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Author manuscript

*J Soc Issues*. Author manuscript; available in PMC 2018 September 01.

Published in final edited form as:

*J Soc Issues*. 2017 September ; 73(3): 618–636. doi:10.1111/josi.12234.

## Exploring the Mother-Adolescent Relationship as a Promotive Resource for Sexual and Gender Minority Youth

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### Abstract

Research often analyzes gender minority youth and sexual minority youth as a single group, a practice that obscures differences in how gender identity and sexual orientation shape health. The present study uses intersectionality to explore similarities and differences in the relationships between minority stress theory variables in a sample of 28 gender minority and 135 sexual minority youth of color. We also explore the mother-adolescent relationship as a potential promotive resource for minority stress research with youth. Results find few differences in minority stressors, promotive resources, or health between sexual and gender minority youth. However, different patterns in the correlations between stressors, resources, and health were observed for each group, underscoring the need for researchers to consider sexual and gender minority youth as distinct groups. Furthermore, study findings suggest that the maternal relationship may be an important promotive resource for both sexual and gender minority youth.

### Keywords

minority stress theory; sexual and gender minority youth; parental acceptance; stigma; health disparities

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Sexual orientation and gender identity are important psychosocial determinants of adolescent health in diverse societies around the world (Egan & Perry, 2001; Patterson, 1995). Compared to youth who identify as heterosexual or who report exclusive opposite-sex attractions or partners, young people aged 13-24 who identify as lesbian, gay or bisexual (LGB), or who report same-sex attraction or behavior, are at higher risk for substance abuse, poor mental health, suicidality, and HIV/AIDS (Institute of Medicine [IOM], 2011). In

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addition, studies indicate that transgender and gender non-conforming youth report poorer health and mental health than do their non-transgender peers (Reisner, Greytak, Parsons, & Ybarra, 2014). As noted by Williams and Mann (in press) and most authors in this issue, minority stressors in the form of stigma, discrimination, and victimization are likely the primary drivers of health disparities among sexual and gender minority populations throughout the world (IOM, 2011).

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According to minority stress theory, acute and chronic experiences with discrimination and the internalization of negative social beliefs about one's social groups or identities all constitute minority stressors that must be negotiated in order to actualize one's health and well-being (Meyer, 2003). In the original conceptualization of minority stress theory, resilience, positive coping strategies, and connections to the LGB community and to LGB affirming spaces were identified as important promotive resources that could offset the negative impacts of minority stressors (Meyer, 2003). In recent years, numerous studies have provided empirical support for the constructs and processes outlined by Meyer (2003), which have deepened the field's understanding of the complex ways in which minority stressors and promotive resources shape sexual and gender minority health and well-being in populations throughout the world (Frost, in press; Hatzenbuehler, Bellatorre, Lee, Finch, Muennig, & Fiscella, 2014; Tebbe & Moradi, 2016)

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At the same time, a growing number of scholars have noted that research on sexual and gender minority health needs to better attend to differences within and between sexual and gender minority populations (IOM, 2011). This criticism has been especially strong in the field of HIV/AIDS, where transgender women have often been studied as a subgroup of men who have sex with men (MSM), which obscures variation between groups and conflates gender and sexuality, two complex constructs (Bauermeister, Goldenberg, Connochie, Jadwin-Cakmak, & Stephenson, 2016; Perez-Brumer, Oldenburg, Reisner, Clark, & Parker, 2016; Poteat, German, & Flynn, 2016). Sexual orientation, for example, is a tripartite construct consisting of attraction, behavior, and identity (Klein, 1990). However, most studies assess a single domain, e.g., HIV research uses the behavioral category of MSM. While potentially appropriate for surveillance research, categories like MSM neglect the personal, social, and political meanings attached to people's sexual desires and practices, such as self-identification as gay, bisexual, or queer, and the potential stressors and resources identification brings (Young & Meyer, 2005).

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Across studies, research underscores that many aspects of human sexuality are socially constructed and influenced by broader social scripts, including heteronormativity (Herek, 2004; Simon & Gagnon, 1986). Similarly, gender is a construct that is socially situated, influenced, and performed (Butler, 2002). Despite calls to assess gender in more complex ways (Herman, 2017), most surveys ask respondents to identify as female or male or as woman or man (Reisner et al., 2015). This approach reflects genderism (Hill, 2003) and long-standing notions that gender identity is aligned with sexual anatomy or secondary sexual characteristics (Reisner et al., 2015). However, gender identity, like sexual orientation, exists on a continuum that is neither fixed nor binary (Egan & Perry, 2001). The umbrella term *transgender* refers to people whose gender identity or expression does not necessarily reflect their assigned sex at birth or is outside a gender binary, and *cisgender*

refers to people whose gender identity is concordant with their assigned sex at birth (Reisner et al., 2015).

