-hatred or discomfort with oneself or with other MSM. More often, however, low self-esteem appeared to represent the psychological distress that YBLMSM felt from being rejected by their families and/or communities, particularly religious communities:

They hear that they're crap. They hear that they're sinners. They hear that they're shit. You know, they hear that from their families. They hear that from, from their church. They hear that from their communities. They're not supported in their life choices and their identity. And those are very, you know, strong, salient forces in individual's identities in that community, and if you hear that enough you start to believe it. (*Vicky, Director*) (UHIP 46)

Internalized homophobia thus became one way in self-esteem was linked to psychological distress among YBLMSM. Participants often described how the need and search for acceptance and validation, through emotional and other of types of support, placed YBLMSM at risk of being abused or taken advantage of by other adults.

One thing I didn't touch on was mental health. And I think that's very important, um, issue that needs to be addressed, especially when dealing with young MSM. Because you have a lot of those that fall into these bouts of depression, have issues of self-esteem, and really not understanding on how to love themselves. So they go out to the streets and look for that love from someone else that's gonna take advantage of them. So, you know... And if you're not really identifying that those issues are there, they turn to substance abuse, they turn to other things that they shouldn't be engaged in. It's a matter of coping mechanisms. So, it's really important that we address that whole mental health aspect as well too. (*Donald, Disease Intervention Specialist*)

Being embedded in a network of support was thus protective and necessary for psychological health because of the resources made available through the network but also because of the general feeling of acceptance YBLMSM felt through their personal relationships. This allowed YBLMSM to develop and access internal psychological resources. When asked to explain the protective function of house parents in the house and ball community, one participant answered:

By providing the safe, the safe space. It is really, is giving them, giving the younger ones the opportunities, via either a safe space, and that can be either physical, a house, an area, but also a safe space in terms of mentally, and physically. So mentally let them know that it's safe, when you're with me, when you're out and about you can be yourself. Or if we're, or you can come here and it's safe to express yourself, and to be yourself, which builds confidence and self-esteem, and image. Um so those mentors do provide that space, and are able to provide that physical safety space or the emotional and mental safe space for the young ones to express themselves, to give themselves up, and to allow them to grow inside. (*Roberto, Program Director*)

The passage highlights the critical role that mentors can play in providing the multiple types of support (e.g., emotional, instrumental, appraisal, identity) that are necessary to foster growth among YBLMSM in light of the social stigma and victimization they experience.

## **Discussion**

The purpose of this study was to explore the factors that influence the development of mentoring relationships, and to describe the presence and roles of mentors, in the lives of YBLMSM. Study participants noted how the presence or absence of mentors influenced YBLMSM's health and well-being. Current findings contribute to a growing literature on the benefits of mentoring relationships for the well-being of youth and young adults (Ahrens et al., 2008; Colarossi & Eccles, 2003; Dant et al., 2014; Farruggia et al., 2006; Hurd et al., 2014; Hurd & Zimmerman, 2014; Sanchez et al., 2006; Whitney et al., 2011). Considerably fewer studies have examined the psychological benefits of mentorship among sexual minority youth (Drevon et al., 2015; Sheran & Arnold, 2012; Torres et al., 2012).

In the current study, distress among YBLMSM was attributed to feelings of rejection and lack of understanding from parents and family due to YBLMSM's sexual identity (Meyer, 2003; Ryan et al., 2009, 2010). Therefore, mentors played a critical role in providing physical and social spaces where youth could feel accepted and have the freedom to express themselves. Facilitation of identity development is one of the key processes by which mentors contribute towards positive youth outcomes (Rhodes, 2005). Particularly through the provision of emotional, appraisal, and informational support, supportive adults may aid YBLMSM in some aspects of sexual minority identity development by providing positive feedback and opportunities to meet other LGBT individuals and participate in LGBT-related events (Cass, 1979; D'Augelli, 1994, Eliason & Schope, 2007; Horowitz & Newcomb, 2002; Rosario et al., 2008). Based on a study with a racially and ethnically diverse sample of self-identified gay, bisexual, and queer (GBQ) men, Sheran and Arnold's (2014) found that gay mentors facilitated sexual identity integration, however, they noted that gay mentors had little influence on sexual identity formation. Findings thus contribute to a considerable gap in the literature regarding the impact of gay mentors on sexual minority health through facilitation of identity development processes.

Mentors provided different types of social support, which helped YBLMSM deal with challenges that they experienced not only as sexual minorities but also as individuals living in communities characterized by poverty and limited opportunity. Mentors were described as playing an important role in shaping YBLMSM's hopes and visions for the future, helping YBLMSM increase their motivation or awareness regarding potential educational and employment opportunities. Accordingly, mentors provided instrumental and informational support such as assistance with applications and education about colleges and universities.

These types of planning and strategizing activities have been associated with development of future-orientated expectations and with improving motivation to achieve goals (Clinkinbeard & Murray, 2012; Gollwitzer et al., 2004; Nurmi, 1991; Oyserman et al., 2004).

Mentors not only provided support, their personal and financial success served as visible example of possible selves that YBLMSM could aspire to. Markus and Nurius (1986) introduced the concept of *possible selves* as the range of ideal and feared selves that individuals imagine becoming in the future. Therefore, the cognitive repertoire of selves that individuals possess symbolizes their hopes and fears but also reflects their sociocultural locations and the social conditions that enhance or constrains this repertoire (Cross & Markus, 1991; Markus & Nurius, 1986). As members of YBLMSMs' social networks, mentors thus have the capability to influence the possible selves that YBLMSMs can envision. In the context of adolescent development, the ability to construct possible selves has been associated with academic achievement, self-esteem, and health-promoting behavior among other positive outcomes (Know et al., 1998; Leondari & Gialamas, 2000; Ouellette et al., 2005). When King and Smith (2004) asked lesbians and gay men to provide descriptions of their best gay and non-gay possible selves, they found that greater salience (e.g., length of narrative) of gay possible selves was associated with higher reports of subjective well-being. Therefore, YBLMSM enactment of possible selves may be one mechanism by which mentor social support and role model visibility promotes positive youth outcomes.

According to Rhode's (2005) model of youth mentoring, understanding the context surrounding these mentoring dynamics is vital. Family and community contexts, for example, may influence the processes by which mentoring relationships develop and impact youth outcomes. In their meta-analysis of youth mentoring program, DuBois and colleagues (2002)



reported that the benefits of mentoring programs increased with increasing “at-risk” status such that youth experiencing individual and environmental risk benefited the most followed by youth experiencing only environmental risk, only individual risk, and no risks at all. Individual and environmental risks include issues such as poor academic performance, homelessness, family poverty, low parental warmth or involvement, peer rejection, and poor neighborhood quality (Bruce & Bridgeland, 2014; Gerard & Buehler, 2004). Findings from the current study support the theoretical linkages proposed by Rhodes (2005) as well as the empirical findings described by DuBois and colleagues (2002). Participants in the current study discussed the benefits of mentors and mentoring relationships largely in the context of risk and adversity that YBLMSM experienced within their families and communities. The overall findings thus highlight the important contribution of mentors in the social support networks of YBLMSM.

