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The Relationship Between Suicide Ideation and Adult Support Among African American Adolescent Lesbians

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Abstract

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LaTonya Watters

MS, Jacksonville State University, 1995

BS, Shorter College, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The suicide rate among African-American youths has significantly increased in recent years. Studies have indicated that racism, sexism, and homophobia put African-American adolescent lesbians (AAALs) at high risk for suicide. Earlier studies recognized the importance of adult support for adults, but the relationship between the AAAL suicide rate and the level of adult support has never been formally studied. Based on social support theory, this survey study examined the relationship between adult social support and attitudes toward homosexuality (as the independent variables) and suicidality and hopelessness (as the dependent variables) in a convenience sample of 200 self-identified 13-to-19-year-old AAALs. Data were collected using the Duke Social Support and Stress Scale (DUSOCS), the Homosexuality Attitude Scale (HAS), the Beck Scale for Suicide Ideation (BSS), and the Beck Hopelessness Scale (BHS). Descriptive statistics and ANOVA correlation and regression analyses were conducted using SPSS 20. The results showed a statistically significant negative relationship between social support and attitude toward homosexuality and the dependent variable, suicidal ideation; a significant negative relationship between social support and hopelessness; and a significant, but weak, positive relationship between social support and attitude toward homosexuality. Lack of family and social support is associated with social isolation and increased risk of suicide among homosexual youths. Finding ways to increase family and social support for AAALs has the potential to promote positive social change by reducing suicidal ideation in this at-risk group.

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Dedication

This dissertation is dedicated to all individuals struggling with their sexual identity or orientation. Suicide should never be an option for you because every life is valuable, be it the life of a homosexual or a heterosexual person.

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Chapter 1: Introduction to the Study

According to the United States Youth Survey Reports, in the age group of 15-to-24-year-olds, 5,000 adolescent and young adult lives are lost every year to suicide (Hillier & Harrison, 2004). Emotional turmoil and social prejudice on account of sexual orientation and same-sex relationships are cited as the cause of death in 30% of these suicide cases (Hillier & Harrison, 2004). The African-American community has also been affected by this depression-related development. The National Center for Injury Prevention and Control (NCIPC, 2010) reported a suicide rate of 5.19 per 100,000 African Americans residing in the United States. This represents a 233% increase for African Americans over the period from 1980 to 1995. This increase is extremely high when compared to the 120% increase in the suicide rate of Caucasian youths (Carrington, 2006). Racism, sexual secrecy, and homophobia have become potent issues affecting African-American adolescent lesbians (AAALs) resulting in risk of suicide (American Association of Suicidology [AAS], 2010). Notably, African-American men are more prone to commit suicide as compared to their female counterparts by a ratio of 4.9:1 (AAS, 2010). This means that African-American women have the lowest suicide rate of all racial/gender groups (AAS, 2010). However, it should be noted that, when comparing racial groups, African-American women exceed their male counterparts in attempted suicide (AAS, 2010).

This study was aimed at examining the role of social support in suicidal ideation among AAALs and was intended to inform future interventions designed to decrease suicidality among this population. A network of family and friends and access to social

and community service agencies has been associated with reducing vulnerability to suicide (Day-Vines, 2007). Nisbet (1996) suggested that the high suicide rate found among African-American women could be reduced by social support. In his study, Nisbet identified friends' and family members' emotional and psychological support in reducing suicides of women in the African-American community. Nisbet's research suggested a negative correlation between attempted suicide and the support of family and friends. At the same time, the study indicated that professional help failed to reduce suicide attempts, apparently because of the reluctant attitude shown by these individuals in following professional guidance. In fact, the subjects showed perceivable decline in their emotional states (Nisbet, 1996).

Existing literature indicates that lesbian, gay, bisexual, and transgender (LGBT) individuals are more prone to completed suicides, suicide attempts, and suicidal ideation in comparison to heterosexual individuals (Paul, Catania, Pollack, & Moskowitz, 2002). Lifetime prevalence rates of suicidal ideation among adult gay men and lesbians have been reported to range from 24% to 41%, while lifetime prevalence rates of suicide attempts have been reported to range from 7% to 20% (Paul et al., 2002). The risk factor for suicide attempts among LGBT ethnic minorities is even higher, which, as O'Donnell, Meyer, and Schwartz (2011) argued, cannot be fully explained by youth, onset of substance abuse, depression, or increased susceptibility to suicide among racial/ethnic minority LGBT group members.

Homosexuality has been identified as a significant contributor to suicide ideation and serious attempts among the young (Stone, Luo, Ouyang, Lippy, & Hertz, 2014).

Specifically, the social stigma of homosexuality is reportedly causing depression and suicide among LGBT persons. Sexuality is a central issue in the lives of young men and women, and the social stigma around sexuality for LGBT persons often results in depression, suicide ideation, and suicidality (Hendin, 2013). The research suggests that, because of the stigma they are subjected to, members of the LGBT community tend to develop an aversive behavior that limits the development of their self-identity, which can be linked to suicide ideation. The negative social attitude and stigma cause stress among LGBT persons. According to social reaction theory, this situation leads to negative reactions, which lead to suicide ideation among members of this population (Hendin, 2013).

The prevailing stigmatization that faces LGBT persons is a central component in suicidal ideation (Hendin, 2013). In fact, the high prevalence of suicide among adult gays and lesbians can be attributed to the abuses and the stigma they experience from the surrounding society (Hendin, 2013). There comes a point when they get so overwhelmed by the abuse that they are rendered unable to handle the stress, an aspect that can be linked to their decision to take their lives (Hendin, 2013). Hendin further noted that social structures appear to be a major cause of minority-community suicides and that, historically, Americans who were ill-treated have found it difficult to cope with emotional issues. Recent studies seem to echo this recognition in their findings that African-American and other youths are reacting with stress-related suicide in a similar manner to their ill treatment by society.

Suicide is rated as the third major cause of death among African-American youths in the United States (Hendin, 2013). The situation is worsening, as Poussaint (2011) observed, in the form of an increasing rate of victim-precipitated homicides among African-American youths. He believed that this problem could partly be attributed to prevalent attitudes in society. On this subject, Joe (2008) advocated for the need to establish the reasons why African-American youths do not seek assistance from the relevant service agencies. To Joe, demonstration of masculinity tends to be a hindrance for men as they perceive the expression of emotions as a sign of weakness. For AAALs in these circumstances, fear of consequences related to their sexual identity is prompting them to conceal their depressive episodes from others who would be able to help them. LGBT persons are more prone to commit suicide in their youth than at any other time in their lives (Hendin, 2013). The chances of AAALs committing suicide are three times those of heterosexual youths across the community (Hendin, 2013). The Center for Special Problems in San Francisco (as cited in Gibson, 1889) pointed out that "these youths face more severe social and cultural oppression than other gay youth and far more serious problems than other adolescents" (p. 5). These feelings of social and cultural oppression are exacerbated by a sense of despair, noted Hendin (2013), to which many young African Americans are exposed at a relatively younger age in comparison with Caucasian youths.

Purpose of the Study

In this study, I explored suicidal ideation among AAALs. The study sought to determine if there is an association between independent variables (demographics and

adult social support) and dependent variables (hopelessness and suicidality) in AAALs. The study can inform psychologists about the relationship between the suicide rate of AAALs and the level of adult support, and they can use this information in designing appropriate interventions to increase community and adult support for the AAAL population.

Currently, an established system of specialized support from their circle of friends and their community is not available to AAALs. This lack is exacerbated by a history of homophobia resultant from mainstream society's dislike of and disregard for the LGBT community. The stigma imposed by a predominantly heterosexual society leaves AAALs vulnerable to feelings of loneliness, isolation, and depression.

Nature of the Study

In this quantitative survey study, I collected data from AAALs ($N = 200$), which will inform developers of interventions about the kinds of interventions needed to reduce suicidality among this population. By combining and analyzing the results from the surveys used, I attempted to show that establishing adult social-support systems for AAALs is much needed and should be seriously considered by psychologists, law makers, and community organizers. By recruiting volunteer participants who are openly lesbian, I assumed that their responses would be honest—a critical requirement for the development of appropriate interventions for this population. Independent variables were the participants' demographics and adult social support; dependent variables were hopelessness and suicidality in AAALs.

Background of the Problem

Internalized homophobia, sometimes also termed *internalized homonegativity*, entails negative attitudes and assumptions concerning homosexuality by LGBT persons (Szymanski, Chung, & Balsam, 2001). LGBT persons have been observed as displaying an aversion to the predominantly heterosexual society, which, they feel, sidelines them. Szymanski, Chung, and Balsam (2001) acknowledged that LGBT persons have this fear because they live in a heterosexist society with a relatively small sexual and gender minority population and with laws that do not acknowledge them. Even though this fear might not be justified, it must be addressed when one wishes to provide assistance to LGBT persons; if it remains unaddressed, it could lead to extensive psychological problems. Therapists working with LGBT clients must closely assess this fear with the client and determine when it is justified and when it is not. It is also crucial to note that when social restraint is internalized by the majority, aggression is directed outward against the marginalized population, but when the minority group internalizes the restraint, its members direct aggression toward themselves, which leads to an increased suicide rate in that population (Nisbet, 1996).

Szymanski et al. (2001) concluded that internalized homophobia among lesbians correlated positively with depression, somatic complaints, and the reported frequency of attempting to appear heterosexual. The authors further found that internalized homophobia correlated negatively with stability of self, overall social support, satisfaction with social support, and gay social support. They suggested that internalized homophobia had a strong correlation with social support and that it affected lesbians who

did not belong to a LGBT support group much more than those who did. Lesbians who did not belong to a LGBT support group reported higher levels of internalized homophobia than lesbians who did belong to a LGBT support group. It has been suggested that lesbians who reported conflicted or confused feelings about their sexual orientation also reported higher levels of internalized homophobia than those who reported little or no conflict about their sexual orientation (Szymanski et al., 2001).

Leach (2014) observed that a significant portion of LGBT youth repeatedly contemplate suicide starting at a young age. The situation seemed to become more critical among homosexual African Americans who showed a stronger inclination toward such thoughts than did their heterosexual counterparts. The author reported that several factors coincided with the study participants' suicidal ideation or suicide attempts, including social isolation, anger, depression, repeated stress, feelings of inadequacy, and sexual-identity difficulties.

Social support is a critical component in the present study because it appears to sustain healthier adolescent functioning. Rutter and Behrendt (2004) highlighted a sense of belonging in teens who related well with family members, community peers, and teammates. They also found that adolescents who reported receiving strong social support and experiencing low levels of isolation exhibited higher resilience and a lower level of suicidal ideation or suicide attempts. Further, their study indicated that adolescents were less likely to be suicidal if they perceived their family, friends, and peers as accepting of their sexuality and if they had more positive friendships. Adolescents who felt supported by counselors, parents, or peers exhibited healthier coping mechanisms and maintained a

more positive outlook about their future. By contrast, adolescents who lacked social support and felt isolated tended to behave in self-injurious ways (Rutter & Behrendt, 2004).

A central aspect to understanding suicidal ideation is its relationship with social support. Rosario, Schrimshaw, and Hunter (2005) reported research results that provided evidence of a linkage between suicide attempts, social support , and social relationships. Among youths with a history of attempted suicide, the researchers found that a large number of negative relationships or lack of support were linked with increased psychological distress. These observations echoed most of the social-support literature, which linked low levels of support with adverse outcomes. In explaining this development, Rosario et al. (2005) noted a difference in the functioning of social relationships for LGBT individuals who had a history of suicide attempts and those who had no such history. LGBT youths are likely to experience belittling and degradation when relating with members of their social network, even from those providing support (Rosario et al., 2005). Particularly, persons who are caring and loving toward the youths are likely to respond negatively upon learning of the young person's LGBT status. LGBT youths with a history of suicide attempts are more likely, in comparison to nonsuicidal peers, to rate those individuals who rejected them as more influential than those who actually supported them (Rosario et al., 2005). The described observations seem to indicate that lack of social support and negative interactions made it very difficult for gay, lesbian, and transgender populations to coexist normally within the general population. These observations also suggested the existence of a significant interaction

between victimization (on the part of society) and family support with respect to the youths' psychological distress. Moderate or high levels of support are considered effective when LGBT youths are experiencing relatively little victimization. However, when high levels of victimization are present in the youths' life, moderate or even high levels of support tend to be ineffective in preventing suicidal ideation (Rosario et al., 2005).

Brown (2008) examined the significance of racial socialization and social support in terms of the resilience of African Americans. The participants in Brown's study were 154 African-American undergraduate students who had completed the Multidimensional Scale of Perceived Social Support, the Teenager Experience of Racial Socialization Scale, and the Connor-Davidson Resilience Scale. Brown assessed findings through multiple regression analysis, and the results suggested that the provision of racially socialized messages and expectations of social support from family, parents, or mental-health providers accounted for the greatest proportion of variance in resiliency scores. Hillier and Harrison (2004) revealed that the experiences of LGBT youths can make for a particularly lonely and stressful time when compared with the experiences of other minorities of the same age. LGBT youths find it difficult to talk to their families about this particular issue (Hillier & Harrison, 2004), which may account for the wide variation in the results reported by Brown (2008).

Gay adolescents who disclose their sexuality may encounter family discord, rejection, and failure in achievement of academic goals when they do not receive the positive support that they need (LiKitts, 2005). Linking this lack of support to suicide

attempts, LiKitts (2005) observed that studies published over the last 2 decades have consistently and significantly found higher rates of suicide attempts (in the range of 20% - 40%) by gay adolescents. However, according to the author, there was no direct correlation between an adolescent's LGBT status and increased suicide attempts. LiKitts argued that increased risk for suicide is a direct result of the psychosocial distress of poor family relationships or discrimination associated with being an LGBT person.

The majority of youth suicides in the United States occurred among Caucasian adolescents, and most interventions are thus based on Caucasian adolescents' suicidal behaviors (Rutter & Behrendt, 2004). However, the suicide rate among African-American adolescents has risen dramatically in the past decade (Rutter & Behrendt, 2004), and African-American youths are now more likely than Caucasian youths to report having attempted suicide. In addition, the problem of suicidality among minority youths may be even more dramatic in inner-city areas, where the rates of attempted suicide among African-American adolescents are twice the national rate (Anhalt & Morris, 1998; LiKitts, 2005).

The literature provides a wide range of information about stress and how unresolved suicidal ideation or suicide attempts can impact a LGBT person's adult life. Risk factors for suicidal ideation and suicide attempts among African-American men include advancing age, interpersonal losses, mental disorders, physical illness, a poor social network, marital conflict or ineffective family functioning, and substance abuse.

Historically, LGBT persons in the United State have experienced overt public discrimination and mistreatment when they disclosed their sexual orientation (Anhalt &

Morris, 1998). Although same-sex sexual behavior has existed throughout history, the subject has historically not been significantly or received much attention (LiKitts, 2005). In fact, it is only in the last 150 years that the labels *heterosexual, lesbian,* and *gay male* have become part the English lexicon, and the subject remains controversial even today when LGBT persons are still stigmatized (Anhalt & Morris, 1998; LiKitts, 2005). Further, adolescents who experience sexual attraction toward someone of the same sex may often reject any kind of LGBT label for themselves (Anhalt & Morris, 1998; LiKitts, 2005).

It is a harsh reality that African-American LGBT persons have to contend with the fact that they live in a largely homophobic community in a society that attaches a long-standing stigma to homosexuality. As a result, LGBT persons are bound by these circumstances to continue taking the position of second-class citizens in social, political, and legal realms. While this situation is the same for all racial and ethnic groups, it is exacerbated in the case of African Americans through their long history of social marginalization and oppression on account of race (Tsai, 2011). Further, Beatty and Kirby (2006) have noted that, even though it may seem unusual that discrimination against LGBT persons is based on an invisible difference, the discrimination is nevertheless pervasive, especially in employment. They found that between 25% and 66% of LGBT persons end up being victims of discrimination in the workplace, which can range from limited career choices, job denial and loss, ostracism, termination, and even violence. Such discrimination can lead to more negative attitudes in life, as a result

of many negative outcomes due to stereotyping, fear, and misunderstanding (Beatty & Kirby, 2006).

Statement of the Problem

As Silenzio, Pena, Duberstein, Cerel, and Knox (2007) observed, same-gender sexual orientation frequently tends to be associated with suicidal ideation, which suggests the likelihood that the risk factors and markers to suicidal ideation among LGBT persons are different in relative importance when comparing LGBT persons to others. If this is indeed the case, then interventions aimed at risk factors for suicidal ideation among AAALs might be expected to need different attributes if they are to address the underlying disparities.

Even with recent developments, researchers have been limited in addressing suicidality among AAALs and the relationship of this to patterns of adult support. There has not been sufficient research undertaken on this topic. It is common for young AAALs to feel hopeless, helpless, isolated from others, depressed, belittled, and uncertain about how to seek appropriate help (Rutter & Behrendt, 2004). The aim of my study was to provide a more comprehensive examination of the relationship between adult social support and suicidality among AAALs.