In the present study, we use intersectionality as a conceptual framework (Cole, 2009) through which to explore similarities and differences in the relationships between minority stressors, promotive resources, and health in a sample of sexual and gender minority youth of color. Intersectionality is an especially important framework in minority stress research with sexual and gender minority youth of color because it draws attention to the ways in which social categories such as gender, sexuality, and race/ethnicity are defined, maintained, and tied to interlocking systems of oppression and privilege (Crenshaw, 1991). Indeed, scholars have noted that minority stress theory, which was originally based on research with predominantly White gay adults, may not capture the diversity of stressors and resources encountered by diverse sexual and gender minority groups (Goldbach & Gibbs, 2017; Haile, Rowell-Cunsolo, Parker, Padilla, Hansen, 2014; Hendricks & Testa, 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015). For example, the stressors faced by a White gay adult cisgender man are likely different than those faced by a young Black transgender woman who identifies as bisexual and must also deal with transphobia (Hendricks & Testa, 2012), adultism (Singh, 2013), and racism (Thoma & Huebner, 2013). Thus, while each group experiences stressors, the nature of these stressors and how they relate to each group's health may differ in important ways.

The original promotive resources identified in minority stress theory focused on resilience, positive coping strategies, and connections to an LGB community and LGB affirming spaces (Meyer, 2003), with less attention to other social and relational contexts. As a result, recent studies with sexual and gender minority youth have proposed examining stressors and resources that reflect a wider range of developmental contexts important for young people, such as families, schools, peers, and social media (Goldbach & Gibbs, 2017). In general, research with sexual and gender minority youth has defined family as (1) "family of origin," e.g., parents, siblings, and other people related by blood or marriage, or as (2) "family of choice," e.g., people unrelated by blood who serve a family-like role by providing closeness, support, and mutual aid. To date, most research with sexual minority youth has focused on the detrimental role of parental rejection (Bouris et al., 2010). Family-based research with gender minority youth is sparser, but suggests transgender adults first experience transphobia in their family of origin (Factor & Rothblum, 2008).

Until recently, most research with sexual and gender minority youth focused on family of choice. As with early formulations of minority stress theory, this work was informed by prior work with White gay adults, which found that HIV positive men relied more on friends than on family (Lovejoy, 1989). More recent studies with sexual and gender minority youth of color have documented non-kin family structures in the House-Ball community (Phillips et al., 2011). While important for understanding the role of diverse family structures for sexual and gender minority youth, recent trends indicate that youth are coming out (Floyd & Bakeman, 2006) and transitioning genders at younger ages, often in the context of their family of origin (Drescher & Byne, 2014). Thus, there is an important opportunity to explore the family context as a potential promotive resource in minority stress research with sexual and gender minority youth.

## Present Study

In the present study, we explore differences in the relationships between minority stressors, promotive resources, and health in a sample of 28 gender minority and 135 sexual minority youth aged 16-19 who participated in *Project READY*, a study of the socio-contextual factors that shape the health of sexual and gender minority youth of color. In addition, a primary purpose of the study is to explore the mother-adolescent relationship as a potential promotive resource in minority stress theory, an approach that integrates contemporary support for sexual and gender minority youth (Brewer, 2014) and developmental perspectives on the importance of parent-child relationships (Resnick et al., 1997). Although family-based research with sexual minority youth of color is growing, this area remains underexplored for gender minority youth. We focused on parents from youth's family of origin, and not family of choice, as the vast majority of youth in *Project READY* reported growing up in their given/biological families. We focus here on maternal resources and not paternal resources because 98.8% of the sample reported growing up with a mother/mother-figure, compared to 61.3% with a father/father-figure.

While our study is exploratory, we draw on prior research with sexual and gender minority youth to examine several exploratory hypotheses. Consistent with prior research showing that gender minority youth report greater stressors, less access to promotive resources, and poorer overall health (IOM, 2011), we first expected that gender minority youth would report greater exposure to minority stressors (e.g., general and school-based victimization), fewer promotive resources (e.g., resilience, school support, LGBT community connectedness, and maternal acceptance, warmth, and communication), and poorer health (depression, suicidal ideation, non-suicidal self-injury, substance use, condomless anal sex, and HIV) than would SMY. Consistent with minority stress theory (Meyer, 2003) and prior research with sexual and gender minority youth (IOM, 2011), we expected that minority stressors would be negatively correlated with poor health for each group, but that these relationships would be stronger for gender minority relative to sexual minority youth. Additionally, we expected that promotive resources would be more positively associated with health among sexual minority compared to gender minority youth.