Family and community context shaped opportunities for connection among YBLMSM and between YBLMSM and other adults. An important contribution of the current study, however, was the impact of homophobia on these opportunities for connection. Often interwoven around narratives of psychological distress and events that prevented youth from making connections with others who could serve as sources of support (e.g., family, religious leaders), homophobia was often described as a precursor to an extreme sense of social marginalization and physical isolation. Homophobia within the family, experienced by youth as rejection from parents and ejection from the home, has been linked to the psychological and physical separation between YBLMSM and their families (Ryan et al., 2009, 2010; Willoughby et al., 2008, 2010).

Participants also expressed concern about religion as a source of homophobia, particularly among Black MSM. Prior studies have noted how religion-based homophobia may

result in rejection from families and, by extension, black communities as a whole (Miller, 2007; Pitt, 2010; Ward, 2005). Although participants offered a few examples of parents and church leaders that were accepting of LGBT youth, homophobia was otherwise described as pervasive by study participants. Rhodes' (2005) model suggests that unique neighborhood characteristics and norms may affect the availability of SNPAs. Within certain neighborhoods or communities, anti-LGBT attitudes and behaviors may represent such norms. These norms, real or perceived tie into fears of rejection that may affect perceptions of support and keep YBLMSM from seeking relationships with adults (Choi et al., 2011; Grossman, 1997; Jadwin-Cakmak et al., 2015; Meyer, 2003; Ross, 1985).

Actual anti-LGBT attitudes and behaviors also keep adults from making themselves available to YBLMSM. These findings appear to be in contrast to recent evidence suggesting that attitudes towards homosexuals have been improving in the United States (Keleher & Smith, 2012). Therefore, homophobia should be examined in the context of specific neighborhood ecologies to understand its impact locally on the social networks of YBLMSM (D'Augelli et al., 1999; Diaz, 1998; Ellison et al., 2011; Glick & Golden, 2010).

Alongside discussions regarding the risks (e.g., abuse and ejection from the home) and, to a lesser extent, the benefits (e.g., closer relationships with parents) of YBLMSM disclosing their sexual orientation and/or HIV serostatus to family, stakeholders also highlighted the benefits of disclosure when it occurred with non-kin peers and other adults. Participants framed these types of connections as part of normal development but more frequently described them as occurring under conditions of necessity and acute stress. Disclosure to non-family members helped YBLMSM gain access to individuals who could offer LGBT-related support or could refer youth to other supportive adults. In other words, YBLMSM gained access to new networks of

support through this type of disclosure. Bean and colleagues (2002) note both the normative and compensatory roles that *very important* non-parental adults play as providers of support to youth in general and at-risk youth specifically. In the current study, mentors appear to play a compensatory role for YBLMSM who are rejected by their parents after disclosure; however, having mentors and other non-familial supports also facilitated disclosure to parents in the first place. The process of sexual identity disclosure between sexual minority youth and non-parental or non-familial supportive adults remains poorly understood and is a critical area for future research.

Researchers have examined how the quality of mentoring relationships is affected by the degree of matching between mentors and mentees with respect to race and ethnicity, gender, and age (Blake et al., 2011; Hirsch et al., 2002; Liang & West, 2011). Studies of demographic matching among sexual minorities were absent from the supportive adult/mentor literature until recently. These early findings appear to differ from current results in which participants stressed the importance of having supportive peers and older adults who were also BLMSM and who represented YBLMSM in leadership positions. Torres and colleagues (2012), for example, found no patterns of demographic matching between GBQ male youth and their mentors. In their study of sexual minority male youth's (SMMY) relationships with non-parental adults (NPA), Sterrett and colleagues (2015) found that SMMY reported higher levels of relationship closeness with female (vs. male) and heterosexual (vs. sexual minority) NPAs but reported no differences between pairs matched and unmatched by ethnicity. Among ethnically matched pairs, however, closeness levels were highest among Black/African-American SMMY (Sterrett et al., 2015). Despite making statements about the importance of YBLMSM connecting with other BLMSM, many of the participants in the current study, female and male, spoke about their own extensive

roles in mentoring and supporting YBLMSM. Future studies should examine the extent to which demographic matching differs and matters between general and vulnerable sexual minority youth.

Matching, however, must also extend beyond simple demographics to consider how other types of shared experiences influence mentoring relationship quality and youth outcomes (Feuer, 2013). Participants described mentoring relationships based on shared experiences of hardship, with mentors' capabilities stemming from their resilience in overcoming these hardships. Many participants also described mentoring as activities that occurred within but also outside the purview of their work-related responsibilities, as well as the mentoring roles that YBLMSM clients embraced as they overcame their own challenges. Some participants, however, noted the importance of extending BLMSM representation beyond LGBT-serving organizations and into the general community. Therefore, the criteria for a good match between YBLMSM and mentor might also vary between natural and formal settings (Bruce & Bridgeland, 2014). The significance of these questions regarding matching increases in the context of resource-poor settings, where social and economic conditions may affect the pool of potential mentors in a given community or neighborhood. These concerns about access and availability regarding natural mentors link to broader issues about the structure and strength of social networks in a given community (Ferlander, 2007; Israel & Antonucci, 1987; Kritsotakis & Gamarnikow, 2007; Lin, 1999; Schwartz et al., 2014). Future studies examining how community characteristics (e.g., visibility of LGBT mentors in the larger community) influence mentor-mentee matching and the quality these relationships are warranted (Rhodes, 2005).

These findings may help inform mentoring programs for sexual minority youth. At present, the number of formal mentoring programs has rapidly increased with recent estimates

placing approximately 7 million youth in mentoring programs (Bruce & Bridgeland, 2014). In response to the opportunity gaps facing young men of color in the United States, President Obama launched the My Brothers Keeper Initiative in 2014, of which a significant component of the initiative is dedicated to expanding availability and access of mentoring programs for young men of color across the country (U.S. White House, 2014). As interest in mentoring programs continues to grow, the need for basic and program evaluation research will also be necessary for answering questions about the impact of mentoring on youth outcomes in the context of the youth's social environment and the program's organizational structure. The My Brothers Keeper initiative employs a vulnerable populations approach by focusing on young men of color experiencing limited opportunity structures, thus addressing the concerns expressed by participants in the current study (Frohlich & Potvin, 2008).