Many LGBT youths seem to experience greater levels of social discrimination, depression, isolation, low self-esteem, and violence than their heterosexual counterparts as a direct result of their sexual identity, gender identity, or sexual orientation (Rosario, Schrimshaw, Hunter, & Braun, 2006). *Identity integration* involves accepting a LGBT identity that resolves internalized homophobia by changing adverse perceptions into

positive ones. This provides feelings of comfort and allows for the disclosure of that identity to others (Rosario et al., 2006). Attempted suicide can be conceived of as a maladaptive health behavior, influenced by both person-level factors such as depressive symptoms, and environment-level factors such as deficits in family functioning and social support (Rosario et al., 2006). While it is possible to identify the potential importance of adult support for AAALs, it is not so easy to establish the extent to which the suicide rate of AAALs may be related to the lack of adult support. This study focused on the relationship between a healthy sexual identity for AAALs and adequate positive adult support, with the independent variable being adult support and the dependent variable suicidal ideation as reported by the AAAL participants.

In this study, I responded to growing public health concerns that are disproportionately linked with some demographic characteristics such as sexual orientation. Among AAALs, low social and emotional support are emerging constructs that lead to a better understanding of AAALs' suicidal ideation.

Research Question and Hypotheses

I designed the research question and hypotheses with intent to examine the relationship between suicidality among AAALs and patterns of adult support. The research question guiding this study asked: Is there a correlation between suicidality among African-American AAALs and patterns of adult support?

Hypothesis 1

$H_0$1: There is no relationship between AAALs' perceived adult social support, as measured with the Duke Social Support and Stress Scale (DUSOCS), and AAALs'

hopelessness, as measured with the Beck Hopelessness Scale (BHS), and attitude toward homosexuality, as measured with the Homosexuality Attitude Scale (HAS).

H_a1: A significant relationship exists between AAALs' perceived adult social support, as measured with the DUSOCS, and AAALs' hopelessness, as measured with BHS, and attitude toward homosexuality, as measured with the HAS.

Hypothesis 2

H_02: Perceived social support, as measured with the DUSOCS, and attitude toward homosexuality, as measured with the HAS, do not significantly predict whether someone should be classified as having suicidal ideation, as measured with BSS.

H_a2: Perceived social support, as measured with the DUSOCS, and attitude toward homosexuality, as measured with the HAS, significantly predict whether someone should be classified as having suicidal ideation, as measured with the BSS.

Hypothesis 3

H_03: Perceived social support, as measured with the DUSOCS, and attitude toward homosexuality, as measured with the HAS, do not significantly predict hopelessness, as measured with the BHS.

H_a3: Perceived social support, as measured with the DUSOCS, and attitude toward homosexuality, as measured with the HAS, significantly predict hopelessness, as measured with the BHS.

Hypothesis 4

H_04: There are no differences in the scores on the HAS among participants with respect to educational level, type of household of origin, or religious affiliation.

H_a4: Significant differences exist in the scores on the HAS among participants with respect to educational level, type of household of origin, or religious affiliation.

Definition of Terms

Homophobia: The fear or hatred of one's own or others' romantic feelings toward someone of the same gender (Asanti, 1998; Weinberg, 1972).

Identity integration: A process that involves accepting a LGBT identity and resolving internalized homophobia by changing adverse perceptions into positive ones. This provides feelings of comfort and allows for the disclosure of that identity to others (Rosario et al., 2006)

Lesbian: A woman whose sexual orientation is toward women (Yarhouse , Tan, & Pawlowski, 2005).

Posttraumatic stress disorder (PTSD): According to American Psychiatric Association (APA, 2000), this is a disorder that occurs after an individual has been exposed to a traumatic stressor, which results in the person's having negative thoughts about the experience. This situation is known to appear within 3 months after a person experiences the traumatic event.

Sex role: The degree to which one adheres to prevailing social expectations for one's gender (Yarhouse et al., 2005).

Sexual identity: Sexual identity has a direct impact on an individual's biological sex such as being male or female (Yarhouse et al., 2005).

Sexual orientation: The direction and persistence of one's experiences of sexual attraction (Yarhouse et al., 2005).

Social network: The set of personal contacts and social relationships that provide functions, including social support (Compton, Thompson, & Kaslow, 2005).

Social support: The presence of a confidant or confidante, parent, or friend, which is associated with fewer psychiatric symptoms, improved coping skills, higher morale, and better adjustment to stressful events (Pearson, 1986).

Stress: "Any condition having the potential to arouse the adaptive machinery of the individual" (Pearlin, 1999, p. 163). Stress can be caused by both positive (eustress) and negative (distress) events (APA, 2000). This study deals with stress as a reaction to negative conditions in the environment and to experiences that leave a negative impact on the emotional and physical health of an individual.

Stressors: The various conditions or environments that cause people to suffer stress; they include personal, psychosocial, environmental, and work stressors (APA, 2000).

Suicidal ideation: Cognitions and thoughts of ending one's life including plans and ideas on how to commit suicide (Chae & Boyle, 2013).

Victim-precipitated homicide: Killings in which the victim is a direct, positive precipitator of the incident. Victim-precipitated homicide is, therefore, an act of suicide, and the term refers to those incidents in which an individual, determined on self-destruction, engages in a calculated life-threatening criminal incident in order to force a police officer or another individual to kill him or her (Chae & Boyle, 2013).

Significance of the Study

Hoffman's (2000) concentric biopsychosocial model advanced the notion that social support mediates taxing life events. The earlier investigation by Coleman and Remafedi (1989) maintained that belongingness and social support are contributory factors to having an optimistic outlook on life and to being hopeful about the future. Their study revealed a modest relationship between suicide and hopelessness after depression was controlled. These studies indicated that social support is a buffer against the negative impact of stressful events associated with developmental stages. The result of Safren and Heimberg's (1999) MANOVA suggested that gay and lesbian youths experience hopelessness, depression, and social isolation, and one of the authors' recommendations was to study the determinants of suicidal tendencies and the role played by increased social support. As indicated by Turner and Turner (1999), perceived social support serves as the starting point in designing appropriate interventions geared to promoting mental health. The authors stated that "perceived social support represents the most direct criterion for assessing the role and significance of network characteristics, of other social resources, and of potentially supportive actions" (p. 304). Social support mediates stress (Kertzner, 2001; Morris, Waldo, & Rothblum, 2001). When lesbians are able to interact socially with fellow lesbians, they feel accepted within their own social spheres (Morris, Waldo, & Rothblum, 2001).

Wilburn and Smith (2005) explored the relationships among suicidal ideation, stress, and self-esteem. The results of their study supported the research hypothesis that increased stressful events predicted suicide ideation. Stress is "any condition having the

potential to arouse the adaptive machinery of the individual," noted Pearlin (1999, p. 163). Stress falls under two types: acute or chronic. The former includes bodily responses to perceived threat, whereas the latter is prolonged and ongoing physical and emotional stress (Robbins, Powers, & Burgess, 2005). Stressors enable individuals to adjust themselves. Depending on the available resources, personal and social stressors can be tolerated (Meyer, 2003). As Meyer (2003) suggested, higher psychopathology in LGBT individuals is the result of "minority stress." According to the minority-stress theory, discrimination, prejudice, and stigma lead to a socially toxic environment. Living in such an environment increases the likelihood that members of sexual minorities will have mental health problems. This stress model of Meyer (2003) defined two minority stressors: distal stressors and proximal stressors. Distal stressors include "prejudice-inspired events" such as sexual or physical abuse and workplace discrimination (Hatzenbuehler, 2009). Proximal stressors include subjective expectations of concealment or rejection. An extension of Meyer's minority stress theory was developed by Hatzenbuehler (2009), who suggested the existence of three psychological processes. In the first process, LGBT persons are more exposed to stress associated with stigmatization. In the second process, the experienced stress leads to increased cognitive, emotional, interpersonal, and social problems, which pose psychological risks. In the third process, these risks moderate the existing link between psychopathology and stress resulting from the sexual stigma. Hatzenbuehler distinguished between alcohol abuse and anxiety and depression as externalizing and internalizing domains. Hypothesis testing

provided evidence of a correlation amongst psychopathology, stress, and sexual stigmatization**.**

The present study is important not only because it allowed me to make recommendations for further research on the topic, but also because my recommendations for more psychological services aimed at creating better systems of adult social support for AAALs that will help gay and lesbian youth. The data I obtained were crucial because they established the groundwork for helping gays and lesbians to reduce homophobia and stress, which might otherwise lead them to commit suicide.

Limitations

Limitations of this study pertain to the initial data analysis. Because the survey instruments used in this study did not yield sufficiently comparable data in their raw form, the answers to the most salient questions could be obtained only by altering the data analysis procedure to use nonparametric techniques that allowed useful tests to determine how strongly the correlations supported or refuted the corresponding hypotheses. The study may be biased because the study participants were young and may have provided answers that could be considered slanted toward some adolescent viewpoints as compared to adult viewpoints. Another limitation is that the sample cannot be considered representative of the whole population of AAALs, in that participants were recruited within a limited area of the southern United States, which is considered the heart of the Bible Belt, where attitudes toward homosexuality may not be representative of attitudes in other parts of the United States.

I used a nonparametric technique to test the hypotheses because the collected data failed to meet the normal distribution assumptions (see Figures 1 and 2) needed to run parametric techniques such as Pearson's *r* and multiple regression analysis. Generalizability of the findings is limited, and applying the results of the study to AAALs in other parts of the country should be done with extreme caution.

Assumptions

My primary assumption was that the participants reported truthfully that they were lesbians who were attending school or had attended school, were working or had been working in an urban, suburban, and rural community. Another assumption was that AAALs would be more likely to have suicidal thoughts than heterosexuals because they tended to experience less positive adult support for their sexual orientation from the communities in which they lived and worked. The final assumption was that the participants would be able to rate their experiences correctly on the scales and surveys provided and which they had volunteered to complete. However, not all participants may have been able to do this owing to the fact that they had repressed their internalized pain for many years because of the culture of their community. These appear to have been valid assumptions, based on what I could ascertain by reviewing the results of the study.

Summary and Overview of the Study

This chapter presented the introduction to the study, in which I described its purpose, nature, background, problem statement, research question, and hypotheses. I provided a definition of terms as used in the study and highlighted the study's importance as well as its limitations and assumptions. In Chapter 2, I review relevant literature,

including the social support theory and factors contributing to suicide. In Chapter 3, I describe the research methods used in this study, including research design and approach. There, I also offer a description of the sample and sample selection, and I discuss instrumentation, data collection, and data analysis procedures. In Chapter 4, I present the results of the study, and use them to draw conclusions and offer recommendations both for increasing practical social support of AAALs and for further research on this topic.

Chapter 2: Literature Review

Introduction

This chapter highlights the extent of the suicide problem in the United States. I describe social support theory, factors contributing to suicide, suicide rates among gay and lesbian youth, and perceptions and psychological factors specific to African-American women. By conducting a review of the literature regarding African-American adolescent lesbians (AAALs) and their experiences, I was able to enhance my own knowledge and understanding as researcher and professional counselor with respect to suicidal ideation. A practical result of conducting this research was a greater familiarity with research methods and the results of previous studies. This review of the literature may also serve to help other researchers gain an overview of how much is known about the topic and what areas are in need of more study.

Literature Search Strategies

In the literature search, I used two sources of information: library databases and relevant websites. First, I had to define terms that were relevant to my study. I searched for publications that focused on the relationship between AAALs and suicidal ideation, and I was concerned with both the process and context of this relationship. In regard to process, I was searching for identifiable indications of the connection between AAALs and suicidal ideation. The context was rather broad and pertained to AAALs in general. Notably, my search for studies that directly addressed suicidal ideation among AAALs yielded few results. Thus, I had to expand the search to identify material that could be linked to the focal point of this study. Key words I used included *suicidal ideation*,

suicide, *lesbian,* and *African-American lesbians*. In regard to context, I included the search terms *lesbians, gays,* and *bisexual* to circumvent literature that focused on suicidal ideation linked to factors that were not directly related to sexual orientation such as poverty or AIDS. I occasionally had to modify the search terms to accommodate the idiosyncrasies of different databases.

I anticipated the scarcity of relevant literature both locally and internationally. However, upon searching the available websites and databases, I was able to locate a variety of articles published on the websites and in peer-reviewed journals. Upon perusing the abstracts of selected publications, I found a number of studies relevant to this research. This literature review includes studies that were published outside the preferred timeline of the most recent 5 years because some older works were highly relevant and uniquely informative about the topic under study. After reviewing the abstracts, I examined the associated documents and included the most relevant publications in this review. Additionally, I examined the lists of references and bibliographies provided in these and other documents in search of additional relevant sources.

Relation to Previous Studies

Chae and Boyle (2013) noted that persons exposed to stressful situations are likely to suffer a range of cognitive deteriorations such as having their reaction time heightened by up to 400% or developing irrational behavior repression. To understand the experiences of AAALs, it is helpful to identify the experiences of others who undergo similarly stressful experiences. Police officers are one such population because they are

exposed to stress from organizational sources (e.g., lacking the supervisor's support, overtime as shift work) and operational sources (e.g., exposure to violence and unpredictability; Chae and Boyle, 2013). Furthermore, the nature of their work is such that they are suspicious of outsiders and have to project courage, which hinders them in seeking assistance when experiencing stress. Thus, the prolonged and exacerbated symptoms can reach a level that takes a large psychological and physiological toll on the police officer (Lanterman et al., 2010).

In covering the subject stress in police officers, Chae and Boyle (2013) identified two types of stressors that officers are faced with: organizational/functional stress, and operational stress. While functional stress relates to the physical and emotional responses that individuals have to differing kinds of pressures arising in their workplace, operational stress may result from experiences that are "critical incident experiences in policing which include the violent and dangerous nature of some aspects of the police work" (p. 93). Similarly, Lanterman et al. (2010) argued that being exposed to violence and trauma is a cause of stress for law enforcement officers. These stressors may result from shooting a person in the line of duty, involvement in high-risk drug raids, or chasing after an armed suspect. Violanti et al. (2006) and Swatt et al. (2007) suggested that exposure to high-risk events can lead to PTSD as well as increased alcohol consumption and substance abuse. In addition, exposure to critical events could lead to suicide ideation (Violanti et al., 2006). Violanti (2004) reported that alcohol use and posttraumatic stress symptoms increased the risk of suicidal ideation. According to Chae and Boyle (2013), some of the symptoms of traumatic stress include flash-backs that lead to the officer's re-

experiencing the initial event, emotional numbing, avoiding activities deemed traumatic, and increased anxiety. These experiences have similarities to those of AAALs when relating to society at large.

African students are another group of people who have been identified as having experienced quite similar societal aversion. Maia et al. (2007) carried out a study on African students to find out to what extent frequent exposure to violence and trauma might lead to suicidal ideation. This study found that most African students were exposed to more violence and trauma as compared to Caucasian students, thus providing essential information for understanding the case of suicidal ideation among AAALs. Maia et al. found that 25 young men demonstrated posttraumatic stress while 14 of them satisfied the criteria for full PTSD diagnosis. A regression analysis of the results obtained in the study showed that those persons with PTSD were 7 times more likely to have suicidal ideation.

A striking aspect that emerged from my review of these studies was the centrality of PTSD in the experiences of these groups. PTSD is a traumatic disorder that stems from the exposure to severe trauma. According to Yuan et al. (2006), PTSD prevalence in police officers ranges from 7% to 19%. Maia et al. (2007) argued that police officers with PTSD have seriously impaired functioning and are at greater risk for medical consultations and a lifetime of suicide ideation. They are also more likely to get divorced. Maia et al. argued that not all traumatized individuals develop PTSD; the risk of developing this disorder is determined by the nature of the trauma itself and any preexisting vulnerability factor and, in most instances, the interplay between the two. Some of the vulnerability factors include uncontrollability of stressful events, deficient

support systems, “genetic susceptibility to general psychopathology or to specific psychological disorders, early adverse or traumatic experiences, personality characteristics such as neuroticism and introversion and recent life stress or life change” (Maia et al., 2007, p. 243).

These factors, observed among police officers, can be useful in understanding the experiences of AAALs. In instances in which the onset of danger cannot be predicted, law enforcement officers will view the environmental and situational characteristics as danger predictors in the future (Lanterman et al., 2010). This, according to Whealin et al. (2008), leads to greater generalized fear every time they confront a similar situation or environment and can lead to frequent or prolonged stress. Grillon et al. (2009) found a connection between predictability and PTSD. The authors believed that individuals who suffer PTSD are very sensitive to unpredictability; thus, if they are exposed to an unpredictable situation, PTSD symptoms are exacerbated.

Lanterman et al. (2010) asserted that stress in the workplace has a damaging impact on the cognitive functioning and emotional health of AAALs. Some of these cognitive and emotional deficiencies include PTSD, anxiety, withdrawal, avoidance, depression, and cynicism, among others. As a means of limiting the negatives that are likely to result from these deficiencies, a need arises to establish early mechanisms that fit each category of victims (Marmar et al., 2006).

Suicide Rates Amongst Gay and Lesbian Youth

Rosario et al. (2005) posited that suicide has been a critical health concern for LGBT youths because of the stigma and condemnation that society attaches to

homosexuality. Thus, it comes as no surprise that many LGBT youths have considered or even attempted suicide because they have not yet, at their young age, developed adequate coping strategies to hold up under this stigmatization.

Suicide was the second most common cause of death of young people, aged 15-19 years, in the United States in the mid-1980s. Furthermore, the suicide rate among young people rose 300% during the 1960s and 1970s, with nearly 5,000 American adolescents or young adults, aged 15-24 years, committing suicide each year during this period (Lindop, 2001). Among youths in general, and African-American youths in particular, the burden of chronic stressors is great and tends to be linked to their cultural, social, and structural positions within U.S. society. Neighborhood disorder, poverty, racial discrimination, and community violence pervade their background. On top of these chronic stressors are other normal developmental trials that youths must face and that can, at times, overwhelm them. With limited life experience to draw upon and their cognitive abilities still in the process of developing, these minority youths are particularly vulnerable (Copeland-Linder et al., 2011).