## Method

### Recruitment

Youth were eligible to join *Project READY* if they: (a) were 13 to 19 years old; (b) were Black and/or Latino; (c) were assigned male sex at birth and currently identified as a cisgender man, a transgender woman, or as gender queer or non-conforming; and (d) reported any same-sex orientation in terms of attraction, behavior, or identity. Recruitment used a combination of outreach at LGBT venues (e.g., social service organizations, parks, areas known to attract large numbers of sexual and gender minority youth) and events (e.g., House balls, social events), snowball sampling, and referrals from other studies. In total, 205 youth were screened; of these, 166 were eligible, 165 were consented, and 163 completed the study. Of the 163 youth who completed the study, 40.5% were recruited via snowball sampling, 38% at an LGBT venue, 7.5% at an LGBT event, 5.5% from another study, and 8.6% via peer referral at an LGBT event.

## Data Collection

Youth over age 18 signed consent forms and minor youth signed assent forms; parental consent was waived and IRB approval was obtained for all procedures. Youth completed an interviewer-administered survey on paper ( $n = 155$ ) or an I-pad/computer ( $n = 8$ ) in REDCap, a secure web-based application (Harris et al., 2009). Data collection occurred in private offices, tents, or mobile health vans. The survey took approximately 90 minutes to complete, and all data were entered and checked in REDCap (Harris et al., 2009). All youth were offered an oral rapid HIV test, for which they provided oral consent. Trained HIV counselors and testers administered all HIV tests and results. Youth received \$15 for completing the survey, \$10 for the HIV test, and \$10 for referring another youth to the study, with a maximum of three paid referrals (\$30).

## Measures

**Gender identity**—A two-step approach assessed gender identity (Herman, 2014), with youth reporting the sex they were assigned at birth (male, female) and the category that best described their gender identity now (male/man, female/woman, transgender man, transgender woman, gender non-conforming/genderqueer, or other). Using these two items, we isolated a sample of 28 gender minority youth who reported male sex at birth and current gender identity of either a transgender woman ( $n = 24$ ) or gender non-conforming/genderqueer ( $n = 4$ ). The remaining 135 youth reported male sex at birth and currently identify as a cisgender man.

**Sexual orientation**—Sexual orientation was assessed with three items that assessed sexual attraction, the gender of youth's sexual partners, and sexual identity (see Table 1).

**Minority stressors**—Eight items assessed minority stressors in the form of school-based and general victimization. Three items assessed verbal harassment, physical harassment, and physical assault due to sexual orientation or gender identity, and one item assessed racial/ethnic discrimination at school (Kosciw & Diaz, 2008). All four items were rated on a 1 (never) to 5 (all the time) scale and a single composite of school-based victimization was created ( $\alpha = 0.70$ ). A general victimization composite was created based on reports of having ever been: hit, kicked, or slapped by a partner; forced to engage in sexual contact; bullied in the past 12 months; and electronically bullied in the past 12 months (Kann et al., 2014; Stone et al., 2014).

**Individual- and community-level resources**—Youth responded to items assessing promotive resources at individual and community levels relevant to adolescents. At the individual level, resilience was measured with the 10-item Connor-Davidson Resilience Scale (2003) ( $\alpha = 0.83$ ). At the community level, six items assessed LGBT community connectedness ( $\alpha = 0.78$ ; Frost & Meyer, 2012), and a six item measure of school-based social support ( $\alpha = 0.68$ ). Both scales were scored on a 1 (strongly disagree) to 5 (strongly agree) scale.

**Maternal resources**—Youth reported maternal knowledge of their sexual orientation or gender identity (Mohr & Fassinger, 2000) and if their mother was rejecting, intolerant,

tolerant, or accepting (D'Augelli, Hershberger, & Pilkington, 1998). One item on a 1 (strongly disagree) to 5 (strongly agree) scale assessed maternal warmth (Resnick et al., 1997). Seventeen items assessed communication about sex on a 1 (never) to 5 (all the time) scale ( $\alpha = 0.93$ ). Except for items on the gender of sexual partners, all items were based on prior work (Bogenschneider & Stone, 1997; Hutchinson & Montgomery, 2007; Rosenthal & Feldman, 1999).

**Health indicators**—Youth reported on their mental health, physical health, and involvement in health risk behaviors. Four items from the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey assessed depression, non-suicidal self-injury (NSSI), suicidal thoughts, and having a suicide plan in the past 12 months, with responses of 0 (no), 1 (yes) (Kann et al., 2014). We used individual indicators of depression and NSSI, and created a composite of the two suicide items to indicate suicidal ideation ( $r = .57, p = .01$ ). Two items assessed substance use in the frequency of binge drinking and marijuana use in the past six months on a 1 (never) to 7 (20 or more times) scale ( $r = .26, p = .01$ ). The same metric and time frame assessed the frequency of condomless anal sex (CAS) with a male partner of different/ unknown HIV-status, recoded as 0 (no), 1 (yes). All three items have been used in prior research with sexual and gender minority youth of color (Bouris, Hill, Fisher, Erickson, & Schneider, 2015). HIV-serostatus was based on the results of an oral rapid HIV antibody test, with 0 (negative), and 1 (positive).