However, in addition to concerns about access to education and employment, participants also discussed the negative impact of homophobia on YBLMSM at community, familial, and individual levels. In light of the multiple epidemics affecting BLMSM in urban areas, and concomitant increasing HIV infection rates among YBLMSM, initiatives that focus on increasing the health and well being of young men of color may need to explicitly address issues impacting gay and bisexual young men of color (Harper et al., 2004; Stall et al., 2008). Without an approach that takes into account the most vulnerable individuals in a given population, well-intended policies and interventions run the risk of exacerbating existing disparities (Frohlick & Potvin, 2008). Therefore, mentoring programs should address homophobia and prejudice as a strategy to reduce structural inequities across communities in the United States. Future research including these topics into mentoring programs and evaluating their impact on BLYMSM are warranted.

Strengthening the availability and quality of mentors may provide opportunities to support the health and development of BLYMSM. Findings from this study contribute to a modest but growing literature on the roles of supportive non-parental adults in the social networks of sexual minority youth and young adults, and consider how the social environment may contextualize the development of these relationships among urban YBLMSM. Future research examining how these relationships develop, grow and sustain over time are warranted in order to inform mentoring programs for YBLMSM.

### **Strengths**

A strength of the current study is the large sample size and wide scope of the interview guide, which allowed for exploration of the research questions across a broad range of domains. Despite the breadth of the questions, participants were not directly asked about the role of mentors in the lives of YBLMSM. Instead, these conversations arose spontaneously during the interviews. This finding uniquely highlights the significant role that participants believe mentors play and is needed for the physical, psychological, social, spiritual, and financial well-being of YBLMSM (Myers et al., 2000). The role of mentors in these specific areas may be important areas of inquiry for future research on mentors and well-being among sexual minority populations. Emerging adulthood is a potentially useful framework to employ in future studies examining the role of mentors among young adults specifically (Arnett, 2007). During this time, young adults experience social role transitions in relation to place of residence, employment opportunities, educational attainment, and romantic relationships (Schulenberg et al., 2005). With the exception of romantic relationships, participants in the current study touched upon the role of mentors in these areas of YBLMSM's lives.

The focus on provider perspectives was also unique because participants were able to link their own experiences, or their personal and professional interactions with YBLMSM, to larger social dynamics occurring at the organization, community, and state levels. Another important strength was the focus on a YBLMSM population located in a large Midwestern urban area. Given that most research on MSM populations in the U.S. occurs in urban centers along coastal areas, containing large visible LGBT communities and neighborhoods, the current study contributes towards a broader perspective and understanding of LGBT experiences.

### **Limitations**

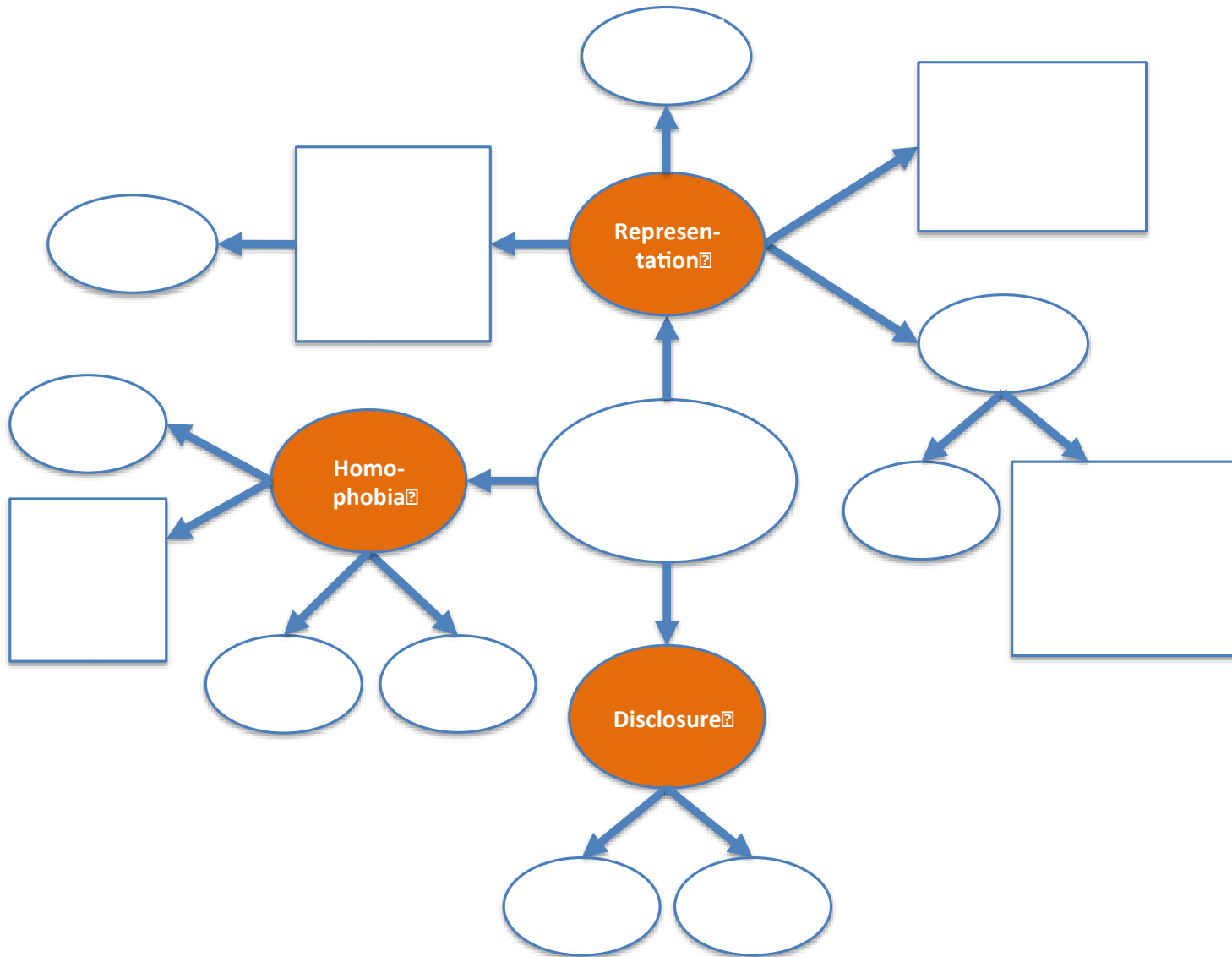
The current study was a secondary analysis of data collected for a larger study focusing on vulnerability to HIV infection among YBLMSM living in the DMA. Therefore, important perspectives may have been excluded as most participants were recruited through professional networks comprised of health and other HIV and AIDS service organizations. The majority of questions in the discussion guide were also framed around the experiences of YBLMSM who were vulnerable to HIV infection. Therefore, focusing on a broader population of sexual minority young adults may reveal different patterns in the presence or absence of mentors and their roles among sexual minorities. In light of existing research gaps in mentoring research, future studies are still necessary to explore YBLMSM's own perspectives on the role of mentors.