For African Americans, youth suicide has been increasing; Day-Vines (2007) observed that the African-American suicide rate increased exponentially over the intervening 2 decades. LeVasseur, Kelvin, and Grosskopf (2013) noted more recently that suicide was the third leading cause of death among 12-to-19-year-olds nationally. Even though African-American youths recorded the lowest suicide rate among all racial groups, concerns have arisen regarding the exponential increase that they have been experiencing while the rates among other racial groups were decreasing. Comparing by

race, the suicide rate among Caucasian males exceeded that of African-American males by 157%, while the gap had decreased to 42% by 1995 (Day-Vines, 2007). Although the risk factors and reasons for suicide among youths have been investigated in general, less research has been devoted to the risk among gay and lesbian youths.

Mustanski, Garofalo, and Emerson (2010) acknowledged that the mental health disparities between LGBT and heterosexual persons may be explained with the minority stress theory, which advances that internal and external manifestation of victimization, prejudice, and social stigma tend to underlie these health differences. In line with this theory, LGBT persons from racial minorities tend to have more mental disorders due to discrimination and prejudice based on race, coupled with discrimination and prejudice from their respective racial communities based on sexual orientation. Exacerbation of the situation for AAALs, as Mustanski et al. observed, derives from the complication that racial minority communities have been found to harbor more negative attitudes toward homosexuality than the Caucasian population.

In their study on the prevalence of DSM-IV mental disorders among African Americans and Latinos, Meyer, Dietrich, and Schwartz (2008) suggested that African Americans and Latinos did not experience more mental disorders when compared to Caucasians. However, in comparison to Caucasians, a higher number of African-American and Latino LGBT persons reported a history of serious suicide attempts. Notable in the observations of Meyer et al. is the finding that a higher risk for suicide is not linked to a higher risk for mental disorders, and it is crucial that the outcomes be distinguished.

An interesting observation by Meyer et al. (2008) deals with the finding reported in many studies that younger LGBT persons are experiencing fewer mood disorders in comparison to older LGBT persons. The authors explained these contrasting results between younger and older LGBT persons also on the basis of the social stress theory, which predicted that the liberalization witnessed with respect to social attitudes toward homosexuality over the last few decades will progressively lower the stress levels and associated disorders among LGBT persons.

The topic of suicide among LGBT youths continues to receive a great deal of media attention, especially when suicides of those aged between 15 and 24 years dominate the news. The attention toward the increased risks to which LGBT youths are vulnerable is replicated across various sampling methods such as representative surveys at community and national levels. Relying on data collected from students coming from 297 schools across 34 counties, Hatzenbuehler (2011) found that LGBT respondents have a significantly higher chance of having attempted suicide over the previous 12 months in comparison with heterosexuals. The author observed that nearly 20% of lesbian and gay youth had at least one encounter with attempted suicide in comparison with the 4% reported by their heterosexual counterparts.

In their Reach for Health study on the resiliency factors influencing African-American and Latino teens who reported suicidal thoughts or suicide attempts, O'Donnell, O'Donnell, Wardlaw, and Stueve (2004) observed that these adolescents also reported having limited contact with adults in their lives. The study revealed that, when the adolescents were in their most vulnerable state, no adults were there to recognize their

condition or provide assistance. If adults were around, they failed to be alert enough to notice the teen's condition and step up to intervene for the teen's sake. The authors identified risk factors affiliated with suicidal thoughts as follows: being female; limited, unmet basic needs; same-gender sex; and depression. Family closeness was cited as a strong resiliency factor. The data were obtained from 879 students in Grade 11 from three neighborhoods in Brooklyn, NY, who participated in the Reach for Health study. The students self-completed a paper-and-pencil survey, either alone or in small groups, that asked them to assess suicidal behaviors. This entailed questions regarding adolescent suicide, number of suicide attempts, desire to actually kill themselves, whether they talked about their suicidal thoughts with anyone, and whether they had an actual plan to commit suicide. Fifteen percent of the students reported that they had seriously considered suicide in the past year, 13% had a plan to end their lives, and 11% had attempted suicide at least once. O'Donnell et al. (2004) disclosed that many of these adolescents were more vulnerable than others. Latino females were reported as being twice as likely to tell someone of an attempt during the preceding year, and adolescents having sex with same-sex partners were 2.5 times more likely to consider or attempt suicide.

These adolescents felt better when discussing these problems with their friends and relatives rather than with psychologists or a teacher. Although suicide rates remained stable in the United States between 1980 and 1995, the rate during the same period more than doubled among African-American youths. The study was supported by the Centers for Disease Control and Prevention and the National Institute of Child Health and Human

Development (O'Donnell et al., 2004). Predictors and correlates for suicidal behaviors for some African-American and Latino youths have been gender, same-gender sexual behavior, depression, limited levels of attachment with family/school, and limited social support (U.S. Department of Health and Human Services [DHSS], 1999, 2012).

Walden (1996) found that the rates of suicide among African-American women were lower than those for other demographic groups. The main focus of the Walden study was to identify certain factors that contributed to protecting African-American women from committing suicide. Quality of support, family support, perceived importance to others, child-rearing responsibilities, and religious membership were five factors that the study identified. Also, seven risk variables were discussed and included: depression, substance abuse, financial stress, academic stress, hopelessness, exposure to violence, and exposure to suicide. The researcher used the Beck Hopelessness Scale (BHS), which stressed decreased rates of suicide. Responses were compared from several survey instruments administered to African-American and Caucasian college women. The survey instruments were the BHS, the Center for Epidemiologic Studies Depression Scale, the Edward's Social Desirability Scale, and the College Stress Questionnaire. These surveys were formulated for this study to measure factors related to suicidal behavior and ideation. The author used a structural equation model to test the fit of a model hypothesized to determine suicide ideation. No model using both African-American and Caucasian women could account for suicide in both groups. However, for the African-American women, religion, family support, quality of support, and self-

importance were factors that insulated this group from suicidal behaviors (Walden, 1996).

Theories of Social Support

Social support is a complex metaconstruct, involving interaction of several terms such as *supportive behavior*, *supportive network resources*, and *subjective appraisal of support*. Efforts to distinguish the different kinds of supportive behavior bring the aspects of instrumental support and emotional support into focus. In the case of instrumental support, the focus is on those behaviors that can be relied upon to develop coping mechanisms and effort. Emotional support, on the other hand, entails behaviors that are able to communicate to a person that they are loved and cared for by others (Smith & Anderson, 2000). For Rosenbaum et al. (2007), emotional support was possible when there was close and intimate contact, whereas social-support resources were activated and proved helpful by enabling people to cope with the negative symptoms resulting from stress and loneliness. Even though scholars have identified various kinds of support resources, Rosenbaum et al. considered the essential element to include emotional support, companionship, and instrumental support.

Rosenbaum et al. (2007) argued that social loneliness tends to arise from an individual's perception that she lacks companionship. Those who are caught up in situations that destroy their friendships are likely to be socially isolated and experiencing aimlessness, boredom, and feelings of marginality. That is why Rosenbaum et al. linked social support with verbal and nonverbal communication that facilitates exchanges, thus

reducing a person's uncertainty, raising his or her self-esteem, and enhancing feelings of connection to others.

According to Cho and Haslam (2010), acculturative and general life stresses are likely to lead to psychological symptoms, distress, and suicidal ideation among vulnerable persons, but social support is an important protective factor. Social support was, therefore, approached as a preeminent contributor to resilience against psychological and physical ill health (Cho & Haslam, 2010).

People in a community need social support because it gives them confidence and encourages them to make positive changes (House & Landis, 2003). Social support simply means engaging in social or peer interactions that allow individuals to deal with their internal and external stress (House & Landis, 2003). It is widely believed that social support reduces an individual's internal and external stress and, in this way, makes him or her more capable of coping when faced with the stressors.

A social-support network comprises the people from whom an individual can reasonably expect to receive help in times of need (House & Landis, 2003). Social support has emotional, practical, and informative dimensions. Data from long-term prospective studies suggested that the lack of social relationships constitutes a major risk factor for mortality (House & Landis, 2003).

Social support may serve as a key psychosocial protective factor in providing resilience in the context of stress, thus reducing vulnerability for a variety of negative health outcomes (Compton et al., 2005). Resources in the areas of social networks and social support , at both individual and community levels, may have direct health-

enhancing effects and may diminish the negative effects of stressors (Compton et al., 2005). Having someone to provide help or emotional support may be a protective factor in the face of negative consequences of illness or stressful situations such as suicide. Social support is a subjective and personal experience, and the perception of social support may be as important as the actual support received (Compton et al., 2005).

Adams and Kimmel (1997) reported that African Americans tended to exhibited a stronger negative perceptions regarding homosexuality. Several reasons have been cited as causing this heightened homophobia among African Americans, with the Black Church emerging as the most quoted reason (Bonilla & Porter, 1990). However, some researchers have discredited the existence of such a relationship (Seltzer, 1992). According to Harper (1991), the African-American cultural nationalism of the 1960s was instrumental in fostering this attitude. Another source of homophobia in African-American America has been heterosexual African-American women (Ernst, 1991). Cochran and Mays (1994) stated that, according to theory, heterosexual women see gay, lesbian, and transgender population as exacerbating the shortage of African-American men. Caucasian gays and lesbians are not as fearful, when compared to educated African Americans, regarding sexual orientation (Chug & Moore, 1991). Because of the homophobia in the African-American community, African-American adolescents often do not get the support they need from the adults in their families, their friends, and their neighbors. This unjustified homophobic fear has made many in the African-American community afraid to even mention the words *lesbian* or *gay* (Cochran & Mays, 1994).

A study of 212 African-American high school students helped researchers to determine if hopelessness and depression could be associated with suicidal thoughts (Molock, Puri, Matlin, & Barksdale, 2006). The researchers aimed to determine whether religious affiliation or religious coping could prevent the participants from committing suicide. Molock, Puri, Matlin, and Barksdale (2006) utilized multiple and logistic regression analysis, and results indicated that risk factors for suicidal ideation and suicide attempts were linked to hopelessness and depression. The findings also indicated the need for additional support in formulating intervention programs for suicide because hopelessness and depressive symptoms were significantly related to suicidal behaviors.

LGBT youth may not have access to information about their sexuality. At a time of life when conformity and acceptance are highly valued, they may try to conceal their sexuality from their family and friends to avoid rejection. In addition, they may already have internalized a negative self-image and may find it difficult to accept themselves (Rivers, 2001).

Compton, Thompson, and Kaslow (2005) focused on two important dimensions of the social environment: family relationships and social support. Data were obtained from a case-control study of 200 African-American men and women, aged 18-64 years, who sought services at a large urban public hospital. This case-control study was an incidence-density-type study, and the odds ratios derived from the logistic regression model estimated the relative rate ratio of suicide attempts between the various exposure levels. The BDI was utilized, and the Pearson correlation coefficients for total BDI-II scores and family adaptability, family cohesion, social embeddedness, and social support

were found to be -0.34, -0.46, -0.44, and -0.49, respectively. The Family Adaptability and Cohesion Evaluation Scale is a 30-item self-report questionnaire that makes reference to one's family of origin. Respondents reply according to a 5-point Likert scale that ranges from 1 = *almost never* to 5 = *almost always*. The Social Embeddedness Scale is a 10-item scale that assesses social embeddedness, including the extent and closeness of the respondent's social network and degree of satisfaction with the support provided by that social network. The Medical Outcomes Study Social Support Survey consists of 19 short items that measure perceived emotional and physical elements of social support (Compton et al., 2005).

A mediating role of depression was discovered by Compton et al. (2005) when they entered depressive symptoms into the logistic regression models. The researchers hypothesized that, compared to the nonattempters (controls), the African-American suicide attempters in the study would report lower levels of family cohesion and family adaptability, as well as lower levels of social embeddedness and social support. Furthermore, they hypothesized that even after controlling for significant demographic and social factors, the social environment variables would be associated with outcome status, which were suicide attempters versus nonattempters. The researchers also explored the association between these social-environment variables and suicide attempt while considering an important person-level variable, namely, depressive symptoms. They predicted that depressive symptoms would be another independent strong risk factor for suicide attempt.

Compton et al. (2005) concluded that social-environment factors, including deficits in family functioning and social support , were strongly associated with suicide attempts among the low-income African-American men and women in the study who were seeking treatment in a large urban hospital. Thus, better family functioning and social support can be considered protective factors in this population. The presence of depressive symptoms, a well-known risk factor for suicide attempt and suicide, appears to mediate the association between social-environment factors and suicide attempts. The findings suggested that more positive adult support would result in an increase of self-confidence and comfort with their sexuality/sexual orientation and a decrease in suicidal thoughts in these African-American suicide attempters. Compton et al. asserted that more positive adult support for AAALs may positively impact their social identity and negatively correlate with suicidality.

Factors Contributing to AAAL Suicide

Rosario, Schrimshaw, and Hunter (2004) completed a longitudinal report on 145 (LGBT) adolescents, describing ethnic and racial differences in the coming-out process. Sexual developmental milestones, sexual orientation, sexual behavior, and sexual identity presented with no pertinent differences. The researchers noted that the African-American adolescent population engaged in gay-related activities indicated limited comfort with others' being aware of their lifestyle and did not tell many individuals about their homosexuality. Caucasian adolescents, by contrast, told others more often. Latino teens behaved similar to the African-American youths in that they disclosed their orientation to fewer individuals than did Caucasians. Analysis of changes occurring in this area showed

that the African-American youths experienced a greater increase of positive attitudes toward homosexuality and their own sexual identity over the years than did Caucasian adolescents (Rosario et al., 2004). These findings supported the coming-out process, which is something all members of the LGBT and questioning community must face.

The coming-out process is different for each individual because it is a personal decision. The individual has to consider many people and situations when deciding to come out. These considerations include family, culture, race, ethnicity, religion, gender, age, political affiliation, and military experience. In additions to these factors, the lesbian and gay population must consider the community and their living, educational, and work environments, as well as many other aspects affecting an individual's life. These groups and communities might have exposed themselves as hating lesbians and gays in other settings. It would be very difficult to come out to family members who have previously made hateful remarks. Some gays and lesbians may have witnessed others being harassed when coming out or even while they themselves were growing up (Miller & Glinski, 2002).

Much discussion has surfaced, and numerous theoretical examples or models have emerged as a result of the coming-out process of LGBT individuals. This process is inclusive of identifying one's self, which involves the unfolding of one's sexual orientation. The individual begins to question whether he or she may be gay, lesbian, or bisexual. This individual also begins to explore the emerging LGBT personality by becoming involved in gay-related social and sexual activities (Rosario et al., 2006).

African-American lesbians, as well as other lesbians of color, face specific challenges attributable to culture that other lesbians do not have to face. African Americans, historically, have had to fight just to prove that they are people of equal ability. The Black Church was the saving grace during slavery, and many African Americans held on to their sanity during hard times through the church community and the cultural practices of African-American religious institutions. However, in conservative African-American churches, homosexuality is commonly viewed as evil or the work of the devil (Asanti, 1998).

Civil rights organizations and other social-support groups for African Americans sometimes ostracize gays and lesbians or discourage their membership completely. Leaders of such groups might be openly homophobic because African-American gay, lesbian, and transgender populations are often perceived as a threat to African-American empowerment. African-American lesbians are different in sexual orientation and represent a threat to the place African Americans hold in the perception of mainstream Caucasian society. Neither assumption is based on fact. This type of thinking can be instilled in African-American children from a young age and make them terrified of feelings of attraction to someone of the same sex. They may later suffer from internalized homophobia or fear and hatred of their own or others' romantic feelings toward someone of the same sex. It is important for African-American lesbians who have decided to come out to connect with people and groups that will support them in the process. It is equally important to become involved with groups that honor the rich culture and history of African Americans in general (Asanti, 1998).

Among African-American women, the association between self-efficacy and suicide attempt is partially accounted for by the mediating roles of perceived social support from family and friends (Compton et al., 2005). Gay and lesbian youths are at greater risk of attempted suicide than heterosexual youths. This risk could reflect a cultural norm because African Americans involved in a homosexual lifestyle are less likely than Caucasians to disclose their sexual orientation to family and friends (Stokes & Peterson, 1998). Family members who become aware of an adolescent's homosexuality need special attention. Because of cultural stigmatization, family members often want to ensure that their child does not become homosexual. Family members must learn to cope with the stigma of having a homosexual family member.

It is crucial to recognize that families go through their own process of coming out, and that the family's new identity needs to be integrated just as much as the adolescent's. The difficulties are very similar to those faced by the adolescents themselves: uncertainty, ambiguity, cultural stigma, and fears about the future. Counselors can help family members only if their own attitude toward homosexuality is positive and consistent with current scientific knowledge regarding homosexuality as a normal variation of sexual expression (Coleman & Remafedi, 1989).

Individuals are defined as homosexual if they engage in sexual activity with partners of the same sex. Weinberg (1972) coined the term *homophobia* to describe hatred, intolerance, and fear of LGBT individuals. Homophobia has been mentioned as the fear of the emotion of love for members of one's own sex, as well as the hatred of those emotions in others. Personal homophobia has been discussed as the individuals'

internalizing the values of mainstream society as they grow up. In this homophobic, discriminatory society, one may have been taught about negative characteristics of homosexuality. As with many in society who disapprove of same-sex activity, gay and lesbian youths may also have been socialized into thinking that engaging in same-sex activities is wrong or evil. This may progress to emotions of self-disgust and self-hatred (Oquendo, Ellis, Greenwald, & Mann, 2001). Interpersonal homophobia refers to behavior between individuals. Hatred may be expressed through jokes, name calling, or even physical violence. Families often pressure their members to conform to the beliefs deemed acceptable to the society at large (Oquendo et al., 2001).