**Demographic characteristics**—Youth reported their age, race/ethnicity, highest level of education, employment status, and housing status.

## Data Analysis

Data were analyzed in SPSS Version 23. Analyses proceeded in multiple steps. We first examined missing data and descriptive characteristics of the whole sample. Missing data was minimal and missing at random. Using intersectionality as a conceptual framework (Cole, 2009), we next explored if sexual and gender minority youth were significantly different on descriptive characteristics, minority stressors, promotive resources, and health using Chi-square and Fisher's exact tests for binary and categorical variables, and *t*-tests and Mann-Whitney U tests for continuous variables. A Holm-modified Bonferroni method was utilized to control for experimentwise error rates, which has been found to minimize both Type I and Type II errors (Jaccard & Guilamo-Ramos, 2002). For these tests, the critical *p*-value was adjusted to  $p = .025$ . Next, we conducted separate bivariate correlations for sexual and gender minority youth in order to examine the relationships between minority stressors, promotive resources, and health for each group. Fisher's *z* transformations were used to transform and statistically compare correlations between sexual and gender minority youth on minority stressors, promotive resources, and health using FZT Computator and G\*Power 3.1.9.2 for effect size calculations (Garbin, 2012). In order to further contextualize the magnitude of significant differences, we calculated effect sizes using Cohen's *d* (Cohen, 1977).

## Results

### Descriptive Characteristics

Table 1 presents demographic characteristics for the total sample and separately for sexual and gender minority youth. The only differences were for racial/ethnic identity ( $\chi^2 = 18.01$ ,  $df = 43$ ,  $p < .001$ ), sexual identity ( $\chi^2 = 46.72$ ,  $df = 3$ ,  $p < .001$ ), and sexual behavior with cisgender women ( $\chi^2 = 6.76$ ,  $df = 3$ ,  $p < .01$ ).

### Minority Stressors, Promotive Resources, and Health

Table 2 shows the results comparing minority stressors, promotive resources, and health between sexual and gender minority youth. Contrary to our exploratory hypothesis, the only difference was that gender minority youth reported a higher mean level of general victimization than did SMY ( $p = .001$ ; see Table 2). Rapid HIV test results indicated that 15.4% of gender minority youth and 14.7% of sexual minority youth were HIV-positive.

### Bivariate Correlations among Minority Stressors, Promotive Resources, and Health

Table 3 presents bivariate correlations between minority stressors, promotive resources, and health for gender minority youth. As hypothesized, minority stressors were positively related to poor health, with different relationships emerging for general and school-based victimization. School-based victimization was positively related to NSSI and substance use, while general victimization was positively related to condomless anal sex. Correlations for gender minority youth partially supported the hypothesis that promotive resources would be negatively related to poor health. Neither resilience nor LGBT community connectedness were significant; however, maternal warmth was negatively related to suicidal ideation and maternal acceptance negatively related to NSSI, suicidal ideation, condomless anal sex, and being HIV positive (see Table 3).

A different pattern of relationships emerged when examining the correlations between minority stressors, promotive resources, and health for sexual minority youth (see Table 4). There was partial support for our hypothesis on minority stressors and poor health, with school-based victimization being positively related to NSSI, and general victimization being positively related to both depression and substance use. Contrary to our hypothesis, LGBT community connectedness was not related to health, and resilience was positively related to condomless anal sex. The only maternal resource significantly correlated with health among SMY was mother-son communication about sex, which was negatively correlated with condomless anal sex.

Comparisons of correlation coefficients revealed significant differences in correlations between sexual minority youth (SMY) and gender minority youth (GMY) on minority stressors, promotive resources, and health variables. A statistically significant difference was observed for the relationship between general victimization and condomless anal sex (GMY  $r = .67$ , SMY  $r = .02$ ,  $z = 3.63$ ,  $p < .05$ ), with a large effect size ( $d = .79$ ). Additionally, significant differences were observed between promotive resources and health for sexual and gender minority youth, which ran counter to our hypothesis. For instance, there was a significant difference in the correlation between maternal acceptance and suicidal ideation