**Table 4.1** Codebook for analyses of data extracted under the "social network characteristics" meta-code

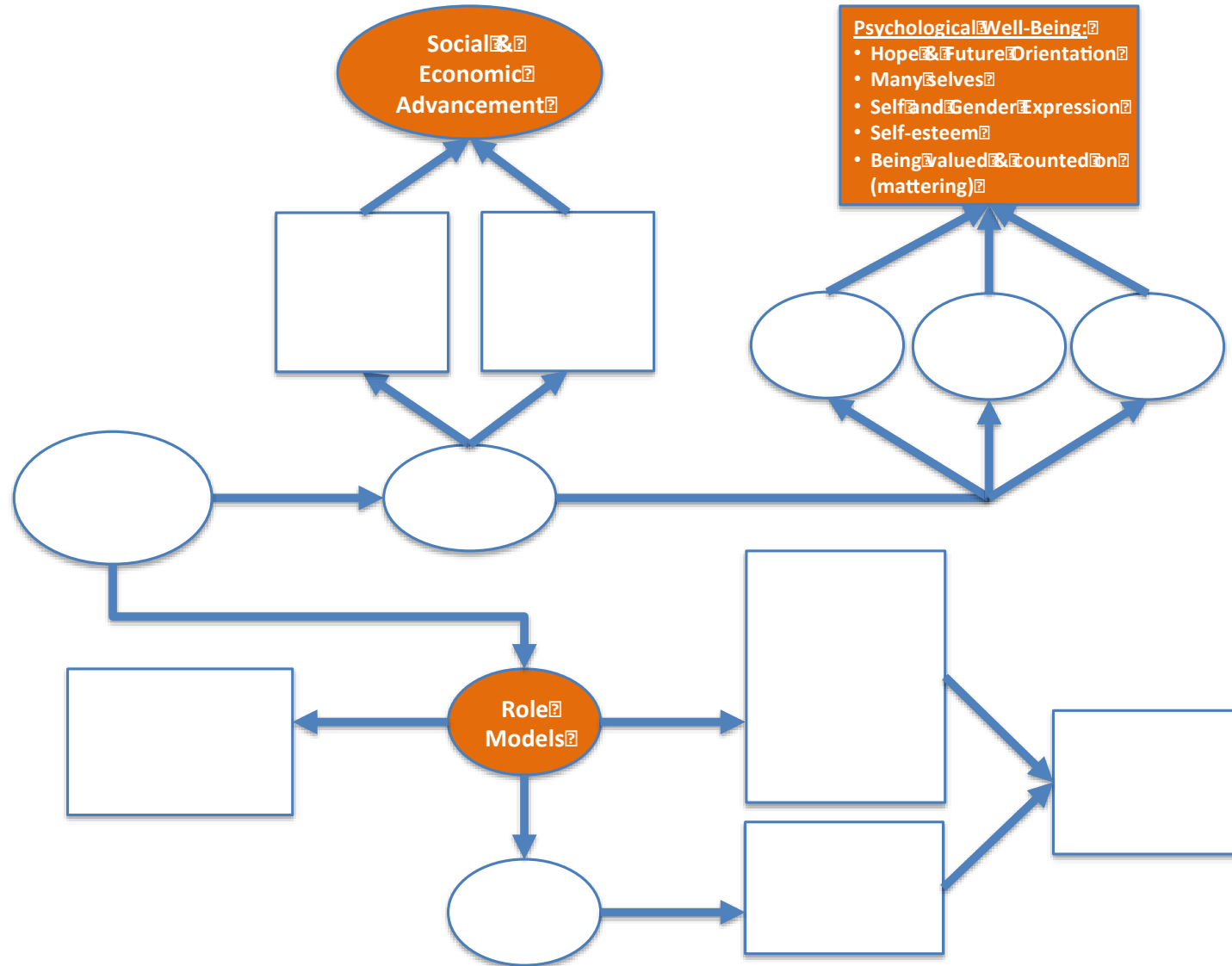
Research Questions:	Domain:	Themes:	Sub-Codes:	Interviews	
				Sources:	References:
What are the factors that impact the development of mentoring relationships in the lives of YBLMSM?	Opportunities and Barriers to Connection	Pervasive Homophobia	Community connection	8	9
			Parent challenges	14	17
			Religion	13	21
			Homophobia	20	28
		Disclosure of Sexual Identity & HIV Status	Sexual identity	24	42
			HIV status	12	16
			HIV stigma	5	8
		YBLMSM Representation	Connectivity	20	48
			Leadership	8	18
			Peer support groups	11	18
Provider perspective	29		71		
GSA	4		11		
What is role of mentors and mentoring relationships in the lives of YBLMSM?	Mentoring Models	Role Models	Visibility	15	21
			Adult MSM support	9	11
			Role models	26	95
		Social & Economic Advancement	Instrumental support	22	41
			Life skills	8	11
			Informational support	37	82
		Psychological Well-Being	Chosen family	13	18
			Appraisal support	9	14
			Emotional support	14	24
			Self-esteem	23	46
Identity support	32		74		
Hope & future	11	21			



**Figure 4.1** Thematic map examining factors influencing development of mentoring relationships



**Figure 4.2** Thematic map examining the roles of mentors



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## CHAPTER V

### Conclusion

The overall purpose of this dissertation was to examine how social support networks of young adult gay and bisexual men (YGBM) are associated with their psychosocial health. Compared to the general population, young adult gay and bisexual men experience elevated levels of psychological distress and substance use (Bostwick et al., 2010; Green & Feinstein, 2012). These health disparities may be explained by sexuality minority stress, theorized as excess social stress resulting from exposures to sexuality-based prejudice, discrimination, and victimization (Meyer, 2003). Through a vast body of literature, researchers have demonstrated direct and indirect benefits of social ties and social support for overall health (Cohen, 2004; House et al., 1988; Thoits, 2011). Social networks may serve as sources of support or strain thus potentially contributing to, exacerbating, or protecting against the social stress and subsequent poor psychosocial outcomes impacting YGBM's health (Abbey et al., 1985; McConnell et al., 2015; Rook, 1984). The structural characteristics and functional qualities of YGBM's social networks, however, lack description and remain poorly understood in the social support and sexual minority health literature. To address some of these gaps, in this dissertation I explored YGBM's social ties to parents, families, and mentors, and I examined the associations between social support or social strain and YGBM's psychosocial health and well-being.

### Summary of Results

In *Chapter II*, I explored the roles of perceived maternal and paternal social support in YGBM's substance use behaviors (cigarettes, alcohol, marijuana, hard drug). More specifically,



I examined the associations between parental supports and substance use, and I tested a stress-buffering hypothesis by examining if parental supports moderated the associations between sexuality-based victimization and substance use. Results indicated that neither maternal nor paternal supports moderated any of the relationships between victimization and substance use, regardless of victimization severity and type of substance. In main effects models, however, maternal support was associated with abstinence from cigarette smoking while paternal support was associated with abstinence from marijuana use among YGBM. Descriptive results indicated that more YGBM were in contact with their mothers than with their fathers. Among those maintaining contact, YGBM reported higher levels of maternal support compared to paternal support. Furthermore, proportions of YGBM reporting cigarette and marijuana use were particularly large compared to previous reports of use among sexual minority and young adult male populations (Halkitis et al., 2014; Johnston et al., 2015; McCabe et al., 2005). Associations between victimization and substance use varied but were strongest with respect to cigarette use. Findings highlight the important and unique roles that mothers and fathers may have on the substance use behaviors, especially cigarette and marijuana use, of young adult sexual minority men.