Beliefs that fall outside the norm of those espoused by mainstream society are often not accepted. People who engage in same-sex relationships may find that they lose friends. Cultural homophobia refers to the norms and social values that portray relationships between men and a woman as superior to same-sex relationships. For example, mainstream films very seldom feature characters in a same-sex relationship. Social and economic facilities promote heterosexuality as the norm and reject homosexuality. For instance, in terms of inheritance laws, the American legal system provides protection to heterosexual couples, but had not come up with the laws to protect homosexual couples until the recent Supreme court decision, a fact that indicated the institutionalized homophobia of American society (Oquendo et al., 2001).

Psychological Factors of African-American Women

African-American women have a unique history in this country, having been introduced to society as slaves. As females in a sexist society and African Americans in a

racist society, they are subject to dual discrimination. Role conflicts between personal developmental needs and family survival needs often result in guilt and depression in African-American women. Discrimination, prejudice, racism, and a legacy of slavery continue to influence the 21st-century status of African-American women, who remain economically, socially, and politically deprived (Carrington, 2006).

A study by Bowleg, Craig, and Burkholder (2004) tested a conceptual model of active coping among a predominantly middle-class sample of 92 African-American lesbians, aged 18-68 years, who were attending an African-American lesbian retreat. An active coping dimension of psychological competence and a psychosocial competence model for African Americans emphasizing the role of individual and environmental factors provided the theoretical framework for the study. A theoretical model was developed to determine if internal factors such as self-esteem and race and lesbian identification and external factors such as social support among lesbian, gay, bisexual persons can predict active coping. The findings confirmed that internal and external factors are a statistically significant predictor of active coping.

Balsam, Beauchaine, Mickey, and Rothblum (2005) asserted that a group of LGBT individuals who participated in a study revealed that they were not heterosexual. The authors reported that, once the participants had identified as not being heterosexual, they were instructed to recruit their sisters and brothers. The group results showed that 79% were heterosexual and 19% were LGBT. A comparison of the 533 heterosexuals, 558 lesbians or gay males, and 163 bisexuals was conducted and their need to receive mental health services was compared. Multilevel modeling analyses revealed that an

individual's sexual orientation predicted suicidal thoughts, suicide attempts, self-injurious behavior, use of psychotherapy, and use of psychiatric medications over and above the effects of the influence of the family. The result of this study showed that an individual's sexual preference was not related in any way to psychological distress, psychiatric hospitalization, or how well an individual thought of him- or herself. This was the first study of its kind.

African-American lesbians and gays are faced with challenges regarding not only their sexuality but also their race. Some seem to believe that they had to select the gay and the African-American minority communities. African-American and Caucasian communities can be homophobic. When homophobia manifests in the African-American community, many lose support from family and friends that would be important resources in developing a positive identity as well as in addressing daily racism. Before African-American lesbians and gays decide to disclose their sexuality to family and friends, they need to think carefully about the positive and negative reactions they are likely to receive; for example, their families may disown them (Rosario & Reid, 2001).

Historically, there has been a paucity of diagnostic and treatment studies on depression among African-American women. Research has suggested that the experience of racism, sexism, and poverty, which often leads to hopelessness and suicide, has increased the risk for depression among African-American women (Carrington, 2006). Historically, underdiagnosis, misdiagnosis, and undertreatment have been characteristic features in relation to meeting the mental health needs of African-American women who were experiencing psychiatric disorders. Notably, psychiatric diagnosis tends to be a

crucial process in treatment-decision making for those who seek mental health services, but this process has even greater significance when applied to African-American women. African-American women screened for depression in an urban hospital setting often present with multiple comorbidities of depression, including but not limited to PTSD, substance abuse disorders, and generalized anxiety disorders (Carrington, 2006).

The immediate and long-term effects of misdiagnosis and underdiagnosis of depression in African-American women may have implications for increased incidence and prevalence of psychiatric and medical disorders. Variations in reliability and validity of diagnostic methods and procedures can be and should be addressed in controlled clinical studies, especially studies whose populations are ethnically and culturally different from populations on which the assessment instruments were standardized. Moreover, multicultural assessments of instruments, applied procedures, and general cross-cultural sensitivity and ethics should be embraced by researchers and clinicians in the field of mental health (Carrington, 2006).

Historically, there has been great disparity in rates of reported suicides among African-American and Caucasian women. The inaccuracies of suicide determination in African-American women have been debated by researchers, perhaps because of the underreporting of suicide among African-American women by their local and state communities. Furthermore, other investigators have reported that suicide rates of African-American women are much higher than those previously reported. In the past, the gap in reported rates of suicide among African-American and Caucasian women had decreased, but because of the high rates of suicide among African-American youths today, the gap

has actually increased. Suicide rates among African-American youths between the ages of 10 and 14 years has increased by 233% between 1980 and 1995, compared to 120% for Caucasian youths during the same time span. Increasing rates of suicide in this population should continue to alert mental health professionals to the need for accuracy in diagnosing African-American women in general with depression and with other mental health disorders as well (Carrington, 2006).

Risk Factors for Suicide

Rudd (2002) asserted that the prospect of realizing that one is gay or lesbian can be so frightening that denial of one's sexual orientation may result in low self-esteem and poor self-acceptance. The author reported on the experiences of a sample of adolescents who were the victims of violent physical assaults resulting from their sexual orientation; they experienced frequent suicidal ideation. Specifically, Rudd found that 40% of a small sample ($N = 50$) had experienced violent assaults, of which 61% were committed by family members. In addition, 44% of those who had experienced violence also reported suicidal ideation.

Savin-Williams (2002) suggested that other stressors that may be accentuated in gay and lesbian adolescents included being homeless, which is often the result of coming out to their family members, and sexual abuse. The researcher found that 10% of adolescents who told their fathers about their sexual orientation were forced to leave home. Savin-Williams reported that, because these adolescents have no shelter, they become homeless and often turn to prostitution to support themselves. The researcher cited two studies on the rate of homelessness among gay and lesbian adolescents: 40% of

homeless adolescents in Seattle and 30% of homeless adolescents in Los Angeles identified as gay or lesbian. Robins (2001, p. 29) reported that 82% of gay and lesbian youths had been verbally abused, and 60% reported being physically attacked during their time at school. In the same study, 53% of the participants who had been bullied reported that they had contemplated self-harm or suicide as a result of the violence experienced. Also, the data suggested that lesbian and gay youths are up to 6 times more likely to attempt suicide than heterosexual youths, with the highest rates of suicide occurring among those who are isolated from support.

Psychological Autopsy

The psychological autopsy is performed by eliciting information from others about a deceased person during the weeks following the death to understand the psychological events that contributed to the person's death. Key elements of a psychological autopsy are face-to-face interviews with informants who are familiar with the deceased's behaviors, thoughts, and feelings; a thorough review of the deceased's clinical records; and a case formulation by a mental health professional who is an expert in death studies. This method remains a highly valuable approach to unraveling the phenomenon of suicide among various ethnic and racial groups, their diverse cultural practices, and the contextual issues that impact their lives. It allows researchers to gain a clearer understanding of suicide among African Americans. Many suicides are unexpected because the individuals who are planning to kill themselves can effectively dissemble or mask their intentions. By dissembling, they can keep the secret about suicide, live clandestinely, and function through masks and false personae. They are able

to live parallel lives to those of other people in a separate world (Gary, Yarandi, & Scruggs, 2003).

Conclusions Drawn Based on the Literature

Social support buffers the severity of stressful experiences and serves as an aid to coping with internal suicidal thoughts. A lack of social support from friends and family has been associated with higher mortality and psychiatric problems. Social support can facilitate coping by strengthening people's ability realistically to appraise stressful events and develop alternative coping strategies. Thus, the environment becomes less threatening to the African-American women's sense of purpose, worth, and adequacy. Social support influences coping ability by altering relationships among stressors, individual perceptions, and coping responses. Social support explains how the opinions and actions of others help individuals to engage in a cognitive relabeling process regarding stressful circumstances, and supportive relationships provide appraisal support or help in redefining role and behavioral expectations (Pearson, 1986).

Stress, loneliness, a sense of not belonging, school failure, rejection, being different, and being excluded from the group are major reasons for depression and suicide. Although millions of African Americans manage not only to survive but to thrive, too many become casualties. Over time, feelings of hopelessness can occur, leading to thoughts of suicide. The individual comes to view suicide as a preferable option to what they experience as untenable circumstances (Gary et al., 2003).

Lesbians can become afflicted by mental health problems just as other women so often are. However, due to their sexual orientation, they face unique mental health

concerns with the uniqueness resulting from the cultural and societal homophobia so prevalent in most heterosexual communities. Upon being internalized, the phobia can result in emotional distress or depression, which explains the higher average number of LGBT persons trying to kill themselves. This situation is exacerbated by the fact that LGBT persons are in conflict with their community's ideals in addition to being in conflict with family and friends, which increases the risk of suicide even more. Suicide among AAALs is an attempt to tackle, or escape, the fear from within. Yet, what becomes evident from the study of causes of suicidal ideation is the fact that people who are close to AAALs can provide the support that could buffer and protect the victim against depression and, ultimately, suicide (Kornstein & Clayton, 2013).

Summary

This chapter included a review of pertinent literature. I discussed studies on suicide in the United States, social support theory, factors contributing to suicide, suicide rates among gay and lesbian youth, and psychological factors of African-American women and their perceptions. In Chapter 3, I describe the research methods used in this study, including research design and approach, sample and sample selection, instrumentation, data collection and data analysis procedures, and ethical considerations and the protection of the participants' rights.

Chapter 3: Research Method

Introduction

This chapter provides a description of the study design and a rationale for its use. I describe characteristics of the sample, sample selection, and sample size and discuss the collection process, instrumentation, and data analysis procedures. Finally, I explain ethical consideration and the measures I took to protect the participants' rights and anonymity.

Purpose of the Study

The purpose of this study was to examine the relationship between suicidal ideation in African-American AAALs and levels of adult social support. Poor family relations, lack of a social-support network, low levels of social support, and hopelessness are risk factors for suicide attempts by African-American women (Compton et al., 2005), but no formal study of the influence of family and social support on suicidality of AAALs has yet been undertaken. This study is intended as a step toward closing a gap in the professional literature with the hope of promoting a better understanding of the vital importance of social support for AAALs in order to combat the alarming rise in suicides among this population.

Research Design and Approach

This quantitative study was nonexperimental and correlational in design. The sample consisted of 200 African-American girls and young women, aged 13-19 years, who self-identified as lesbians. Parental consent was required for all participants under the age of 18 years, with parents expressing their support and interest and ensuring that

the child met all of the criteria before participating in the study. The parental consent form (see Appendix A) mandated that any minor interested in the study provide the researcher with phone or mail contact information for her legal guardian. As the researcher, I discussed the study with the parents or guardians in full detail to obtain their informed consent later by mail or in person.

Demographic information was collected on urban, suburban, or rural residences; race; religious affiliation; and type of household of origin (see Appendix B). The volunteer participants were recruited through advertisements in gay publications, the National Women's Football Association, the Atlanta Gay Pride Parade, social-support groups for lesbians, and youth drop-in centers, and also through referrals from peers. I advertized the project as a study of health. The participants completed the Beck Scale for Suicide Ideation (BSS; see Appendix C), which measures current suicidal intent by scaling various dimensions of self-destructive thoughts and wishes. I also administered three other instruments: The current level of hopelessness was measured with the Beck Hopelessness Scale (BHS; see Appendix D); personal attitudes toward homosexuality were assessed with the Homosexuality Attitude Scale (HAS; see Appendix E); and to measure levels of social support, I used the Duke Social Support and Stress Scale (DUSOCS; see Appendix F).

The participants gave verbal and written consent to follow the study procedures; their participation was voluntary and confidential. I designed this study to determine the relationship between adult social support and suicide attempts or suicidal ideation by AAALs. I analyzed the data collected using SPSS-20 and descriptive statistics, ANOVA,

and correlation and regression analyses, which I discuss in greater detail in Chapters 4 and 5.

Participants

The sample consisted of 200 female middle and high school students from urban, suburban, and rural areas in and around Atlanta, Georgia. Participants targeted were African-American girls and young women who self-identified as LGBT or as being attracted to persons of the same sex. The recruitment was completed over a 3-month period through various methods ranging from e-mail advertisements to flyers and cards distributed in LGBT-identified residences and neighborhoods. Getting the target population to respond to the invitation for an interview without offering an incentive was likely to be a difficult undertaking. That is why I adopted peer recruitment as a form of incentive. I provided interested prospective participants with cards that contained my contact information as the researcher and asked them to encourage their friends to contact me for more information. All participants provided voluntary and signed consent. For those under the age of 18 years, I obtained written parental consent. Due to the nature of the study, some interested persons had to be excluded because of difficulties in securing parental consent. Participants were selected with the following criteria: They had to be (a) African-American and female; (b) self-identified lesbians; and (c) adolescents with parental consent to participate in the study.

Procedures

Informed Consent

The informed consent form includes background information about the study, requirements for participation, a discussion of confidentiality, the voluntary nature of the study, and ethical concerns (see Appendix A). I provided an e-mail address and phone number so that potential participants could contact me for additional information regarding the study or their participation if they had any unanswered questions.

The adolescents who expressed an interest in voluntarily participating in the study were given a packet with four surveys: the BSS, BHS, HAS, and the DUSOCS to determine if there is a positive relationship between perceived adult social support for AAALs and their social identity. I also included an instruction sheet for completing all enclosed forms and a completion date for mailing all information back to me. A self-addressed stamped envelope was provided in the study packet so that all completed information could be mailed directly to me. I debriefed each client after the surveys had been returned.

Participants who wanted to receive the results of the study could check a box on the consent form, so that I could share the results with them upon completion of the study. The results would be disseminated through individual mailboxes in the same manner that the study was introduced and the surveys were administered.

Demographics

I used a brief demographics questionnaire to collect data regarding sexual orientation, gender, age, and ethnicity of the participants (see Appendix B). The

demographics questionnaire was also used to collect information regarding the participant's household while growing up (i.e., raised by two parents, a single parent, stepparent, grandparent, other family member, or adoptive parents).

Instrumentation

Beck Scale for Suicide Ideation (BSS)

The BSS (see Appendix C) is a self-report instrument designed to help clinicians assess the existence and intensity of suicidal ideation in adolescents and adults (Beck, Kovacs, & Weissman, 1979). Each item comprises three statements, graded in intensity from 0 to 2. A low total score classifies the participant as a suicidal ideator. The scale is divided into three parts: Part 1, consisting of five items, screens the individual's attitude toward life and death. Attitudes toward life and death include the desire to live, the desire to die, reasons for living or dying, actively having attempted suicide, and passively having attempted suicide. If the results indicate no contemplation of a suicide attempt, the individual is instructed to skip the second part (Items 6-19) and complete Part 3. Those whose results indicate a contemplation of suicide complete the entire instrument. Part 2 evaluates suicidal ideation and the individual's anticipated reactions to those thoughts. This part measures frequency, duration, and acceptance of suicide ideation; control over suicide ideation; and the deterrents to or reasons for suicide. The individual's anticipated reactions to the suicidal ideation include planning, opportunity, capacity, expectation, and actual preparation for committing suicide; suicide note and postsuicide arrangements; and deception about his or her suicide ideation. Part 3 identifies the number of previous

suicide attempts and the seriousness of intent to die during the last suicide attempt (Beck et al., 1979).

The BSS was standardized on participants who were receiving psychiatric services and were identified as suicide ideators. Reliability data were limited to the first 19 items on the BSS. The inpatient sample produced a coefficient α reliability estimate of .90, and the outpatient sample produced an α of .87, indicating high internal consistency for both samples. Test/retest stability was performed on 60 inpatients, and a correlation of .54 ($p < .01$) was found between tests administered 1 week apart, indicating moderate test/retest reliability. Concurrent validity was demonstrated through correlation of the BSS and SSI with $r = .90$ ($p < .01$) for an inpatient sample, and $r = .94$ ($p < .001$) for an outpatient sample. Additional concurrent validity was ascertained through an inpatient suicide-ideator sample on the Beck Depression Indicator (BDI) with .48 ($p < .01$), the BHS with .48 ($p < .001$), and previous suicide attempts .32 ($p < .01$). Beck et al. (1979) did not provide cut-off scores; instead, the authors directed the clinician to look at the total score and at each item's score for warning signs of suicide risk.

The BSS is used by researchers to qualify aspects of a person's intentions and ideations of self-harm. The first five items are useful for identifying suicidal ideation. All respondents answer Question 20, and anyone who has attempted suicide in the past is requested to rate Question 21. The seriousness of suicidal ideation is calculated by summing the ratings for the first 19 items. The total range starts with 0 and ends with 38. There is no definite end point; escalated scores suggest an increase in suicidal risk (Palmer & Connelly, 2005).

A sample of 119 female suicide attempters in Holden's (2005) study completed the BSS. Hypotheses regarding 1-, 2-, or 3-factor models failed to support common-factor analysis of the BSS; however, confirmatory principal-components analysis supported hypothesized one- and two-dimensional models. Motivation and preparation were identified as two suicidal ideation factors. Scores based on this two-dimensional model presented convergent validity with other suicide indices (Holden, 2005).