(GMY  $r = -.48$ , SMY  $r = -.01$ ,  $z = 2.35$ ,  $p < .05$ ), as well as for maternal warmth and suicidal ideation (GMY  $r = -.53$ , SMY  $r = -.12$ ,  $z = 2.15$ ,  $p < .05$ ), with medium effect sizes ( $d = .47-.51$ ). Although not significant for either group in bivariate correlations, a significant difference was observed for maternal communication and HIV status (GMY  $r = -.31$ , SMY  $r = .15$ ,  $z = 2.16$ ,  $p < .05$ ), with a medium effect size ( $d = .47$ ). In regards to the relationship between school support and maternal acceptance, the correlation was stronger for GMY compared to SMY (GMY  $r = .44$ , SMY  $r = .03$ ,  $z = 2.03$ ,  $p < .05$ ), with a small-medium effect size ( $d = .44$ ). A significant difference also was observed for the correlation between school support and maternal communication, with a stronger correlation among GMY compared to SMY (GMY  $r = .51$ , SMY  $r = .11$ ,  $z = 2.07$ ,  $p < .05$ ) with a small-medium effect size ( $d = .45$ ). The correlation between maternal acceptance and warmth also was significantly stronger for GMY compared to SMY (GMY  $r = .75$ , SMY  $r = .47$ ,  $z = 2.12$ ,  $p < .05$ ), with a medium effect size ( $d = .46$ ). Lastly, there was a significant difference in the relationship between NSSI and HIV-positive status for GMY compared to SMY (GMY  $r = .47$ ; SMY  $r = .03$ ,  $z = 2.20$ ,  $p < .05$ ), with a medium effect size ( $d = .48$ ).

## Discussion

Although a growing body of research is examining the social factors that shape the health of transgender youth (e.g., Reisner, Greytak, et al., 2014), few studies have explored differences in the relationships between minority stressors, promotive resources, and health between sexual and gender minority youth of color during late adolescence. The present study provides exploratory data to address this gap and extends prior research with minority stress theory by exploring the mother-adolescent relationship as a potential promotive resource for sexual and gender minority youth. Contrary to our hypothesis, there were few significant differences between sexual and gender minority youth in minority stressors, promotive resources, or health. However, there were differences in how minority stressors and promotive resources were related to health for each group, underscoring the different ways in which gender identity and sexual orientation may relate to social processes and health (Egan & Perry, 2001; Patterson, 1995). In addition, we found that resources at the maternal levels were a more reliable correlate of health than were individual resilience or LGBT community connectedness, especially for gender minority youth. Taken together, these findings suggest that research should attend to the differences between how minority stressors and promotive resources may shape the health of sexual and gender minority youth, and that minority stress research with sexual and gender minority youth should examine parents and families as a potential promotive resource.

Though there were no differences in health between sexual and gender minority youth, study findings point to high rates of victimization and poor health during late adolescence, a developmental period with important implications for subsequent health. Notably, approximately 15% of each group tested positive for HIV, highlighting the continued burden of HIV among young MSM and transgender women of color (Prejean et al., 2010). The only difference between groups was that a greater percentage of gender minority than sexual minority youth reported general victimization, a finding consistent with prior work (Clements-Nolle, Marx, & Katz, 2006). Other studies examining differences in health between transgender women and MSM have produced mixed findings (e.g., Bauermeister et



al., 2016; Sanchez, Finlayson, Murrill, Guilin, & Dean, 2010). For example, in a study with 60 transwomen and 300 MSM of color age 15 and up in the New York House/Ball community, transwomen did not differ from MSM on self-esteem, depression, condomless anal sex, or LGBT community connectedness (Sanchez et al., 2010). However, transwomen reported higher levels of experienced stigma, stressful life events, and exchange sex with men (Sanchez et al., 2010). In a study with 23 transwomen and 123 MSM of color ages 16 - 29 in Detroit, there was no difference in access to promotive resources (Bauermeister et al., 2016). However, transwomen reported higher rates of gender discrimination, daily hassles, poor mental health, and socioeconomic vulnerabilities (Bauermeister et al., 2016). Potential factors missing from our study include whether youth's gender expression deviated from social norms, length of time since transitioning genders, and other measures of gender, sexual, or structural stigma. Such factors impact exposure to minority stressors, resources, and health (Hatzenbuehler et al., 2014; Testa, Jimenez, & Rankin, 2014).

A primary purpose of this study was to explore the mother-adolescent relationship as a promotive resource in minority stress theory. Group comparisons revealed no differences in maternal acceptance, warmth or communication. However, correlational findings point to different relationships between maternal resources and health for each group, with maternal acceptance and warmth appearing important for the mental health of gender minority youth, and acceptance being negatively correlated with HIV serostatus for gender minority youth. Notably, neither resilience nor LGBT community connectedness were related to health for either group. Although these findings do not diminish the importance of LGBT communities, it is likely that these connections become more salient over time. Goldbach and Gibbs (2015) argue for a developmentally informed adaptation of minority stress theory that accounts for stressors and supports in developmental contexts outside of the LGB community, including the family context. Similarly, Hendricks and Testa (2012; see also Scandurra et al., in press) recommend that minority stress theory be adapted to account for how transgender people experience and process stressors and resources differently than their LGB peers. Our findings indicate that both approaches are worthy avenues to pursue when working sexual and gender minority youth.