In *Chapter III*, I explored how YGBM defined their families, and examined whether perceived familial social support and familial social undermining were associated with psychological distress among YGBM within different family types. Analyses also accounted for internalized homophobia and sexuality disclosure among YGBM. Descriptive findings indicated that YGBM's definitions of family consisted of one or a combination of the following networks: family of origin, friends or roommates, and/or family by romantic partnership. Results also indicated that familial social support and social undermining, respectively, were associated with

depression and anxiety. These associations varied with respect to the type of family that YGBM defined, suggesting that the content of who gets classified within family networks plays a role in shaping perceptions of social support and social undermining. While the vast majority of YGBM included family of origin in their family networks, the majority of YGBM also counted friends and partners among their family networks. Therefore, chosen families appear to play a prominent role in the lives of YGBM (Nardi, 1999; Weston, 1991). Findings also highlight the importance of examining co-occurring social support and social stress processes in the families of origin and chosen families of YGBM.

In *Chapter IV*, based on interviews with individuals who work with young Black and Latino men who have sex with men (YBLMSM), I conducted a qualitative analysis to explore the role of mentors in the lives of YBLMSM and to examine the factors influencing development of mentoring relationships. Results indicated that pervasive homophobia, disclosure of sexual identity and HIV status, and representation and visibility of YBLMSM in the community influenced the development of mentoring relationships by creating opportunities for and barriers to social connections. Mentors also served multiple purposes in the lives of YBLMSM. As role models, they were visible examples of achievement, success, and resilience for YBLMSM. Mentors also contributed to YBLMSM's psychological well-being, providing emotional and identity support to increase self-esteem and stimulate hope and visions for the future. They also played a more active role by creating opportunities for social and economic advancement through the provision of informational and instrumental supports related to education and employment. Findings thus highlight the supportive roles of mentors, especially for YBLMSM experiencing challenges related to social and economic disadvantage. These challenges,

however, reflected the urban community and neighborhood conditions that also limited access to and availability of mentors in the first place.

### **Main Themes Across Studies**

**Theme 1:** *Young adult sexual minority men have complex networks of social support.*

An important theme across the three studies of this dissertation is the complexity regarding the structural characteristics of YGBM's social networks. In the GBM health literature, the focus on adolescent and adult health has largely been on psychological risk factors associated with experiencing prejudice and sexual risk factors associated with HIV and other STI infections (Jimenez, 2003; Meyer, 2003; Savin-Williams, 1994). This has contributed to prominent narratives in which GBM are depicted as extremely isolated, disconnected from their families and communities, or they are seen as connected to other GBM only in the context of sexual relationships. As a result, researchers have focused on the absence of YGBM's social networks or they have prioritized sexual networks within YGBM health research (Goodroad et al., 2000; Kegeles et al., 1996; Kelley et al., 2010; Meyer, 1995). By broadening the scope of social networks and YGBM health research, a more complete picture will emerge of how different sub-networks overlap and interact to shape the health of YGBM.

*Chapter I* and *Chapter II* findings revealed that the vast majority of YGBM were raised by a mother while less than half indicated being raised by a father. Among those raised by a parent, the majority maintained contact with their parent although YGBM were more likely to have lost contact with their father. Furthermore, among the nearly three-fourths of YGBM who lived with others, almost half and nearly one-quarter of them were living with their mother or father, respectively. *Chapter II* findings also revealed the large extent to which YGBM included their parents (family of origin) as well as their friends and romantic partners in their definitions

of family. In total, YGBM described six different types of families. One of these was a family of origin only group, which accounted for one-third of all YGBM's families. The remainder was five different chosen family groups, the majority of which still included family of origin but in some combination with friends and/or romantic partners. Chapter IV findings further elaborated on the social networks of YGBM beyond parents and family, demonstrating the potentially critical role of mentors in the lives of YBLMSM. Mentors were sometimes described as the adult male figure otherwise missing from youths' lives when fathers were absent. More frequently, mentors were described as former clients (community members) or current employees of community-based organizations that served GBM.

Findings from this dissertation offer a more nuanced understanding of the ways YGBM are connected to their parents and family of origin as well as to chosen families and mentors. Rather than isolated, YGBM were found to be embedded in rich social networks where family, peer, and community networks overlapped. Populations of YGBM that lacked social ties constituted a vulnerable group. Future research should focus on further describing and elaborating upon the structural characteristics of YGBM's social networks. This will provide greater context for understanding the extent to which YGBM are connected to or isolated from others, thus providing a more accurate representation of embeddedness. Application of sexual minority stress theory may further elucidate how embeddedness is linked to access of individual and community-level coping resources in the face of sexuality-based victimization (Meyer, 2003).

**Theme 2:** *Young adult gay and bisexual men receive social support, yet also experience social stress within their social support networks.*

This theme pertains to the functional characteristics of YGBM's social networks and how these networks serve as both sources of social support and social strain. Research on the associations between parent or family relationships and sexual minority health outcomes has largely occurred in the context of adolescents experiencing parental rejection (Bouris et al., 2010). Until recently, few researchers have focused on perceptions of parent or family support, and lack of conceptual clarity has led some researchers to confound parent and family measures (Ryan et al., 2009, 2010; Willoughby et al., 2010). With the exception of one notable example, researchers have also rarely examined parent support further to distinguish between perceptions of maternal and paternal support among sexual minority young adults (Needham & Austin, 2010). While interest has grown on the role of family support in YGBM health, family support and family strain have not been examined concurrently. The supportive role of mentors in YGBM's lives also remains largely unexamined. Realistically, YGBM may receive social support but also experience social strain within the same social tie or social network. Both of these dimensions of social relationships must be considered across different parental (maternal and paternal), familial (origin and chosen), and other (mentors) close relationships in order to better understand YGBM's access to resources through their relationships.

Each chapter of this dissertation addressed a gap in the literature regarding the supportive dimensions of social relationships. Findings from *Chapter II* revealed that importance of examining maternal and paternal support separately; YGBM generally perceived greater social support from mothers compared to fathers. Nonetheless, maternal and paternal supports were both associated with YGBM abstinence from certain types of substances. Within a developmental context, these findings also highlight the potentially influential role that parents continue to have beyond adolescence and into young adulthood. *Chapter III* expanded on the

concept of family to include friends and romantic partners, with YGBM reporting on perceptions of both familial social support and familial social strain. Levels of support and strain varied across family types although average support levels were consistently higher than average strain levels. Both support and strain were associated with psychological stress, however, the associations also varied between family types. A critical observation here is that YGBM experience support and strain within the family network. Finally, *Chapter IV* findings highlight the supportive functions of individuals outside of family networks and in the communities of YGBM. Mentors were associated with family only when described as replacing supportive roles that were lost and otherwise held by parents and fathers. In general, mentors provided a range of support, including emotional, appraisal, informational and instrumental support.