In a cross-sectional study by Friedman (1997), a sample of 120 stratified randomly selected 16-year-olds were assessed for suicidal ideation. The sample consisted of African Americans, Hispanics, and Caucasians, both male and female, who attended urban high schools. Information was obtained using the BHS, the BSS, the Family Crisis Oriented Personal Evaluation Scales, and the Hare Self-Esteem Scale. The female students reported more suicidal ideation than their male counterparts. There were no significant differences among ethnic groups. Of these adolescents, 10% had reported a suicide attempt, 4% admitted a suicide attempt at the time of reporting it to someone else, and 23% admitted suicidal ideation during preadolescence. The multivariate analysis included family, demographic, psychological, and behavioral characteristics to determine potential connections to the probability of admitted suicidal ideation. Self-esteem, substance use, and being female contributed to high numbers of admitted suicidal ideation (Friedman,1997).

Beck Hopelessness Scale (BHS)

The BHS (see Appendix D) is a tool for measuring negative attitudes among the study participants about the future. The tool comprises 20 items or questions. It helps to

determine the likelihood that a person will commit suicide. This instrument was conceptualized by Beck (1988), a social psychologist. The reliability (KR-20 coefficient, which is a measure of the scale's internal consistency) ranges from .82 to .93. Previous research indicated a statistically significant test/retest reliability of at least .66 (Beck, 1988). Regarding validity (concurrent validity), Beck examined the relationship between clinical ratings of hopelessness and BHS scores. The correlation between the BHS and the ratings for a sample of suicide attempters was .62; for a sample from the general population, it was .74 (Beck, 1988).

All of the items in this instrument were added together. The scoring template was useful as it enables one to count the number of blackened circles, using the template to get the total score and interpret the results. According to Beck (1988), the manual helps with the interpretation of the scores in that it contains cut-off guidelines. However, the author went one step further and emphasized that the cut-off scores should be based on clinical decisions rather than on reliance on the guidelines (Beck, 1988).

The BHS consists of 20 true/false statements that assess the extent of negative expectancies about the future. It is scored by adding the keyed responses of hopelessness for each of the 20 items. The possible range of scores extends from 0 to 20 (Steer, Kumar, & Beck, 1993). Johnson and McCutcheon (1981) and Topol and Reznikoff (1982) previously used the BHS with adolescents. The Kuder-Richardson-20 (KR-20) coefficient was .86; the higher the score, the more negative was the outlook for the future.

Homosexuality Attitude Scale (HAS)

The HAS was created by Kite and Deaux (1986) and used in the present research. The HAS is a 21-item Likert scale ranging from 1= *strongly agree* to 5 = *strongly disagree*, which evaluates a homosexual's stereotypes, misbeliefs, and anxieties. The internal consistency for this tool was excellent with an $\alpha > .92$. The test/retest reliability was good with $r = .71$. The HAS was reported reliable for the gay and lesbian population. In the present study, I was mostly concerned with the overall total score as an indication of the participants' attitudes toward their own sexuality and toward the homosexual and lesbian community.

Duke Social Support and Stress Scale (DUSOCS)

Perceived emotional support was measured using 12 items on social support from the DUSOCS. The social component consists of 12 items with three response options (*none, some, a lot*) and is scored on a scale from 0 to 100, with higher scores indicating greater social support. In this study, I sought to assess the participants' perceived emotional support, defined as the availability of people the individual trusts and, in this case, people whom the lesbian adolescent can rely on and who make her feel cared for and valued (Parkerson, 1999).

I obtained permission to use the DUSOCS in this study (see Appendix E). The DUSOCS was validated with 249 adult family-practice patients and the use of the Family Strengths, the Family Inventory of Life Events, and the Duke Health Profile (DUKE) as comparison instruments. The basis of its validity was established when the DUSOCS family-support measure had demonstrated clinically expected positive relationships with

the DUKE health measures (regression coefficients of +7.4 to +18.7) and negative associations with the DUKE anxiety and depression measures (-11.6 to -34.5), as well as positive associations with anxiety and depression (+18.9 to +32.1). Family and nonfamily stress contributed more than severity of illness to elevated levels of anxiety and depression and decreased levels of mental health, social health, and self-esteem, while family and nonfamily stress contributed only half as much as severity of illness to lowered physical health (Range, 2005).

The DUSOCS provides the participants with a packet that asks them to decide the extent to which each person or group of persons on a given list are supportive or stressful at this time in their lives. Each respondent receives a raw score for each check mark made. The scores are then calculated for the DUSOCS Family Support; the raw scores are summed for the six categories of family members under Section IA. If the special supportive person in Section IC is a family member, the raw scores are added for yes/2 to the sum of IA. If the person is not a family member, the test administrator will add the raw score for no/0, divide by 14, and multiply by 100 to obtain the Family Support Score on a scale from 0 to 100. Thereafter, the score for DUSOCS Non-Family Support is calculated. Here, the administrator divides by 10 and multiplies by 100 to obtain the Non-Family Support Scale on a scale from 0 to100. Next, the score for DUSOCS social support is calculated. Here, the administrator will sum the raw scores for Sections IA, IB, and IC; divide by 22; and multiply by 100 to obtain the social-support score on a scale from 0 to 100. For Social Stress, the DUSOCS Family Stress Score is obtained by summing the raw scores for the six categories, with 2 points for yes, dividing by 14, and

multiplying by 100 to obtain the Family Stress Score on a scale from 0 to 100. The DUSOCS Non-Family Stress Score is obtained by summing the raw scores for the four categories, dividing by 10, and multiplying by 100. The DUSOCS Social Stress Score is divided by 22 and multiplied by 100 to obtain the Social Stress Score on a scale from 0 to 100 (Duke University Medical Center, 2007).

When one has a variable generated from such a set of questions that returns a stable response, the variable is considered reliable. Cronbach's α is an index of reliability affiliated with the variation accounted for by the true score of the underlying construct. Construct is the hypothetical variable that is being measured. The α coefficient varies in value from 0 to 1 and can be utilized to address the reliability of factors extracted from dichotomous (i.e., questions with two possible answers) or multipoint (i.e., rating scale: 1 = *poor*, 5 = *excellent*) questionnaires or scales. The higher the score, the more reliable will be the generated scale (Hatcher, 1994). The reliability of the scale has been found to be internally consistent with a Cronbach's α ranging from .55 to .70 (Cronbach et al., 1991).

Data Analysis

With this research, I sought to determine if a relationship existed between adult social support and attitude towards homosexuality as the independent variables and suicidality in AAALs as the dependent variable. This nonexperimental, quantitative study used the BHS, BSS, HAS, and the DOSOCS as data collection instruments. A convenience sample of 200 self-identified AAALs, aged 13-19 years, completed the surveys addressing family issues, the social environment, and self-perception. The data

were cleaned, screened, and analyzed using the SPSS 20 version, where descriptive statistics, ANOVA, and correlation and regression analyses were conducted.

Data Management

Four sets of hypotheses were tested for statistical significance using correlation, regression analysis, and ANOVA.

Hypothesis 1

$H_0$1: There will be no relationship between the AAALs' perceived adult social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and the AAALs' hopelessness as measured with the Beck Hopelessness Scale (BHS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS).

H_a1: A significant relationship exists between the AAALs' perceived adult social support as measured with the DUSOCS and the AAALs' hopelessness as measured with BHS and attitude toward homosexuality as measured with the HAS.

Table 1 shows the data management steps for Hypothesis 1.

Table 1

Data Management Steps for Hypothesis 1

Instrument	Description	Questions Selected for Analysis
Beck Hopelessness Scale (BHS)	The BHS consists of 20 true/false statements that assess the extent of negative expectancies about the future. It is scored by adding the keyed responses of Hopelessness for each of the 20 items. The possible range of scores is 0 to 20. The KR-20 coefficient was .86. The higher the score, the more negative was the outlook for the future.	1. I might as well give up because there is nothing I can do about making things better for myself. 2. My future seems dark to me. 3. I just can't get the breaks, and there's no reasons I will in the future.
Homosexuality Attitude Scale (HAS)	The HAS was specifically formulated to be used with younger adolescents, including high school youth. The Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*, with comments such as "homosexuals are sick" and "homosexuals females are generally more masculine than other females" (Price, 1982, p. 473).	All questions were used
Duke Social Support and Stress Scale (DUSOCS)	The social-support component consists of 12 items with 3 response options (*none, some, a lot*). It is scored from 0 to 100, with higher scores indicating greater social support. For the purposes of this study, an assessment of perceived emotional support was sought, which is defined as the availability of people an individual trusts, whom the lesbian adolescent can rely on, and who makes her feel cared for and valued.	1. Family Support Scores 2. Non-Family-Support Scores

Note. KR-20 = Kuder-Richardson-20.

Hypothesis 2

$H_0$2: Perceived social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS) will not significantly predict whether someone should be classified as having suicidal ideation as measured with Beck Scale for Suicide Ideation (BSS).

H_a2: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predicted whether someone should be classified as having suicidal ideation as measured with the BSS.

Table 2 shows the data management steps for Hypothesis 2.

Table 2

Data Management Steps for Hypothesis 2

Instrument	Description	Questions Selected for Analysis
Beck Hopelessness Scale (BHS)	The BHS consists of 20 true/false statements that assess the extent of negative expectancies about the future. It is scored by adding the keyed responses of Hopelessness for each of the 20 items. The possible range of scores is 0 to 20. The KR-20 coefficient was .86. The higher the score, the more negative was the respondent's outlook toward the future.	1. I might as well give up because there is nothing I can do about making things better for myself. 2. My future seems dark to me. 3. I just can't get the breaks, and there's no reason I will in the future.
Beck Scale for Suicide Ideation (BSS)	The BSS is a self-report instrument designed to help clinicians assess the presence and severity of suicidal ideation in adolescents and adults.	1. I have no wish to live. 2. I have a moderate to strong wish to die. 3. I have a moderate to strong desire to kill myself. 4. I cannot keep myself from committing suicide. 5. I am sure that I shall make a suicide attempt.

Note. KR-20 = Kuder-Richardson-20.

Hypothesis 3

$H_0$3: Perceived social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS) will not significantly predict hopelessness as measured with the Beck Hopelessness Scale (BHS).

H_a3: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predicted hopelessness as measured with the BHS.

Table 3 shows the data management steps for Hypothesis 3.

Table 3

Data Management Steps for Hypothesis 3

Instrument	Description	Questions Selected for Analysis
Homosexuality Attitude Scale (HAS)	The Homosexuality Attitude Scale (HAS) was specifically formulated to be used for younger adolescents, including high school youths. The tool has internal consistency of $\alpha > .92$ and the test/retest reliability was good with $r = .71$. The Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*, with comments such as "homosexuals are sick" and "homo-sexual females are generally more masculine than other females" (Price, 1982, p. 473).	All questions were used

Hypothesis 4

$H_0$4: There will be no differences in the scores on the Homosexuality Attitude Scale (HAS) among participants with respect to educational level, type of household of origin, or religious affiliation.

H_a4: Significant differences existed in the scores on the HAS among participants with respect to educational level, type of household of origin, or religious affiliation.

Because scoring guidelines for each of the instruments were geared toward different approaches and intended for analyzing each instrument separately and in its entirety (i.e., unrelated to any other instrument), comparisons of the modified scores required interpretation on a case-by-case basis to ensure that the findings were consistent with the context in which the questions had been asked and reflective of the participants' intended meaning. For example, while 96.1% of the respondents reported favorable views toward homosexuality in general and only 4% reported a moderate to strong desire to kill themselves, more than half (56.45%) reported some level of negative response (or hopelessness) on the BHS, and almost two thirds (61.5%) indicated that they received important support from their families and social networks. A summary of the reliability and validity of each of the instruments used in this study is set forth in Table 4.

Table 4

Respective Reliabilities and Validities of the BHS, the BSS, the HAS, and the DUSOCS

Author	Instrument	Reliability
Beck, A. T. (1988)	Beck Hopelessness Scale (BHS)	Reliability ranges from .82 to 0 .93. Previous research indicated a statistically significant test/retest reliability of at least 0.66. The correlation between the BHS and the ratings for a sample of suicide attempters was 0.62, and 0.74 for a sample from the general population.
Beck and Steer (1991)	Beck Scale for Suicide Ideation (BSS)	No published data are available concerning reliability and validity.
Kite and Deaux. (1986)	Homosexuality Attitude Scale (HAS), later modified to MATHS	The internal consistency for this tool was excellent with an $\alpha > .92$. Test/retest reliability was good with $r = .7$
Duke University Medical Center Department of Community and Family Medicine. (2007)	Duke Social Support and Stress Scale (DUSOCS)	Reliability of the scale has been reported as internally consistent with a Cronbach's α ranging from .55 to .70.

Research Question and Hypotheses

Research Question

The research question guiding this study asked: Is there a correlation between suicidality among AAALs and the level of adult support? Four null hypotheses were set forth and tested to answer the research question.

Hypothesis 1

$H_0 1$: There will be no relationship between the AAALs' perceived adult social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and the AAALs' hopelessness as measured with the Beck Hopelessness Scale (BHS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS).

H_a1: A significant relationship exists between the AAALs' perceived adult social support as measured with the DUSOCS and the AAALs' hopelessness as measured with BHS and attitude toward homosexuality as measured with the HAS.

I used a Pearson coefficient of product-moment correlation to assess the relationships among social support, attitude toward homosexuality, and hopelessness. Pearson's *r*, or the Pearson product-moment correlation coefficient, is a commonly used statistical procedure for gathering an index of the relationship between two variables when the relationship between the variables is linear and when the two variables are continuous, meaning that they can take any value (Cohen & Swerdlik, 2005).

Hypothesis 2

H_02: Perceived social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS) will not significantly predict whether someone should be classified as having suicidal ideation as measured with Beck Scale for Suicide Ideation (BSS).

H_a2: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predicted whether someone should be classified as having suicidal ideation as measured with the BSS.

To analyze the results of the BSS, I conducted a multiple regression analysis to determine to what extent social support and attitude toward homosexuality explained the variance in suicidal ideation. Multiple regressions are analyses of relationships between

more than one independent variable and one dependent variable to understand how each independent variable predicts the dependent variable (Cohen & Swerdlik, 2005).

Hypothesis 3

$H_0$3: Perceived social support as measured with the Duke Social Support and Stress Scale (DUSOCS) and attitude toward homosexuality as measured with the Homosexuality Attitude Scale (HAS) will not significantly predict hopelessness as measured with the Beck Hopelessness Scale (BHS).

H_a3: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predicted hopelessness as measured with the BHS.

I used a Pearson product-moment correlation coefficient, or Pearson's *r*, to correlate the relationships between hopelessness, measured with the BHS, as the dependent variable and perceived social support , measured with the DUSOCS, and attitude toward homosexuality, measured with the HAS, as the two independent variables.

Hypothesis 4

$H_0$4: There will be no differences in the scores on the Homosexuality Attitude Scale (HAS) among participants with respect to educational level, type of household of origin, or religious affiliation.

H_a4: Significant differences existed in the scores on the HAS among participants with respect to educational level, type of household of origin, or religious affiliation.

I used an ANOVA to determine whether significant differences existed between attitude toward homosexuality as the dependent variable, measured with the HAS, and demographic variables as the independent variables.

Ethical Considerations

I provided the participants with a list of resources for social support, mental health services, and medical care. As the researcher, I did not foresee any problems with ethical issues because the participants had received adequate information about the study on the informed consent form, which explained the purpose of the research, the procedures to be followed, and the need for parental consent for all underage participants (see Appendix A). I proceeded with the distribution of the informed consent from to potential participants only after the Internal Review Board (IRB) of Walden University had granted permission to undertake the study.

Summary

In this chapter, I described the research methods used in the study, including research design and approach. I provided a description of the population, sample, and sample selection. I discussed the instrumentation, data collection, and data analysis procedures. The results of the study are presented in Chapter 4. Conclusions were drawn based on the findings, and recommendations are offered for providing practical social support to AAALs to curb the alarming rise in suicidality among this population and for further research on this topic.

Chapter 4: Results

Data Analysis

This chapter presents the results of the quantitative analysis. I collected the data from a sample ($N = 200$) of African-American girls and young women, aged 13-19 years, who self-identified as lesbians. I recruited participants through advertisements in gay publications, the National Women's Football Association, the Atlanta Gay Pride Parade, social-support groups for lesbians, youth drop-in centers, and through referrals from peers. The surveys could be completed in any location that suited the respondents and could be returned to me via a self-addressed, stamped envelope that I had included with the survey packet. The participants came from urban, suburban, and rural areas in and around Atlanta, Georgia. For all participants under 18 years of age, I secured parental consent. Recruitment took 3 months, and data collection took an additional 3 months to complete. In the first section of the survey, I collected demographic information about the participants, which I present in this chapter as descriptive statistics with frequencies and percentages.

In this chapter, I present the results of my examination of the relationship between the perceived level of adult support and the AAAL respondents' social identities, suicidality, and demographic characteristics. I used SPSS to analyze the responses collected from a convenience sample of 200 AAALs using five instruments: a demographics questionnaire, the BHS, the BSS, the HAS, and the DUSOCS.