### **Methodological Challenges and Limitations**

One of the biggest challenges in working with gender minority youth of color is that they are a small and hard-to-reach population. Using data from the CDC's Behavioral Risk Factor Surveillance System, Herman, Flores, Brown, Wilson, and Conron (2017) estimate that transgender youth comprise 0.7% of the 13 - 17 year old and 0.7% of the 18 - 24 year old youth population in the US; these figures are estimated at 0.65% and 0.57% in Illinois, which includes youth of all racial/ethnic groups. As with prior work (e.g., Bauermeister et al., 2016; Sanchez et al., 2010), gender minority youth in our sample were derived from a larger convenience sample that included cisgender MSM. As such, our study is limited by sampling and generalizability concerns, and cannot speak to causal relationships or to specific mechanisms of influence. Longitudinal research that examines causal pathways with larger and more diverse samples is needed. It also should be noted that statistical power was limited due to sample size, as has been the case with prior research with transgender youth of color (e.g., Bauermeister et al., 2016). However, in a post-hoc power calculation for mean

differences in general victimization, our primary indicator of minority stress, using G\*Power 3.1.9.2 (Faul & Erdfelder, 1992) revealed a medium effect size of  $d = .55$ , with statistical power  $(1-\beta) = .75$ , with an alpha set at .05 (Cohen, 1977). Still, research with larger and more diverse samples of gender minority youth of color are needed to further contextualize knowledge on the relationships between stressors and health, and how family relationships may be harnessed to support young people's health and well-being.

Issues of intersectionality are of critical importance in health research with sexual and gender minority youth of color, as sexual orientation and gender identity interact with age, race/ethnicity, and class on exposure to stressors and resources (IOM, 2011). We used intersectionality as a conceptual framework (Cole, 2009) through which to examine differences in the relationships between stressors, resources, and health for sexual and gender minority youth. Larger samples are needed to quantitatively examine how social identities interact to shape these relationships. This work will be made easier when standard measures of gender identity are incorporated in to large surveillance systems (Reisner et al., 2015). Future research should focus on resilience, as Crenshaw's (1991) original discussion of intersectionality focused on how social differences can be “a source for social empowerment and reconstruction” (p. 1241). Indeed, qualitative work using intersectionality as a conceptual and methodological framework has identified “intersectionality-facilitated resilience” (p. 766, Bowleg, 2012) and resistance among sexual and gender minority people of color (Bowleg, 2012; Singh, 2013). New measures of resilience that account for how sexual and gender minority youth of color cope with stressors and systems that undermine health and well-being are needed (see Testa et al., 2015).

### Implications and Conclusion

Despite these limitations, study results converge with existing literature on differential understandings of sexual orientation and gender identity, and suggest the value of considering the mother-adolescent relationship as a promotive resource to minority stress research with sexual and gender minority youth, especially for gender minority youth. In combination with high rates of maternal acceptance and warmth reported by sexual and gender minority youth, our findings add to the growing literature on the potential promise of involving parents in health promotion work with sexual and gender minority youth (Bouris et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). The *Family Acceptance Project* (Ryan, 2010) and *Lead With Love* (Huebner, Mello, Thoma, McGarrity, & MacKenzie, 2013) are two U.S. programs that have developed evidence-based materials and videos that feature families of color. Although neither program has been evaluated in a randomized controlled trial, the *Family Acceptance Project* is recognized as a Best Practice for Suicide Prevention by the American Foundation for Suicide Prevention. In addition, organizations outside the US are developing programs that promote parental support for sexual and gender minority youth (Graham & Kiguwa, 2004).

These programmatic efforts are important, as they recognize parenting sexual and gender minority youth is different than parenting cisgender heterosexual youth, and that parent-child relationships are influenced by youth's level of outness, parent's responses to their child's sexual orientation and/or gender identity, and parents' ability to buffer youth from

experiences with stigma and discrimination (D'Augelli, 2005). Thus, one cannot assume parenting practices that operate as promotive resources for heterosexual youth operate similarly for sexual and gender minority youth (Bouris et al., 2010; Thoma & Huebner, 2014). Families should also continue to be studied as potential sources of stress, as parental rejection is associated with poor health (Ryan, Huebner, Diaz, & Sanchez, 2009). This work should occur in diverse social and global settings (see Scandurra et al., (in press) for an example of minority stress in Italy) to fully understand minority stress and health.