Taken together, the three studies of this dissertation paint a more complete picture of the supportive functions of YGBM's social networks. These findings counter dominant narratives of parental rejection among sexual minority youths, casting mothers and fathers in supportive roles. Assumptions regarding the supportive roles of family, however, are also challenged given the finding that YGBM perceive support but also strain in families of origin and even among families they choose or construct. It may be critical to further examine the roots of social strain, particularly in light of sexual minority stress theory and the unique impact that sexuality-based social strain may have on YGBM health (Meyer, 2003). Finally, the supportive roles of mentors must not be underestimated in the lives of vulnerable YGBM.

**Theme 3:** *Social ties and social support are important determinants of health among young adult sexual minority men.*

This final theme relates to the relevance of social networks and social support as social determinants of YGBM health. The presence of social ties and social support has been linked to

numerous physical and psychological health outcomes (Cohen et al., 2004; House, 1988; Peggy, 2011; Uchino, 2006, 2009). Researchers have increasingly applied social network and social support theory to understand psychosocial processes impacting health outcomes within sexual minority populations (Frost & Meyer, 2012; McConnell et al., 2015; Needham & Austin, 2010; Snapp et al., 2015; Wong et al., 2013). Given the multiple health disparities impacting YGBM, social network theory may serve as a useful framework for examining how social networks influence substance use behavior, psychological health, and overall well-being among YGBM (Bostwick et al., 2010; King et al. 2008; Stall et al., 2008).

Across the three studies of this dissertation, social support was examined with respect to YGBM behavioral (*Chapter II*) and psychosocial (*Chapter III* and *Chapter IV*) health. In *Chapter II*, perceived maternal support was associated with abstinence from cigarette use while perceived paternal support was associated with abstinence from marijuana use. *Chapter III* findings indicated that, in some cases, YGBM reporting higher perceived familial support had fewer depressive and anxiety symptoms. Conversely, higher perceived familial undermining was associated with greater depressive and anxiety symptoms. *Chapter IV* findings also suggested that social support (from mentors) contributes towards improved psychological health among YGBM. The aspects of psychological health discussed here were self-esteem, feelings of hope, and future orientation. An important distinction between *Chapters II and III* and *Chapter IV* is that while parental and familial support were global measures of support, mentor support was described in terms of distinct emotional, identity, informational, and instrumental elements of social support.

Evidence from the three studies of this dissertation suggest that social support, a functional characteristic of social networks, plays a role in the psychological health and

substance use behaviors of YGBM. Future research should examine the mechanisms by which structural and functional characteristics of social networks may be linked to YGBM health behaviors and health outcomes. For marginalized populations like YGBM, lack of intact social networks as well as supportive social connections may be important social determinants of YGBM health. While Meyer's (2003) sexual minority stress theory is helpful for exploring the links between distal (e.g, victimization and discrimination) and proximal (e.g., internalized homophobia and depression) processes, Hatzenbuehler (2009) builds on this theory by proposing more specific psychological mediational pathways linking stressors to health. Some of these include social isolation, hopelessness, negative self-schemas, and alcohol expectancies, which merit further investigation in light of the findings presented in this dissertation (Hatzenbuehler, 2009).

### **Limitations**

Several study limitations must be acknowledged to guide further interpretation of the findings presented in this dissertation. Quantitative and qualitative data for this dissertation come from the United for HIV Integration and Policy (UHIP) study where the goal of the study was to examine social and structural determinants contributing towards vulnerability of HIV infection among YMSM. This particular focus on HIV/AIDS guided development of the data collection instruments and likely primed individual to think about their answers in relation to HIV/AIDS. Therefore, all analyses for the current dissertation are considered secondary data analyses focused on social support and substance use and psychological distress outcomes. While the breadth of the original study allowed for exploration of relationships across a range of domains, important variables missing within domains limited more in-depth exploration of these relationships (e.g., confounding variables). Therefore, only certain structural and functional



characteristics of social networks could be examined (Israel 1982). The limitations for the quantitative and qualitative methodological approaches of the study are discussed separately below.

### *Quantitative Data*

Survey data come from a cross-sectional study, thus causal relationships between study variables were impossible to discern and relationships may only be discussed in terms of associations. In the absence of longitudinal data, Cohen and Wills (1985) note there are three possible causal interpretations between social support and health conditions: social support changes health conditions; health conditions change levels of social support; a third factor changes levels of social support and health conditions. For example, providing social support to depressed individuals may ease their symptoms. On the other hand, depressive symptoms may influence individual's perceptions of support, keep individuals from seeking social support, dissuade others from providing support, or even cause others to engage in social undermining. Alternatively, a demanding work schedule may cause or exacerbate depressive symptoms and/or limit the time an individual has to seek support from others. Furthermore, two or more of these scenarios may play out simultaneously, indicating bi-directional causal relationships between social support and health conditions.

A community-based convenience sampling technique was used to recruit participants for the current study. Recruitment occurred in LGBT venues and events such bars, dance clubs, and pride events and also through community-based organizations serving LGBT populations. One possible consequence is that the study sample represents youth who are more socially connected and thus perceive having greater social support whereas those not attending or participating represent youth who are isolated and especially marginalized. Recruitment in these types of

social space and events may also result in inflated reports of substance use. Historically, gay bars and clubs and gay pride events have provided critical spaces for sexual minorities to socialize in relative safety, with alcohol consumption being an important or even preferred part of participation in these venues (D'Emilio & Freedman, 1988). Other individual characteristics may also differentiate between youth recruited at LGBT-related venues and those socializing elsewhere. To minimize this bias, recruitment also occurred on-line via social networking sites. Community partners also set up workstations at their agencies where clients or other youth could learn about the study and complete the on-line survey.

Study participants were self-identified gay and bisexual young adult men between the ages of 18 and 29 who were living in the Detroit Metropolitan Area, therefore study findings may not be generalizable to other populations. Small sample size also may have also limited the ability to detect meaningful associations between study variables. This also limited the opportunity to stratify the sample and perform relevant sub-analyses.

#### *Qualitative Data*

A community-based convenience sampling technique was used to recruit individuals for study participation in face-to-face individual interviews. Snowball sampling was used to recruit participants who worked with YMSM, with nominations coming from study community partners and from study participants. Therefore, findings may represent perspectives that are specific to this particular group of individuals who work with YMSM but who are also connected and work with each other. Key perspective may have been missed from individuals not immediately connected to this network. Though not necessarily a limitation, many participants worked with YMSM in their roles as service providers. Thus, narratives about youth may have tended to revolve around highly marginalized and vulnerable youth. Nonetheless, efforts were made to

recruit participants who worked with YMSM across a broad range of settings and roles, resulting in 48 interviews included for analyses and reaching a point of data saturation.