I aimed to determine (a) if statistically significant positive correlations existed between AAALs' perceived adult social support and the other variables, as measured with

the BHS, HAS, and DUSOCS; (b) if a statistically significant negative relationship existed between AAALs' perceived adult social support and their suicidality, as measured with the BSS; (c) if statistically significant relationships existed between AAALs' adult social support and their attitude toward homosexuality and hopelessness, as measured with the HAS and the BHS; and (d) if statistically significant differences existed among AAALs' attitudes toward homosexuality with respect to their demographic characteristics.

I declared statistical significance if the *p* values of the inferential test statistics were less than $p = .05$. In what follows, I present the findings in two sections: The first section presents the demographic profile of the participants; the second section contains the operationalization of the variables, followed by hypothesis testing, specifically concerning (a) the relationship between AAALs' perceived adult social support and their level of hopelessness and attitude toward homosexuality ($H_0 1$ and $H_a 1$); (b) the relationship between AAALs' adult social support and their social identity ($H_0 2$ and $H_a 2$); (c) the relationship between AAALs' adult social support and their suicidality ($H_0 3$ and $H_a 3$); (d) the relationship between AAALs' adult social support and attitude toward homosexuality and hopelessness ($H_0 4$ and $H_a 4$); and (e) the relationship between demographic characteristics of the participants and their attitude toward homosexuality. In Table 5, I outline the null and alternative hypotheses and the dependent and independent variables used in the statistical testing.

Table 5

Hypotheses and Variables

Hypotheses	Independent Variables	Dependent Variables
$H_0$1: There will be no relationship between AAALs' perceived adult social support as measured with the DUSOCS and AAALs' hopelessness as measured with the BHS and attitude toward homosexuality as measured with the HAS. H_a1: A significant relationship exists between AAALs' perceived adult social support as measured with the DUSOCS and AAALs' hopelessness as measured with BHS and attitude toward homosexuality as measured with the HAS..	Perceived adult social support measured with the DUSOCS: 1. Social support 2. Social stress	Social identity evaluated with the BHS.
$H_0$2: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS will not significantly predict whether someone should be classified as having suicidal ideation as measured with BSS. H_a2: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predict whether someone should be classified as having suicidal ideation as measured with the BSS.	Perceived adult social support measured with the DUSOCS: 1. Social support 2. Attitudes	Tendency toward suicidality evaluated with the BSS.

(*table continues*)

Hypotheses	Independent Variables	Dependent Variables
$H_0$3: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS will not significantly predicts hopelessness as measured with the BHS. H_a3: Perceived social support as measured with the DUSOCS and attitude toward homosexuality as measured with the HAS significantly predict hopelessness as measured with the BHS.	Perceived adult social support measured with DUSOCS: 1. Social support 2. Attitudes	Social identity evaluated with the BHS.
$H_0$4: There will be no differences in scores on the HAS among participants with respect to educational levels, type of household of origin, or religious affiliation. H_a4: Significant differences exist in the scores on the HAS among participants with respect to educational levels, type of household of origin, or religious affiliation.	Characteristics measured using the Demographic Questionnaire: 1. Age 2. Household 3. Religion	Perceptions of the participants toward homosexuality and its behavioral consequences evaluated with the HAS.

Demographic Profile of the Participants

The demographic profile of the participants (N = 200), expressed as frequencies (counts and percentages) in each of the specified categories, is summarized in Table 6. The responses to the demographics questionnaire confirmed that every participant satisfied the inclusion criteria. All participants were between the ages of 13 and 19 years with an average age of 16 years. About 25.7% (n = 55) were 13-16 years of age, and 72.5% (n = 145) were between 16 and 19 years of age. The participants reported that they were raised in a variety of households. Less than one fifth (n = 37, 19%) were raised in a

traditional household with both biological parents. About half (*n* = 101, 51%) were raised in a single-parent household, with most of the participants (*n* = 98, 24.5%) reporting that their mother was the single parent. Less than one third (*n* = 60, 30%) were raised in a nontraditional household of which *n* = 36 (62%) included a biological mother and stepfather, whereas *n* = 10 (5%) included a biological father and stepmother. The guardians of *n* = 17 (9%) included at least one biological grandparent. Only one of the participants was raised by nonrelated adults.

The educational level of most of the participants was relatively high, with about two thirds (*n* = 130, 65%) attending college, and about one third (*n* = 70, 35%) reporting some high school attendance. With respect to religion, the majority (*n* = 142, 72%) professed Christian affiliations (Protestant or Roman Catholic), whereas one fifth (*n* = 41, 20%) were Muslim. Only 8% (*n* = 16) professed no religious faith. In response to the question *Do you have any adult support?* (i.e., adults that the person could talk to concerning her sexual orientation), about one half (*n* = 102, 52%) replied with *Yes*. In response to the question *Does your community have a gay/lesbian community center?* over one half (*n* = 113, 58%) replied with *Yes*, implying that there was a place they could visit to get help or talk with someone about gay/lesbian issues.

Table 6

Demographic Profile of the Participants (N = 200)

Characteristics	Category	*n*	Percentage
Gender	Female	200	100.00%
Sexual Orientation	Gay/Lesbian	200	100.00%
Ethnicity	African American	200	100.00%
Age (Years)	13-14	25	12.50%
	15-16	30	15.00%
	17-19	145	72.50%
Household	Single-parent (1 biological parent)	101	50.60%
	Nontraditional (1 stepparent, 1 biological parent)	60	30.00%
	Traditional (both biological parents)	37	18.60%
	Other (neither biological parents)	2	1.40%
Parents/ Guardians	Biological mother only	98	49.00%
	Biological mother and father	37	18.50%
	Biological mother and stepfather	36	18.00%
	Biological grandparent(s)	17	8.50%
	Stepmother and biological father	10	5.00%
	Nonrelated adults	1	0.50%
	Biological father only	1	0.50%
Educational Level of the Respondent	College student	130	65%
	Some high school	70	35%
Religion	Protestant	101	50.50%
	Roman Catholic	42	21.00%
	Muslim	41	20.00%
	None	16	8.00%

Operationalization of Variables

The HAS scores were based on a 5-point scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, and 5 =*agree*). The six DUSOCS subscale scores were based on a 3-point scale (0 = *none*, 1 = *some*, and 2 = *a lot*) for (a) family support score (FS); (b) nonfamily support score (NFS); (c) social-support score (SS); (d) family stress score (FST); (e) nonfamily stress score (NFST); and (f) social stress score (SSST). The BSS measured suicide ideation using a 3-point scale (0 = *none*, 1 = *weak,* and 2 = *moderate/strong*). I estimated the reliability of these scales using Cronbach's α, which is the most commonly used measure of the reliability of questionnaire items based on three-item or more-item scores (Hogan et al., 2001). However, I dichotomously coded the scores for each of the BHS items (0/1 = *False*/ *True*), for which the appropriate reliability coefficient was the Kuder-Richardson 20 (Field, 2009). Reliability coefficients > .7 indicated a reliably measured scale, assuming that the item scores measured one concept in one logical direction, from the lowest to the highest level (Allen & Yen, 2002). I conducted reverse coding on the negative values before undertaking other data analysis methods.

DUSOCS. The raw scores for the 20 DUSOCS items consistently measured social support (see Appendix G, Table G1) or social stress (see Appendix G, Table G2) in one logical direction from 0 = *none* to 2 = *a lot*; so they followed the hypothesis. Family members (i.e., partners, children, grandchildren, parents, grandparents, siblings, and blood relatives) tended to receive higher scores than nonfamily members. After scoring

each scale up to 100, indicating a maximum level of support or stress (Parkerson, 1999), I found the two scales to be reliable measures (Cronbach's α = .749 and .834, respectively).

Social-support scores. I calculated the total scores of the DUSOCS family social-support scores by adding all the raw scores of each case, dividing the sum by 14, and then multiplying by 100. I calculated DUSOCS nonfamily social-support scores by adding all the raw scores together, dividing the scores by 12, and multiplying by 100. The DUSOCS nonfamily social-support scores ranged from 0 to 100. I calculated the DUSOCS social-support scores by adding all the raw scores for each case to obtain the total scores, dividing by 22, and multiplying by 100. The DUSOCS social-support score ranged from 21.43 to 100.

Social stress scores. I calculated the DUSOCS social stress scores by adding all the raw scores for each case to obtain the total scores, dividing by 22, and multiplying by 100. The DUSOCS social stress score ranged from 0 to 59.09.

The scores of the DUSOCS social support and stress ranged from the 21.43 - 100 and 0.00 - 59.09, respectively. The mean of the DUSOCS social support was 61.5 with a standard deviation of 13.62, while the mean of DUSOCS social stress was 29.16 with a standard deviation of 14.75. The distribution of the DUSOCS social support and DUSOCS social stress was normal, as shown in Table G3 and Figures 1 and 2 (see Appendix G).

BSS. The raw scores for the 19 items on the BSS as shown in Table G4 (see Appendix G) measured the participants' levels of suicide ideation in one direction from *zero* to *moderate/strong,* satisfying the assumptions of the reliability analysis. The BSS

provided very reliable measures (Cronbach's α = .983). There was, however, a problem with the operationalization of the BSS. According to the instructions, the respondents who scored 0 for Items 4 and 5, indicating that they exhibited no suicide ideation, were meant to skip Items 6 to 19, but the respondents did not comply with these instructions. This error was a weakness of the BSS, which the authors (Beck & Steer, 1991) did not recognize. Instrument developers usually recommend not to use skip instructions in the paper and pencil tests, but they have been used quite regularly in computerized assessments. Participants invariably ignore these instruction and assume that every item must be answered (Gendall & Ramsay, 2001; Mesmer, 1982). Lack of compliance with the skip instruction complicated the operationalization of the BSS. To take this issue into account, the participants were divided into two groups: suicide ideators (*n* = 39, 20%) who scored at least 1 on Items 4 and 5, and nonsuicide ideators (*n* = 161, 81%) who scored zero for Items 4 and 5. I computed the BSS separately for each group by addition of the scores for Items 1 to 19. A score of 38 indicated the highest level of suicide ideation. In this manner, a BSS score for each participant was generated.

BHS. The dichotomous responses to the 20 items on the BHS were not reliably measured, nor were they measured in one logical direction (see Appendix G). The reliability coefficient for the 20-item scores (Kuder-Richardson 20 = .647) was less than .7; thus, summing the scores could not be justified. The low value of the coefficient implied that the responses might be multidimensional. The nine items reflecting a positive attitude toward the future (1, 3, 5, 6, 8, 10, 13, 15, and 19) were endorsed as True by the majority of the participants (55.5% - 79.5%), whereas the 12 items reflecting a

negative attitude toward the future (2, 4, 7, 9, 11, 12, 13, 14, 16, 17, 18, and 20) were endorsed as True by fewer participants (9.5% - 39.5%). The BHS provided very reliable measures with the Kuder-Richardson 20 = .971 and .870, respectively.

HAS. The attitudes of the participants toward homosexuality were measured by using the 21 items on the HAS, as shown in Table G6 (see Appendix G).The responses tended to be polarized toward low scores or high scores with very few participants taking a neutral stance (0% - 3.5%). The majority of AAALs (51.0% - 97.5%) *strongly disagreed* or *agreed* with nine items (3, 7, 9, 10, 11, 12, 16, 17, and 18), reflecting negative attitudes toward homosexuality. The majority (51.0% t - 95.5%) also strongly agreed with the 12 items (1, 2, 4, 5 ,6, 8, 13, 14, 19, 20, and 21) manifesting positive attitudes toward homosexuality. The reliability coefficient for the 21 items was found to be very high (Cronbach's $\alpha = .890$). I used reverse coding to combine negative and positive items. Consequently, it was justifiable to construct the HAS by adding the scores for the 21 items, with a score of 105 indicating the highest level of positive attitude toward homosexuality.

Reverse scoring. The high scores of an attribute indicate high levels of the variable. For instance, the variable receives a high score of 5 (*strongly agree*) and a low score of 1 (*strongly disagree*). Reverse scoring helps to transform all the 1s of the variable in the study to 5s. Similarly, I transformed all 2s into 4s, all 3s remained 3s, all 4s became 2s, and all 5s became 1s. Reverse scoring of all the negatively keyed items creates consistency among the items.

Normality of scales. The distribution of the scales, stratified into social support and social stress is illustrated in Figures 1 and 2 (see Appendix G). The shape of the frequency distribution histograms were symmetrical bell-shaped curve, indicating that the scores in each of the two scales were normally distributed. The practical implications were that parametric descriptive statistics (e.g., means and standard deviations) and inferential statistics (e.g., Pearson's correlation and linear regression analysis), which theoretically assume normally distributed variables, were inappropriate for the purposes of this study (Field, 2009). In this context, I used the four scales pertaining to social support, hopelessness, attitude toward homosexuality, and suicidal ideation.

Hypothesis 1

Null Hypothesis 1 tested the relationships between adult social support and social identity. The aim was to determine whether the relationships, if any, between perceived adult social support, as measured with the DUSOCS, and hopelessness, as measured with the BHS, and attitude toward homosexuality, as measured with the HAS, were statistically significant.

To determine the relationship between AAALs' perceived adult social support (DUSOCS) and AAALs' hopelessness (BHS) and attitude toward homosexuality (HAS), I conducted a Bivariate Pearson correlation analysis. Correlation analysis helps one to understand the level of association between two variables. The value of the correlation coefficient ranges between 0 and 1; thus, the level of the association can be determined by calculating the Pearson correlation coefficient. When Pearson's *r* value is between 0 and 0.4, the association is considered weak; between 0.4 and 0.6, the association is of

medium strength; and above 0.7, the association is considered strong (Kirkwood, 1998, p. 76). I conducted bivariate correlation analyses to determine the relationship between social support, hopelessness, and attitude toward homosexuality.

A moderate but significant negative relationship was found to exist between social support and hopelessness ($r = -0.30$, $p < 0.01$). There was also a weak but positive relationship between social support and attitude toward homosexuality ($r = 0.25$, $p < 0.01$). In addition, there was a strong but negative relationship between hopelessness and attitude toward homosexuality ($r = -0.89$, $p < 0.01$). Therefore, Null Hypothesis 1 was rejected and the alternate hypothesis accepted instead. These results are also presented in Table 7.

Table 7

Correlational Analysis Between Social Support, Hopelessness, and Attitude Toward Homosexuality (N = 200)

		Social Support	Hopelessness	Attitude Toward Homosexuality
Social support	Pearson Correlation	1		
	Sig. (2-tailed)			
Hopelessness	Pearson Correlation	-.304*	1	
	Sig. (2-tailed)	.000		
Attitude toward homosexuality	Pearson Correlation	.246*	-.890*	1
	Sig. (2-tailed)	.000	.000	

Note. *Correlation was significant at the 0.01 level (2-tailed).

Hypothesis 2

Null Hypothesis 2 tested the relationships among social support, attitude toward homosexuality, and suicidality. I used stepwise regression analysis for hypothesis testing. Social support and attitude toward homosexuality were the independent variables (predictors), and suicide ideation was the dependent variable. The data shown in Table 8 indicates that attitude towards homosexuality predicts (or explains) 44.6% of the variance in suicide ideation; social support and attitude toward homosexuality collectively predict (or explain) 47.5% of the variance in the dependent variable (suicide ideation).

Table 8

Model Summary Relationship Between Suicidal Ideation, Social Support, and Attitude Toward Homosexuality

					Change Statistics				
Model	*R*	R^2	Adjusted R^2	*SE* of the Estimate	R^2 Change	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.668[a]	.446	.443	.296	.446	159.416	1	198	.000
2	.689[b]	.475	.470	.289	.029	10.867	1	197	.001

a. Predictors: (Constant), HAS

b. Predictors: (Constant), HAS, BSS

Tables 9 and 10 indicate that attitude toward homosexuality and social support together significantly predicted suicidal ideation; however, Table 8 demonstrates that, when attitude toward homosexuality is entered into the equations first, social support drops out. This may be due in part, to the significant relationships among attitudes toward homosexuality and social support (see Table 7).

Table 9

ANOVA Analysis Between Suicidal Ideation, Attitude Toward Homosexuality, and Social Support

Model		Sum of Squares	*df*	Mean Square	*F*	Sig.
1	Regression	14.003	1	14.003	159.416	.000
	Residual	17.392	198	.088		
	Total	31.395	199			
2	Regression	14.912	2	7.456	89.113	.000
	Residual	16.483	197	.084		
	Total	31.395	199			

a. Dependent variable: Suicide ideation

b. Predictors: (Constant), Attitude towards homosexuality

c. Predictors: (Constant), Attitude towards homosexuality, social support

From Table 9 it is evident that a significant association existed between suicide ideation and attitude toward homosexuality with $F = 159.416$, $p < 0.001$ and both attitude towards homosexuality and social support with $F = 89.113$, $p < 0.001$.

Table 10

Regression Coefficients Between Suicidal Ideation, Attitude Toward Homosexuality, and Social Support

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
		B	*SE*	Beta	*t*	Sig.	Lower Bound	Upper Bound
1	(Constant)	2.482	.182		13.612	.000	2.122	2.841
	Attitude towards homosexuality	-.034	.003	-.668	-12.626	.000	-.040	-.029
2	(Constant)	2.624	.183		14.331	.000	2.263	2.985
	Attitude towards homosexuality	-.032	.003	-.616	-11.421	.000	-.037	-.026
	Social support	-.005	.002	-.178	-3.296	.001	-.008	-.002

a. Dependent variable: Suicide ideation

The analysis showed a significant negative relationship between suicide ideation and attitude toward homosexuality (B = -.034, $p < 0.001$). The analysis also showed a significant negative relationship between suicide ideation and social support (B = -.005, $p < 0.001$). Similar results were obtained for the relationship of attitude toward homosexuality scores: When the HAS scores increased, the BSS scores decreased. Therefore, Null Hypothesis 2 was rejected and the alternate hypothesis was accepted instead.