## Acknowledgments

This work was funded by the University of Chicago Institute for Translational Medicine grant CTSA UL1 TR000430, the University of Chicago Center for Health Administration Studies, and the University of Chicago STI/HIV Intervention Network (SHINE). Additional support came from the Center for AIDS Prevention Studies grants R25 DA028567 and R25 HD045810. This manuscript was also made possible with help from the Third Coast Center for AIDS Research (P30 AI 117943). The views and findings in this manuscript are those of the authors and do not necessarily represent the official position of the National Institute on Drug Abuse, the National Institute on Child Health and Human Development, the National Center for Advancing Translational Sciences, or the National Institute for Allergies and Infectious Diseases. The University of Chicago Survey Lab assisted with refining and piloting the survey instrument. The Project READY Team, consisting of the Illinois Safe Schools Alliance, Test Positive Aware Network, the Night Ministry, Chicago Elite Performing Arts Center, and TaskForce Community & Prevention Services, provided invaluable research assistance with recruiting participants and collecting data.

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## Biographies

**Alida Bouris, PhD, MSW**, is Associate Professor at the Social Service Administration and Co-Director of the Chicago Center for HIV Elimination at the University of Chicago. Her work focuses on the development of family-based interventions to reduce disparities in mental health and HIV/AIDS among young MSM and transgender women of color. In addition, she studies the social-contextual factors associated with poor mental health among LGBT youth of color, and how structural inequalities and co-occurring psychosocial problems are linked to health.

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**Table 1**  
**Demographic Characteristics of Gender Minority Youth (GMY) and Sexual Minority Youth (SMY), Project READY, Chicago, IL, August 2013-August 2014**

Demographic	GMY (n=28) % (n) or <i>M</i> (SD)	SMY (n=135) % (n) or <i>M</i> (SD)	Total (N=163) % (n) or <i>M</i> (SD)	<i>p</i>
Mean age	18.4 (0.8)	18.5 (0.8)		.513
Race/ethnicity				<.001
African American/Black	57.1 (16)	83.7 (26)	79.1 (129)	
African American/Black and Latino	10.7 (3)	3.7 (5)	4.9 (8)	
Hispanic/Latino	0.0	5.2 (7)	4.3 (7)	
Multiracial	32.1 (9)	7.4 (10)	11.7 (19)	
Education				.350
8 <sup>th</sup> grade or less	0.0	1.5 (2)	1.2 (2)	
Some high school	57.1 (16)	37.0 (50)	40.5 (66)	
12 <sup>th</sup> grade but no degree	7.1 (2)	5.9 (8)	6.1 (10)	
High school diploma / GED	25.0 (7)	34.0(46)	32.5 (53)	
Some college	10.7 (3)	21.5 (29)	19.6 (32)	
Employment				.918
Employed part or full-time	28.6 (8)	27.6 (37)	27.8 (45)	
Not employed	71.4 (20)	72.4 (97)	72.2 (117)	
Current living situation				.158
Homeless	14.3 (4)	3.7 (5)	5.5 (9)	
Transitional shelter	3.6 (1)	1.5 (2)	1.8 (3)	
Living with parents/family	50.0 (14)	58.5 (79)	57.1 (93)	
Living with friends/partner	25.0 (7)	32.6 (44)	31.3 (51)	
Living alone (not in a shelter)	7.1 (2)	3.7 (5)	4.3 (7)	
Sexual attraction				.286
Only cisgender males	67.9 (19)	54.8 (74)	57.1 (93)	
Mostly cisgender males	14.3 (4)	20.0 (27)	19.0 (31)	
Equally cisgender males and females	7.1 (2)	21.5 (29)	19.0 (31)	
Mostly cisgender females	3.6 (1)	1.5 (2)	1.8 (3)	
Mostly transgender females	3.6 (1)	1.5 (2)	1.8 (3)	
Other non-heterosexual attraction	3.6 (1)	0.7 (1)	1.2 (2)	
Sexual orientation				<.001
Gay/same gender loving/queer	46.4 (13)	65.9 (89)	62.6 (102)	
Bisexual	10.7 (3)	31.1 (42)	27.6 (45)	
Heterosexual/straight	32.1 (9)	0.7 (1)	6.1 (10)	
Other non-heterosexual	10.7 (3)	2.2 (3)	3.7 (6)	
Sexual behavior history				
Cisgender women	28.6 (8)	55.6 (75)	50.9 (83)	.009
Transgender women	17.9 (5)	14.8 (20)	15.3(25)	.684
Cisgender men	100.0 (28)	92.6 (125)	93.9 (153)	.137

Demographic	GMY (n=28) % (n) or <i>M</i> (SD)	SMY (n=135) % (n) or <i>M</i> (SD)	Total (N=163) % (n) or <i>M</i> (SD)	<i>p</i>
Transgender men	3.6 (1)	5.9 (8)	5.5 (9)	.620
None	0.0	0.7 (1)	2.5 (4)	-