## **Recommendations Moving Forward**

### *Overall Approaches*

Current findings contribute towards a richer and more complex portrait of YGBM's social support networks. Although some descriptive results were presented in this dissertation regarding structural and interactional characteristic of YGBM's social networks, the focus was primarily on the supportive functional elements of these networks (Israel, 1982). Future studies should include other social network measures that may shed light on the mechanisms by which social networks are related to YGBM health. In their study of non-parental adults (NPAs) within sexual minority male youth's (SMMY) networks, for example, Sterrett and colleagues (2015) instructed youth (egos) to list individuals (alters) they were connected to and then group these individuals according to their social ties. Using other descriptive information provided about the network members and these relationships, researchers were able to conduct more in-depth analyses and generate visual representations (sociograms) demonstrating structural and interactional characteristics of SMMY's social networks (Sterrett et al., 2015). Future research may also benefit from including the perspective of both egos and alters in the construction of social network measures, and examine their association with SMMY's psychosocial health.

Often times, the default function assigned to social networks is that of social support, which has contributed to a very limited understanding of the positive and negative dimensions of social ties (Rook, 1998). As described in *Chapter III*, findings suggest that social support and social undermining should be considered as both of these measures together accounted for a significant proportion of the variance in levels of depression and anxiety among YGBM.

Conceptually, social undermining refers to everyday experiences that diminish a person's self-esteem and self-worth (Abbey et al., 1985; Rook, 1984; Schuster, et al., 1990). In the context of sexual minority youth and their families, understanding the effects of these seemingly minor slights, especially if they are rooted in homophobia, may provide greater insight into the family social environment and its influence on YGBM health (Bronfenbrenner, 1986; Moos & Moos, 1976). Researchers should consider both risk and protective elements of YGBM's social networks whether measuring perceptions of support and strain in reference to a specific person or specific network of people.

My findings suggest that social ties and social support are important social determinants of YGBM health. Overall, YGBM appear to have multiple social ties through which they receive or access social support. Researchers have increasingly called for development and application of strengths-based frameworks that address sexual minority health in terms of their resilience, assets, and skills rather than risk and disease (Coker et al., 2010; Horn et al., 2009; Kubicek et al., 2013; Mayer et al., 2014; Russel, 2005). Other researchers have also called for social-ecological approaches, emphasizing the importance of understanding sexual minority health and health behaviors in social and cultural contexts (Diaz, 1998; Harper, 2007). Research that continues to examine the complexity of YGBM's social networks will inherently contribute towards building a greater understanding of these contexts and thus provide a foundation from which to examine social determinants of health.

*Intersectionality Theory.* Findings from Chapter IV (Study III), in particular, highlight the need to examine the social support needs of YBLMSM in the context of the multiple social identities that they occupy. Intersectionality theory situates individuals' lived experiences at the intersections of their various social identities, which becomes particularly important for

understanding the experiences of marginalized groups in the context of simultaneously occurring systems of oppression based on race, gender, and class (Crenshaw, 1991). Originally conceptualized to examine the role of discrimination and disadvantage in the lives of Black women, intersectionality theory has been expanded to include groups who may also experience marginalization based on ethnicity, sexual orientation, and disability status (Crenshaw, 1989; Szymanski & Moffitt, 2012; Weber, 1998; Yuval-Davis, 2006).

Some researchers suggest that overlapping systems of oppression based on race, ethnicity, gender, class, and sexual orientation increase sexual minority populations' vulnerabilities to adverse health outcomes (CDC, 2013; Hunter, 2010; Moradi & Subich, 2003). For example, according to the theory of syndemic production of health disparities, health disparities affecting sexual minority men are the result of converging epidemics (e.g. depression, substance use, and HIV infection) brought upon by stressors related to the history of urban migration and marginalization of racial, ethnic, and sexual minority populations in the United States (Bruce & Harper, 2011; Stall et al., 2008). Intersectionality theory has only recently been applied to the study of sexual minority health, and some work has been done regarding the experiences of YBLMSM with respect to mental health and vulnerability to HIV infection (Egan et al., 2011; Mizuno et al., 2011).

Other researchers have proposed frameworks, guided by intersectionality theory, for the future study of YBLMSM health in social contexts. Wilson's (2008) dynamic ecological model of identity formation emphasizes the role of socioecological factors in shaping ethnic, sexual, and masculine identity formation, thus giving insight into identity formation and conflict among bisexual African-American men. Black masculine socialization, for example, may create masculine social role expectations that directly conflict with same-sex behavior sexual behavior

or with claiming a gay or bisexual identity, which creates identity formation conflict within Black MSM (Malebranche et al., 2007; Miller et al., 2005; Wilson 2008). Zea and colleagues (2003) stress the importance of examining how experiences of discrimination, racism, homophobia, and oppression shape construction of Latino's gay men's sexual identities and their sexual risks thus highlighting the implications for psychological and sexual health. Therefore, social determinants of health may be defined not only by their level of influence (e.g. micro-, meso-, and macrosystems) but are also defined in relation to individual social identities situated within systems of power that exist across these levels. The emphasis on identity formation implies that developmental processes and milestones become important foci for understanding how the social environment impacts individual health.

A main criticism of intersectionality theory is the lack of guidance regarding its application in research methodology. Bowleg (2008) argues that the theory itself may contradict the positivist paradigm and ontological assumption employed by scientists, particularly in quantitative research. The author cautions, however, that both qualitative and quantitative researchers may intend to apply intersectionality theory to the study design but ultimately carry out an additive or other non-intersectionality analysis of the phenomenon under investigation, which leads to inconsistent findings (Kertzner et al., 2009; Reisen et al., 2013). Bowleg suggests that both qualitative and quantitative methods must be closely reexamined and used in combination when attempting to answer questions related to intersectionality.

### *Parent Research*

More research is needed to explore how mothers and fathers may differentially influence sexual minority health and development beyond adolescence and into emerging adulthood. Research on the parent-child relationship with fathers is especially lacking in this area.

Furthermore, studies on these relationships from the parent perspective are needed (Bouris et al., 2010). Understandably, researchers have focused a great deal on the negative consequences of sexual identity disclosure experiences of sexual minority youth when they disclose to parents. More recently, evidence provides a more nuanced depiction of this process, highlighting negative but also positive responses from mothers and fathers (Carpineto et al., 2008; Goodrich, 2009; Jadwin-Cakmak et al., 2015). Current findings did not support a protective role of maternal and paternal support in the relationship between sexuality-based victimization and substance use. Future studies may need to consider sexuality-specific or substance-specific support from parents (Beattie & Longabaugh, 1999; Doty et al., 2010). Finally, longitudinal data would allow researchers to examine normative and non-normative trajectories of substance use as well as shifts in social network structure and social support needs during the transition from adolescence to young adulthood (Needham & Austin, 2012; Simons-Morton et al., 2004; Van Ryzin et al., 2012; White et al., 2006; Wrzus et al., 2013).