Hypothesis 3

Null Hypothesis 3 tested the relationships among perceived social support, attitude toward homosexuality, and hopelessness. Hypothesis testing sought to determine whether perceived social support, as measured with the DUSOCS, and attitude toward

homosexuality, as measured with the HAS, could significantly predict hopelessness, as measured with the BHS.

To determine if there is a significant relationship between perceived social support (DUSOCS) and attitude toward homosexuality (HAS) and hopelessness (BHS), I conducted stepwise regression analysis. Social support and attitude toward homosexuality were the independent variables (predictors); hopelessness was the dependent variable. The results showed that attitude toward homosexuality predicted (or explained) hopelessness 79.3%; when combine with social support, the variables collectively predicted 80% of the variance of hopelessness (see Tables 11 and 12). This indicated that social support contributed only 0.8% more of the variance of hopelessness. Therefore, one may conclude that attitude toward homosexuality significantly predicted hopelessness among the study participants.

Table 11

Model Summary Between Hopelessness, Social Support, and Attitude Toward Homosexuality

					Change Statistics				
Model	*R*	R^2	Adjusted R^2	*SE* of the Estimate	R^2 Change	*F* Change	*df* 1	*df* 2	Sig. *F* Change
1	.890	.793	.792	3.27062	.793	757.134	1	198	.000
2	.895	.800	.798	3.21862	.008	7.449	1	197	.007

a. Predictors: (constant), Attitude toward homosexuality

b. Predictors: (constant), Attitude toward homosexuality, social support

Table 12

ANOVA Between Hopelessness, Social Support, and Attitude Toward Homosexuality

	Model	Sum of Squares	*Df*	Mean Square	*F*	Sig.
1	Regression	8099.023	1	8099.023	757.134	.000
	Residual	2117.997	198	10.697		
	Total	10217.020	199			
2	Regression	8176.193	2	4088.097	394.622	.000
	Residual	2040.827	197	10.360		
	Total	10217.020	199			

a. Dependent variable: Hopelessness.

b. Predictors: (Constant), Attitude toward homosexuality.

c. Predictors: (Constant), Attitude toward homosexuality, social support.

A significant association existed between hopelessness and attitude toward homosexuality with $F = 757.135$, $p < 0.001$ and hopelessness and both attitude toward homosexuality and social support with $F = 394.622$, $p < 0.001$.

The results also showed that a significant negative relationship existed between attitude toward homosexuality and social support and the level of hopelessness (-0.463) among the study participants based on $t = -27.536$, $p < 0.001$. This means that attitude toward homosexuality significantly predicted hopelessness among the study participants and, in fact, better than social support (see Table 13).

Table 13

Regression Coefficients Between Hopelessness, Social Support, and Attitude Toward Homosexuality

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
		B	*SE*	Beta	*t*	Sig.	Lower bound	Upper bound
1	(Constant)	62.862	1.196		52.554	.000	60.503	65.221
	Attitude toward homosexuality	-.463	.017	-.890	-27.516	.000	-.496	-.429
2	(Constant)	64.962	1.406		46.195	.000	62.189	67.735
	Attitude toward homosexuality	-.451	.017	-.868	-26.426	.000	-.485	-.417
	Social support	-.047	.017	-.090	-2.729	.007	-.081	-.013

a. Dependent variable: Hopelessness.

Null Hypothesis 3 was, therefore, rejected and the alternate hypothesis was accepted instead. When the level of attitude towards homosexuality increased, the level of the hopelessness decreased, and vice versa. Similarly, when both attitude toward homosexuality and social support increased, the level of hopelessness among the study participants decreased.

Hypothesis 4

Null Hypothesis 4 tested the relationships between the participants' demographic characteristics and their attitude toward homosexuality, as measured with the HAS. Hypothesis testing through three one-way ANOVAs and a Tukey post hoc analysis aimed at revealing whether significant differences existed in the scores on the HAS, based on the demographic characteristics of the participants (see Table 14).

Table 14

Descriptive Statistics of Age, Household Type, and Religious Affiliation

Variable	*n*	Minimum	Maximum	Mean	*SD*
Age	200	13	18	16.05	1.89
Household type	198	1	4	1.86	1.01
Religious affiliation	200	1	4	1.87	1.01

Table 15 shows the results of the one-way ANOVA. The only significant difference was observed with respect to types of household in which the participants grew up. I, therefore, conducted the post-hoc analysis for that variable only.

Table 15

ANOVA Analysis for Demographic Variables and Attitude Toward Homosexuality

		Sum of Squares	*df*	Mean Square	*F*	Sig.
Age	Between groups	111.027	32	3.470	.968	.522
	Within groups	598.473	167	3.584		
	Total	709.500	199			
Household	Between groups	142.785	31	4.606	12.785	.000
	Within groups	59.801	166	.360		
	Total	202.586	197			
Religious affiliation	Between groups	38.199	32	1.194	1.207	.223
	Within groups	165.156	167	.989		
	Total	203.355	199			

Table 16 shows that there were significant differences between single-parent and nontraditional households when compared to traditional and other types of households. Traditional and other types of households displayed more positive attitudes toward homosexuality than did single-parent and nontraditional households. The data did not support rejection of Null Hypothesis 4 with respect to the lack of significant differences between single-parent (one biological parent) and nontraditional (one stepparent, one biological parent) households or with respect to the lack of differences between traditional (both biological parents) and other (neither biological parents) households.

Table 16

Tukey HSD Post Hoc Analysis of Attitude Toward Homosexuality and Household Type

					95% Confidence Interval	
(I) Household type	(J) Household type	(I-J) Mean Difference	*SE*	Sig.	Lower bound	Upper bound
Single parent	Nontraditional	4.67500	2.14393	.132	-.8809	10.2309
	Traditional	18.38571*	2.10715	.000	12.9252	23.8463
Other						
Nontraditional	Single parent	-4.67500	2.14393	.132	-10.2309	.8809
	Traditional	13.71071*	2.53179	.000	7.1497	20.2717
	Other	10.92500*	3.38985	.008	2.1404	19.7096
Traditional	Single parent	-18.38571*	2.10715	.000	-23.8463	-12.9252
	Nontraditional	-13.71071*	2.53179	.000	-20.2717	-7.1497
	Other	-2.78571	3.36671	.841	-11.5103	5.9389
Other	Single parent	-15.60000*	3.08564	.000	-23.5962	-7.6038
	Nontraditional	-10.92500*	3.38985	.008	-19.7096	-2.1404
	Traditional the 8571	3.36671	.841	-5.9389	11.5103	

Notes. *The mean difference is significant at the 0.05 level.

Summary

This chapter presented the results of the statistical exploration of the relationships between patterns of adult support, social identity, suicidality, and demographic characteristics of AAALs. All of the scales provided reliable measures, as indicated by their reliability coefficients (Cronbach's α or Kuder Richardson 20 >0.70). I tested the four hypotheses underpinning this study by using bivariate correlation analysis, regression analysis, and ANOVA. Null Hypothesis 1 stated that there would be no relationships between AAALs' perceived adult social support, as measured with the DUSOCS, and their social identity, as measured with the BHS and the HAS. This hypothesis had to be rejected because, among those participants who were not suicide ideators, optimistic attitudes toward the future and positive attitudes toward homosexuality increased when there was a high level of family and nonfamily social support. Moreover, feelings of hopelessness, manifesting as negative attitudes about the future, decreased when there was an increase in family and nonfamily social support. Optimistic attitudes toward the future and positive attitudes toward homosexuality decreased when there was a lack of family and nonfamily support.

The results also showed that age and religious affiliation did not significantly correlate with differences in attitude toward homosexuality. The evidence showed, however, that characteristics of the households in which the participants grew up correlated with attitude toward homosexuality.

Chapter 5: Discussion, Conclusions, and Recommendations

Overview

The purpose of this study was to determine if a correlation existed between patterns of adult support and suicidality among AAALs. The expectation was that, if the study could demonstrate the importance of a positive support system for AAALs, to which they could turn when they felt stress or pressure from a homophobic society, this fact would result in a potential avenue toward reducing suicidality. The research demonstrated that social support was a vitally important component that could affect the level of physical and mental health of AAALs. Poorly developed social networks, the absence of a social-support network, as well as diminished levels of social support, as measured with the DUSOCS, and hopelessness, as measured with the BHS, have been identified as risk factors for suicide attempts among African-American women.

This chapter presents the results of a statistical exploration of the relationships between patterns of adult support, social identity, suicidality, and the demographic characteristics of AAALs. I analyzed the responses of a convenience sample of 200 AAALs, collected with five instruments: a demographics questionnaire, the BHS, the HAS, the DUSOCS, and the BSS. I constructed the scales by adding the item scores, which had two, three, or five options, measured at the nominal or ordinal level. All of the scales were reliable measures, as indicated by their reliability coefficients (Cronbach's α or Kuder-Richardson 20 > .7). The scores were not consistently normally distributed; the use of parametric statistics was, therefore, not justifiable. I tested the four hypotheses

underpinning this study by using Pearson correlation, multiple regression, and ANOVA analyses.

Findings of this study indicated the need for sustained intervention with AAALs to curb the alarming rate of suicides in this vulnerable population. To counteract the impact of negative social relationships effectively, underlying causes of such relationships must be identified. If the cause rests with the parents, then therapy should involve the AAAL's family, presuming that the youth and her parents agree to the intervention. If the source rests with peers, it would be advisable for the AAAL to make different friends and also to connect with lesbian organizations. Because the research involved an adequate sample size ($N = 200$), future researchers might consider the present study as an opportunity to revisit the hypotheses and use a larger sample. Future studies should also consider random sampling, which was not done in this study. The use of a convenience sample limits generalizability of the results, which may even include some biased views.

Null Hypothesis 1 stated that there would be no relationship between AAALs' perceived adult social support as measured with the DUSOCS and AAALs' hopelessness as measured with the BHS and attitude toward homosexuality as measured with the HAS.

Therefore, I rejected Null Hypothesis 1and accepted the alternate hypothesis instead. Pearson correlation analysis showed a moderate but significant negative relationship to exist between social support and hopelessness. There was also a weak but positive relationship between social support and attitude toward homosexuality. In

addition, there was a strong but negative relationship between hopelessness and attitude toward homosexuality.

Null Hypothesis 2 stated that perceived social support, as measured with the Duke DUSOCS, and attitude toward homosexuality, as measured with the HAS, will not significantly predict whether someone should be classified as having suicidal ideation as measured with the BSS. I had to reject this null hypothesis because multiple regression analysis provided evidence that (a) the more support that an AAAL received from nonfamily members, the greater the likelihood that she would not be a suicide ideator; and (b) the more stress an AAAL experienced with respect to family members, the greater the likelihood that she would be a suicide ideator.

Null Hypothesis 3 stated that perceived social support, as measured with the DUSOCS, and attitude toward homosexuality, as measured with HAS, will not significantly predict hopelessness as measured with the BHS.

A significant relationship existed between social support and hopelessness; the findings also showed a negative association between hopelessness and social support and attitude towards homosexuality together. I, therefore, rejected this null hypothesis and accepted the alternate hypothesis instead, which stated that perceived social support and attitudes toward homosexuality were significant predictors of hopelessness in AAALs.

Null Hypothesis 4 stated that there would be no differences in the scores on the HAS among participants with respect to educational level, type of household of origin, or religious affiliation.

I rejected this null hypothesis because the results of Kruskal-Wallis tests indicated that AAALs who were either professed Roman Catholics or Muslims or had been raised in a traditional household exhibited less positive attitudes toward homosexuality than other participants.

As I explained under Limitations of the Study in Chapter 1, the survey instruments I used yield sufficiently comparable data in their raw form, but the data analysis procedures that I used did not yield comparable results because the data required modifications to meet assumptions. By modifying the data, I could make comparisons and reach conclusions about how strongly the correlation supported or refuted the corresponding hypothesis. I used a nonparametric technique to test the hypotheses because the collected data failed to meet normal distribution assumptions (see Figures 1 and 2) needed for running parametric techniques such as Pearson's *r* and linear regression.

Conclusions

By engaging with the continuum of behaviors and psychosocial variables that are known to relate to the degree of suicide risk, this study lead to some timely insights concerning psychosocial variables such as the level of familial and nonfamilial support, which may be correlated with suicide risk. As I have shown, the quantity and quality of social support determined how an individual was able to cope with internal and external pressures. Indications were that lesbians who perceived receiving a high level of social support were less psychologically distressed and, hence, scored more positively on the BHS. As previously mentioned, social support can be viewed as a discriminant variable

for suicide among lesbians. Thus, a critical need exists for the continued support and funding of social networks for AAALs as one important means of mitigating suicidal ideation among these young women.

Adolescent suicide among LGBT individuals remains a tragedy based on a large number of risk factors, as recognized in the existing literature and reviewed in Chapter 2. The main focus of this study was on the potential importance of positive social support as a powerful means of reducing suicidality among AAALs (Oquendo et al., 2001). One of the fundamental issues revealed in this study was that most adolescents become vulnerable to suicidal ideation in the absence of help or assistance from adults. Therefore, the teens' condition is likely to worsen if no support is forthcoming from family members, local schools, churches, youth centers, governmental and nongovernmental organizations, to mention only a few.

Social support offers an opportunity to reduce the severity of the stressful experiences that contribute to suicidal thoughts among lesbians. Therefore, there is a need for friends and family members to provide social support in order to reduce psychiatric problems and the high mortality rate among AAALs resulting from isolation and discrimination against lesbians on the part of mainstream society. Through supportive relationships, AAALs tend to become able to achieve a sense of purpose, worth, and adequacy and to overcome stressful circumstances that can otherwise lead to suicidal thoughts and suicide attempts (Oquendo et al., 2001).

The Relevance of Social Support

The lack of a strong system of support through friendships and the community at large emerged as one of the critical issues contributing to suicidal ideation among AAALs. Isolation and the feeling of loneliness, based on the standards shaped by a heterosexist society, leaves many AAALs in a vulnerable state. One of the critical issues revealed in this study was related to the effects of homophobia. It appears that for many generations the African-American community displayed a negative attitude toward gay men and lesbians. An unexamined and often irrational fear was internalized by many lesbians, which emerged as one of the factors that could cause psychological problems and exacerbate suicidal ideation (Rutter & Behrendt, 2004). Social support in the form of family or community support becomes all the more important because it helps to reassure lesbians that they have a rightful place in this society, and it encourage them not to feel isolated and out of place.

Fighting internalized homophobia remains one of the most important ways of making lesbians understand and accept their sexual orientation (Elze, 2003; Silenzio et al., 2007). Lack of social support may contribute to social isolation, cumulative stress, difficulties with sexual identity, depression and feelings of inadequacy, negative family interactions, and negative social attitudes that largely contribute to suicidal ideation. As revealed in this study, the most important way out of this deadly impass is to encourage identity integration by raising awareness of the effects of internalized homophobia that disregards LGBT identities in a most harmful way. Adult support offers one of the

appropriate ways in which internalized homophobia can be mitigated by changing the adverse perceptions about lesbians into positive ones.

Approaches to Providing Social Support

Familial and Social Integration

As revealed in the study, the greater the level of parental acceptance of the adolescent's sexual orientation, the more likely it was for her to feel comfortable about being lesbian. Parental acceptance boosted her self-esteem and gave her a sense of belonging within the community, with teammates, peers, and family members. As revealed in the study, strong social support and low isolation contributed to resilience and low levels of suicide risk among AAALs. Adolescents who felt supported by their parents, counselor, or peers showed higher resilience and exhibited healthier coping mechanisms. They also maintained a positive outlook toward the future. By contrast, those who felt isolated because they lacked social support tended to behave in self-destructive ways and showed a tendency toward suicidal ideation (Robinson, 2010).

As revealed in the literature, social and familial integration plays a significant role in the reported suicide rates among all ethnic groups. Integration remains one of the critical factors in examining the rate of suicides among African-American lesbians. As the study revealed, a supportive social network could provide a buffer against adverse experiences that might otherwise have led to suicidal thoughts and attempted suicide (Gary et al., 2003). On the other hand, lack of social support from family and friends contributed to increased hopelessness, depressive symptoms, and suicidal ideation, as also reported by the sample of AAALs in this study.

It is important to note that adolescent homosexuality is a fundamental risk factor that contributes to suicidal thoughts and suicide attempts among lesbians. The psychological distress arising from poor family relations, discrimination, or social isolation associated with being gay, has contributed to the increasing rate of suicides among African-American adolescents (O'Donnell et al., 2011). Suicidal ideation in African-American women is the result of many factors, including poor social networks, poor family functioning, PTSD, hopelessness, aggression, a low ethnic identity, low spirituality/religiosity, substance abuse, interpersonal losses, and mental disorders (Proctor & Groze, 1994). The essence of adult support is basically to improve the quality of life by offering psychological, mental support or other forms of assistance to young women in order to reduce the predominance of hopelessness, social isolation, depression, low self-esteem, and other factors that may contribute to suicidal thoughts and attempted suicide.