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**Table 2**  
**Comparison of Minority Stressors, Promotive Resources and Health among Gender Minority Youth (GMY) and Sexual Minority Youth (SMY), Project READY, Chicago, IL, August 2013-August 2014**

	<b>GMY (n = 28)</b>	<b>SMY (n = 135)</b>	<b>Total (n = 163)</b>	<b>p</b>
<u>Minority stressors</u>	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>	
School-based victimization score	1.71 (0.74)	1.50 (0.66)	1.54 (0.68)	.127
General victimization score	1.54 (1.43)	0.88 (0.90)	1.00 (1.04)	.001
<u>Promotive resources</u>				
Resilience	3.74 (0.71)	4.00 (0.72)	3.96 (0.72)	.087
Community connectedness	4.08 (1.04)	3.93 (0.82)	3.96 (0.86)	.393
School support and safety	4.06 (0.80)	4.10 (0.80)	4.07 (0.80)	.844
Maternal acceptance	3.59 (0.80)	3.55 (0.75)	3.55 (0.76)	.771
Maternal warmth	4.70 (0.82)	4.53 (0.95)	4.56 (0.93)	.368
Maternal communication	3.02 (1.07)	2.84 (1.00)	2.87 (1.01)	.416
<u>Health indicators</u>	<u>% (n)</u>	<u>% (n)</u>	<u>% (n)</u>	
Depression	28.6 (8)	23.7 (32)	24.5 (40)	.586
NSSI	7.1 (2)	3.7 (5)	4.3 (7)	.414
Suicidal ideation	17.9 (5)	12.6 (17)	13.5 (22)	.458
HIV-positive	15.4 (4)	14.7 (19)	14.8 (23)	.932
	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>	
Substance use	3.82 (2.06)	3.72 (1.87)	3.73 (1.89)	.802
Condomless anal sex	2.13 (1.78)	2.04 (1.47)	2.06 (1.52)	.809

**Table 3**  
**Bivariate Correlations for Minority Stressors, Promotive Resources, and Health among Gender Minority Youth (n = 28), Project READY, Chicago, IL, August 2013 – August 2014**

Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. School victimization	-	.24	-.30	-.01	-.37	-.46*	-.41	-.24	.22	.54**	.28	.41*	.34	.03
2. General victimization		-	.10	-.54**	.01	-.05	-.30	-.17	.21	-.11	.29	.01	.67**	.20
3. Resilience			-	.07	.35	.12	-.03	.34	-.34	-.30	-.23	.28	-.09	-.03
4. Community connectedness				-	.26	-.18	-.06	.37	-.25	-.05	.07	.20	-.35	-.09
5. School support and safety					-	.44*	.30	.51**	-.11	-.24	.10	-.34	.05	-.23
6. Maternal acceptance						-	.75**	.27	-.18	-.40*	-.48*	-.37	-.12	-.41*
7. Maternal warmth							-	.31	.04	-.07	-.53**	-.28	-.25	.38
8. Maternal communication								-	-.26	-.20	-.27	-.13	-.21	-.31
9. Depression									-	.44*	.32	-.10	.51*	.27
10. Non-suicidal self-injury										-	.23	.23	.15	.47*
11. Suicidal ideation											-	.30	.32	.41*
12. Substance use												-	-.18	.17
13. Condomless anal sex													-	.20
14. HIV-positive														-

Note:

\*  $p < 0.05$ ,

\*\*  $p < 0.01$

Table 4

**Bivariate Correlations for Minority Stressors, Promotive Resources, and Health among Sexual Minority Youth (n = 135), Project READY, Chicago, IL, August 2013 – August 2014**

Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. School victimization	-	.29**	-.36**	.07	-.29**	-.18	-.05	-.11	.01	.22**	.09	.03	.03	-.07
2. General victimization			-.08	-.08	-.12	-.02	-.02	.04	.20*	.11	.02	.19*	.02	.11
3. Resilience				-.01	.14	.14	.10	.11	.10	-.17	.00	.09	.19*	.00
4. Community connectedness					.22**	.09	.17*	.09	.01	.05	.12	-.11	-.06	-.05
5. School support and safety						.03	.14	.11	-.20*	-.15	-.08	-.03	-.12	.03
6. Maternal acceptance							.47**	.28**	-.11	-.05	-.01	-.01	-.07	-.10
7. Maternal warmth								.24**	-.21*	-.19*	-.12	-.12	.03	.07
8. Maternal communication									.03	.06	-.01	.00	-.15	.15
9. Depression										.17	.47**	.19*	.17	.02
10. Non-suicidal self-injury											.28**	.06	.03	.03
11. Suicidal ideation												.09	.04	.11
12. Substance use													.10	.11
13. Condomless anal sex														.09
14. HIV-positive														

Note:

\*  $p < 0.05$ ,

\*\*  $p < 0.01$