### *Family Research*

Queer and feminist theory may help guide future research related to the chosen family networks of LGBT individuals. Even as federal and state laws change to allow same-sex couples to adopt children and to marry, Muraco (2006) warns of the “pervasive cultural belief that biological family connections are the most salient and durable bonds between individuals” (pg.1313). In other words, society privileges social ties that are based on biological relationships or that can be legally recognized. Oswald and colleagues (2009) thus note the importance of *queering the family* in family studies by challenging heteronormative assumptions about who gets to count as family. One means of accomplishing this, for example, is by conducting research in which study participants have the opportunity to define family networks on their own

terms. Israel (1982) refers to this as the content, or the meanings that individuals assign to their relationships, which is an interactional characteristic of social networks. Current examples of this include recent quantitative studies focusing on the house and ball communities of Black YGBM (Kubicek et al., 2013a, 2013b; Wong et al., 2013). Researchers have also provided rich ethnographic and other qualitative accounts of chosen family and friendship networks among LGB populations (Arnold & Bailey, 2009; Bailey, 2013; Nardi, 1999; Muraco, 2006; Oswald, 2002; Stacey, 2005; Weeks et al., 2001; Weston, 1991). My study of perceived family support and psychological distress is among the first quantitative studies to present a family typology of family networks among YGBM.

### *Mentor Research*

With only eight published peer-reviewed studies to date, the research literature on mentors and sexual minority youth remains in its infancy. As this body of work continues to grow, researchers must take into account the same issues that plague existing mentor research. Currently, a lack of consensus around terminology (e.g. mentor, non-parental adult, very important non-parental adult, role models) and definitions makes it difficult to compare findings across studies and thus identify key aspects of mentor and mentoring relationships that are important for sexual minority health. Sterrett and colleagues (2015) propose using social support theory as unifying a framework. From this perspective, supportive adults are understood based on their contribution of support in four general domains of adolescent psychosocial adjustment: academic functioning, self-esteem, behavioral problems, and emotional problems (Sterrett et al., 2015). A limitation of this approach is that it does not take into account potentially negative social interactions with supportive adults. Furthermore, aside from the academic function



domain, this approach does not situate supportive adults within the broader social networks of YGBM.

Rhodes (2005) provides a conceptual model of youth mentoring, much of which remains untested in the general and sexual minority health literature. Important questions also remain regarding mentors' connectivity to other individuals across youth's social networks, mentors' roles in relation to others. Under what circumstances do mentors stand alone versus serving a complimentary or supplementary role to others? To what extent do youth have more than one mentor? This model may provide a good starting point from which to conduct empirical studies and develop theory pertaining to sexual minority health.

### **Implications for Public Health Practice**

Findings from this dissertation suggest that social ties and social support are associated with abstinence from substance use, decreased levels of psychological distress, and increased levels of psychological health among YGBM. Therefore, findings potentially have implications for clinical care and social work practice with YGBM. In their assessments of psychosocial health, it may be important for providers to evaluate YGBM's social ties to mothers and fathers as well as chosen families and other supportive adults such as mentors. Providers should also consider YGBM's perceptions of social support and social strain in order to make evaluations regarding the overall contributions of particular social relationships. Providers can then identify social network members that have particularly influential roles in the lives of YGBM, and work with YGBM to either change their perceptions of support or perhaps include these influential people as part of their care.

Given my findings that maternal support was associated with abstention from cigarette use, a substance use parent-based intervention could serve to increase maternal support directly

or improve YGBM's perceptions of maternal support. However, it may also be worthwhile to address other aspects of maternal behavior. Scherrer and colleagues (2012), for example, found that maternal nicotine dependence, parenting (rule inconsistency), and expectations (pressure to succeed in school) were associated with young adult tobacco use. Others have also reported associations between maternal homophobia (e.g., discomfort with homosexuality and rejecting behaviors) and young adult cigarette smoking (Rosario et al., 2009, 2014). In a review of parent-based interventions to prevent tobacco use among youth, Thomas and colleagues (2016) found that authoritative parenting was an especially effective component of these interventions. Therefore, it may be critical to address these other aspects of maternal behaviors.

Similarly, parent-based interventions could focus on aspects of paternal social support to address marijuana use among YGBM. My findings represent a departure from previous studies in which paternal support was not associated with decreased marijuana use among young adults (Hurd & Zimmerman; von Sydow et al., 2002). However, researchers have found this association when paternal support was part of a latent parental support measure (Brook et al., 1999; Morojele & Brook, 2001; Needham & Austin, 2010). Further research is needed to examine the dynamics between mothers and fathers and how this potentially influences substance use behaviors among YGBM.

Findings from this dissertation have important implications for future development of family-based interventions designed to address sexual minority health issues. Better understanding of who family members are, according to the perspective of the sexual minority youth, may help counselors and programs develop and tailor interventions to the specific needs of a given family. This would have direct consequences in helping families develop communication strategies that improve and sustain the quality of the relationships thus elevating

the family system as a whole (Cox & Paley, 2003; Vangelisti, 2003). As the family network grows more cohesive, the better equipped it will be to manage changes in relationships dynamics that inevitably occur as children enter adulthood but also as parents become older (Walsh, 2003).

Despite the large body of literature on mentors and other supportive adults, significant gaps remain in our understanding of the roles of mentors in the lives of sexual minority youth and young adults (Dubois et al., 2011). Evidence to-date suggests that mentors and mentoring relationships contributes towards sexual minority health and well-being in the areas of psychological health, sexual health, substance use behaviors, academic achievement, and job attainment (Bird et al., 2012; Drevon et al., 2015; Gastic & Johnson, 2009; Johnson & Gastic, 2015; Sheran & Arnold, 2012; Sterrett et al., 2015; Torres et al., 2012). Each of these areas merits further investigation in the context of natural and formal mentoring relationships. Local and federal investments in mentoring programs have led to a growing network of mentoring program spanning the United States (Bruce & Bridgeland, 2014; My Brother's Keeper, 2016). This infrastructure translates into an enormous potential to reach YGBM and other sexual minorities given the focus of the My Brother's Keeper (2016) initiative on vulnerable young men of color.

## **Conclusion**

Support from parents, families, and mentors was associated with decreased substance use, decreased psychological distress, and improved well-being, respectively, among YGBM. These relationships were further examined by parent gender, family type, and mentor roles. Taken together, the results from this dissertation draw attention to the multiple ways in which strengthening YGBM's social networks has the potential to promote health within these populations.

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