Better Access to Information

As revealed in the study, lesbian youths may not have adequate access to information about their sexuality. Adolescence is deemed a critical time in the life of an individual. Conformity and acceptance are based on the kind of emotional support an individual receives from the people around him or her. Adolescence can be a very challenging time, and for homosexual youths the trials and tribulations of adolescence can be downright dangerous. Therefore, the lack of a safe haven, where the lesbian adolescent is able to discuss her struggles and problems, makes her vulnerable to suicidal thoughts and even attempted suicide. According to Robinson (2010), adolescent suicide

is the second most common cause of death among individuals aged 15-24 years. Therefore, enhancing ways in which AAALs can access relevant and helpful information represents an important intervention that could spare some lesbian adolescents from committing suicide.

As revealed in the study, lesbian adolescents who felt esteemed and cared for were more likely to have an optimistic perception regarding their sexuality and, therefore, also a more positive outlook for the future. Adult support is also important because it helps LGBT youths to gain access to the right information, which places them in a better position for getting control of their lives. As discussed in the literature review chapter, personal control seems to be realized only when youths are exposed to cognitive restricting techniques among other useful measures, which help them to overcome feelings of rejection and low self-esteem, among other negative attitudes and identifications (O'Donnell et al., 2011).

The Role of Civil Rights Organizations

For a long time, civil rights movements and other social-support groups have played a key role in augmenting homophobia in the African-American community. African-American gay, lesbian, and transgender population have often been perceived as a threat to the empowerment of the African-American community (O'Donnell et al., 2011). This assumption has contributed to generational homophobia. The role of civil rights organizations and other social-support groups remains important because these groups can facilitate the inclusion of African-American lesbians in their communities and families (Gary et al., 2003). Social support from such organizations is likely to help in the

fight against cultural stigmatization and discreditation and the continuing erroneous assumptions regarding LGBT persons.

Psychiatric Diagnoses

Psychological distress arising from lack of adult social support is one of the main factors leading to adolescent suicidal ideation. Posttraumatic disorders, substance abuse, and generalized anxiety disorders are some of the problems that affect AAALs. The importance of the psychiatric diagnosis in the treatment process rests upon the fact that the appropriate diagnosis helps to identify the major causes of psychological distress among those seeking mental health services (Robinson, 2010). Social support is important in this context because it can help health professionals to get the right information about the suffering individual and avoid misdiagnosing or underdiagnosing the problem.

Psychological pressure remains one of the critical causes of internalized phobias among lesbians. Suicide attempts are often the result of ongoing conflicts that arise from a harsh relationship with family and friends. The lesbian youth may decide to handle the fear from within, and some may opt to take their lives as a final solution (Gary et al., 2003). Therefore, supportive networks from family and friends can act as a buffer against suicide and depression among lesbians and gays. As revealed in the study, in order to mitigate the high rate of adolescent suicide among AAALs, there is a need for the establishment of strong social support networks and increased levels of social support in order to enhance the sense of belonging, worth, and purpose of lesbian youths (O'Donnell et al., 2011; Proctor & Groze, 1994).

Professional Support

The sample in this study consisted entirely of school-age girls between 13 and 19 years, raised in a variety of households. About two thirds were attending college, and about one third reported some high school attendance. The social context provided by the school strongly influences adolescent development in young girls. As revealed in this study, most of the school experiences of these AAALs have contributed to their isolation, stigmatization, and the discrimination and prejudice suffered on the hands of society. It is important to point out that teachers and heads of schools are required to provide social as well as professional support to lesbians and gays (Bryant & Harder, 2008; O'Donnell et al., 2011). The presence of supportive professionals and peers may enhance the availability of information that can help AAALs to understand their sexual orientation and not see it as a negative condition, but rather as something that should not be a cause for worry. In addition to the support from family members and friends, the majority of the youths in this study rated professionals as helpful. The study also revealed that attitude towards homosexuality significantly contributed to suicidality and hopelessness in this sample. Therefore, interventions should most appropriately be focused on changing attitudes toward sexual orientation in AAALs in a positive direction.

Implications for Social Change

Thousands of young people aged 15-24 years continue to succumb to the pressures of life and commit suicide each year in the United States. The results of this study highlight the dramatic increase in suicide rates among African-American adolescents in recent years as well as the fact that these young people are at higher risk of

committing suicide than their Caucasian counterparts. The issue of increased suicidality among minority youths has been even more pronounced in inner-city areas where the rate of attempted suicides among African-American adolescents is fully twice the national rate for this age bracket (Silenzio et al., 2007). While attitudes are changing across the country, almost one third of these tragic suicides are still associated with the victims' sexual orientation and societal prejudice against same-sex relationships. The study of family and social risk factors for suicide is facilitated with the use of thoughtfully developed theories and models of health behavior such as the social support theory. A thoughtfully constructed model has the potential to promote the development of interventions to reduce the risk of suicidality among AAALs. The model should be able to deal effectively with attitudes toward homosexuality because it has been established that this variable significantly affects suicidality and hopelessness among AAALs.

Implications for Counselors

Cultural stigmatization associated with a lesbian identification presents counselors with numerous challenges and opportunities in working with lesbian clients. Robinson (2010) mentioned that lesbian clients usually seek counseling for two reasons: One of the main reasons presented is that they are struggling with a poor or unsatisfying relationship with their partner or with other people around them. The second compelling reason arises when lesbian clients are in no relationship at all. The main implications of this study are based on how counselors are required to handle these two situations during therapy.

Working With Individuals

Most lesbian clients are willing to work on finding solutions to the various concerns regarding social-support networks. As previously discussed, the African-American LGBT population faces a myriad of issues that tend to challenge their sexual identity, often due to internalized homophobia. Furthermore, the psychological pressures resulting from this issue reduce the ability of AAALs to develop meaningful personal relationships (Bryant & Harder, 2008; Silenzio et al., 2007). In this case, social change can come about when counselors encourage their lesbian clients to develop a pictorial image of their social-support network to gain a better understanding of the challenges at hand. Therefore, the main implication for counselors, which this study reinforces, is the urgent need for familial and social integration as the primary way of developing positive social-support relationships that benefit AAALs. Another important implication is that counselors themselves should have a positive attitude toward homosexuality so that they will exhibit and inspire hopefulness for the future when dealing with suicidality issues. Counselors should include activities that facilitate the identification and use of support networks that are so important to saving young lives.

Working With Lesbian Couples

As previously discussed, suicidal thoughts and suicide attempts among the LGBT population are due to a number of risk factors, and lack of friendships and social support are of critical importance among them. The difficulty in finding productive ways of solving disagreements with their families is often exacerbated by the lesbian couple and their peers, adding to the psychological pressures. Silenzio et al. (2007) repeatedly

highlighted the need to develop communication and the sharing of common goals between the LGBT population and other people in the community. The role of the counselor in helping lesbian couples to build positive social-support networks is mainly based on offering information that can enhance direct self-growth as well as improve the couple's current and future relationships with other members of society. While focusing on the development of support networks is decidedly beneficial, another vitally important area of intervention to decrease suicidality involves fostering a positive and healthy attitude within the AAAL about being a lesbian.

Recommendations for Action Based on the Findings

Many young people in the United States continue to experience the devastating emotional turmoil resulting from the social stigma associated with same-sex relationships. In some cases, this internal turmoil can lead to the ultimate reaction of suicide. This tragic outcome has, however, been shown to be largely avoidable if the social support in the victim's life is strong and dependable. Clearly, when this level of social support is unavailable within the victim's family, social services must stand ready to pick up the slack. As many states across the country enact more enlightened laws that allow same-sex marriage and are supported in this by Supreme Court decision, societal attitudes are likely change over time, reducing the severity that social stigma so often entails. Nevertheless, adolescents in particular are at high risk for a wide range of negative outcomes, including increased substance abuse and poor academic performance during their formative years, making the need for community-based social services all the more urgent. A multidisciplinary approach, as well as Supreme Court decisions that

acknowledge LGBT marriage, may be required, particularly for young people who have demonstrated suicidal tendencies, including the several warning signs disclosed by the BSS. Additional resources need to be allocated to community-based social services to develop informed and timely programs that can offer these young people a social-support network that might otherwise be lacking in their lives.

Recommendations for Further Study

Additional studies should be conducted with a larger sample of AAALs and also with samples including both male and female homosexual youths. Future phenomenological studies on this topic should examine the perceptions of the participants regarding the impact of various factors within their spectrum of availability to perceive suicide as a sensible means. In this vein of thinking about suicide, the notion emerges that the interplay between the acceptability of suicide as a remedy for the stressors of life and the nonacceptance of gender roles, which are considered normative in society, should be investigated with AAALs (Robinson, 2010). Qualitative research in this area would provide significantly more information about the experiences and perceptions in this population. The results of this type of study could assist with the education of African Americans about the prevalence of suicide within their community. It would also allow mental health professionals to construct adequate prevention, intervention, and treatment strategies for African Americans who display suicidal tendencies.

Future studies in this area should also be conducted about the interventions designed to reduce the stigma associated with mental and emotional health. This would obviously be geared toward the general population as regards seeking therapeutic

solutions. Accordingly, such continuous sensitization with regard to mental health could provide an extensive framework where African-American lesbians could find a platform to deal with their life problems (O'Donnell et al., 2011). This could relay the understanding that the support system enables this population to access reliable persons with whom to share their frustrations. Such a framework, if further studied, could become an integral part promoting solution to the problem of suicidality among AAALs.

Conclusion

In recent years, great strides have been made with respect to the civil rights of people who identify themselves as LGBT. However, recent history also has shown that the granting of civil liberties does not in itself guarantee a positive social experience. This study upheld the notion that the lack of personal and social support for members of this minority population can have deadly consequences. While this study was designed primarily to examine the role of social support in decreasing suicidality, the results indicated that it would be even more efficient to focus on AAALs' attitude about being a lesbian to improve their outlook on life and prevent suicidality. Although social support did not have the expected strong influence on suicidality, this does not diminish society's responsibility to the population of interest, which is to find ways to support them and protect them from the consequences of their social isolation and lack of support.

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Appendix A: Informed Consent Form

Title of the Study: The Relationship Between Suicide Ideation and Adult Support Among African American Adolescent Lesbians

Researcher: LaTonya J. Watters, MS, LPC, NCC

Department of Psychology, Walden University

Dissertation Chair: Dr. Savior Dixon-Saxon, PhD, LPC, NCC

Department of Psychology, Walden University

Purpose of the Research

I understand that the purpose of this study is to gain a better understanding and examine the relationship between suicidal ideation in African American adolescent lesbians and adult social support. Participants are African American adolescents who identify themselves as being lesbian. The study is part of the investigator's dissertation research in the Department of Psychology at Walden University.

How Participants are Selected

I understand that participants for this study will be recruited through gay publications, gay/lesbian support groups, youth drop-in centers, and referrals from friends. I understand that participants recruited in this study must meet the following criteria in order to participate in this study: (a) They are African American adolescent lesbians; (b) parental consent will be given for any underage participants to participate; (c) they have self-identified as lesbians; (d) they will be presumed to be honest in their dealings with their sexual orientation, both positive and negative experiences; and (e)

they will be honest in their experience with adult support, either the lack of support or telling someone whom they trusted about their sexual orientation.

Study Procedures

I understand that the nature of my participation includes completing four (4) scales in the packet: the Beck Hopelessness Scale, Duke Social Support and Stress Scale, Homosexuality Attitudes Scale, and Beck Scale for Suicide Ideation, which entails an instruction sheet for each scale and date for mailing all information back to the researcher. Also, participants will complete a short demographics questionnaire. I understand that the scales will take appropriately 90 minutes total to complete.

I understand that my participation and all information that I will provide will be held in the strictest confidence and that all identifying data such as names and addresses will not be made public. I further understand that all identifying data will be secured in a locked file cabinet at the researcher's home office. I also understand that storage of the study data will be confined to the researcher's personal computer and destroyed after the data have been transcribed and analyzed, after a period not to exceed 7 years.

Risks and Benefits

Possible Risks. I understand that my participation in this study involves little or no physical harm to me. I also understand that my participation in the study will include answering questions about my personal experience with being an adolescent lesbian and adult social support. Because these experiences may be painful to remember or to reveal, I understand that I may experience temporary emotional distress or strong emotions while completing the scales. Should this occur, I understand that I may contact the researcher

and request a referral to a professional with whom I can discuss my feelings about the study.

Benefits. I understand that my participation in this study will provide information about suicidality among African-American adolescent lesbians and its correlation of adult support. The information may be added to the limited body of research in order to gain more insight into African-American adolescent lesbians and adult social support. I also understand that there will be no monetary compensation for my participation.

Confidentiality/Anonymity

I understand that all documents, scales, and information pertaining to this research study will be kept confidential in accordance with all applicable federal, state, and local laws and regulations. I understand that data generated by the study may be reviewed by the Institutional Review Board (IRB) of Walden University or by federal agencies charged with assuring proper conduct of the study and compliance with federal regulations. I understand that all identifying information will be removed from the data to preserve my anonymity. I understand that the results of this study may be published. If any information relating to me is published, I will not be identified by name or any other distinguishing characteristic.

Disclaimer/Withdrawal

I understand that I am free to decide whether or not to participate in this study. I further understand that nonparticipation in the study or withdrawal from the study will not prejudice future interactions with the researcher or with Walden University.

Participants' Rights

For questions regarding my rights as a research participant, I understand that I may contact Walden University at 1-866-492-5336. I may also contact the supervisor of the study, Dr. Savior Dixon-Saxon, at (xxx) xxx-xxxx.

Reporting and Disclosure

I understand that the researcher has an ethical obligation and mandate to report information that may suggest abuse, neglect, or exploitation of vulnerable persons. I further understand that if I share certain information that the researcher may have an obligation to report this information to the proper ethics board or the division of protective services.

Consent to Participate

Signing my name below indicates that this study has been explained to me, I have read the consent form, and I agree to participate. I will be given a copy of the signed consent for my records.

- If you are interested in receiving the results of the study, please check _____.

_____ _____
Participant's Signature Date

_____ _____
Researcher's Signature Date

_____ _____
Witness's Signature Date

Appendix B: Demographics Form

Please answer these 10 questions with the most accurate information.

1. What is your age? _____

2. What is your gender? (check one): ___ Male ___Female

3. What is your sexual orientation? (check one)

___ Straight

___ Gay/Lesbian

___ Bisexual

4. What is your ethnicity? _____

5. What type of household were you raised in? (mark the best answer)

___ Traditional (both biological parents were in the home)

___ Nontraditional (at least 1 biological parent and a stepparent were in the home)

___ Single Parent (only 1 biological parent was in the home)

___ Other (neither biological parent was in the home)

6. Mark which best describes your household:

___ Biological Mother and Father

___ Biological Mother and Stepfather

___ Stepmother and Biological Father

___ Biological Mother only

___ Biological Father only

___ Nonrelated Adult(s)

___ Biological Grandparents (or least 1 Grandparent)

7. Do you have any adult support? Meaning, any adults that you can talk to concerning your sexual orientation. ___Yes ___No

8. Does your community have a Gay/Lesbian Community Center? It may have a different name, but is there a place where gays and lesbians can go to get help or talk with someone about gay/lesbian issues? ___ Yes ___ No

9. What is your highest level of education?

___ Elementary School

___ Some Middle School

___ Graduated Middle School

___ Some High School

___ Graduated High School

___ GED

___ Currently in College

___ Some College

___ Received a BS or BA degree from College

10. What is your religious affiliation? _____

Appendix C: Permission to Use the Beck Scale for Suicide Ideation (BSS)

August 20, 2008

Pearson

Sent via Email to: lwatt001@waldenu.edu

19500 Bulverde Road

San Antonio, TX 78259

Walden University
C/o LaTonya Watters

Re: Beck Scale for Suicide Ideation (BSS) herein the "Test"

Dear: LaTonya Watters

Thank you for your correspondence dated August 20, 2008 requesting permission to use the Test for your dissertation research study.

As the publisher we have no objection to the use of this Test for the purpose as stated above subject to the following Terms and Conditions:

Use the Test, as it is intended to be used when sold by Pearson, in your dissertation research study.

Review and analyze Test responses so long as no actual test items are included in the body or appendices of your research results.

This grant of permission is non-exclusive and is not to be construed as granting you any rights other than the permission described above.

This permission is granted singularly for the purposes stated above. If permission beyond what is specifically granted herein is required, a separate permission would be required. Thank you for your interest in our materials. If you need additional assistance, please contact me directly at the below email address, at 210 -339-5345, or toll free at 800-228-0752 ext. 5345.
Sincerely,
William H. Schryver
William H. Schryver
Permissions Specialist
Clinical Assessment
Pearson
pas.licensing@pearson.com

Appendix D: Permission to Use the Beck Hopelessness Scale (BHS)

Appendix C: Permission to use BHS

August 20, 2008

Pearson

Sent via Email to: LaTonya Watters

19500 Bulverde Road

San Antonio, TX 78259

Walden University
C/o LaTonya Watters

Re: Beck Hopelessness Scale (BHS) herein the "Test"

Dear LaTonya Watters:

Thank you for your correspondence dated August 20, 2008 requesting permission to use the Test for your dissertation research study.
As the publisher we have no objection to the use of this Test for the purpose as stated above subject to the following Tee«5íand Conditions:

Use the Test, as it is intended to be used when sold by Pearson, in your dissertation research study.

Review and analyze Test responses so long as no actual test items are included in the body or appendices of your research results.

This grant of permission is non-exclusive and is not to be construed as granting you any rights other than the permission described above.

This permission is granted singularly for the purposes stated above. If permission beyond what is specifically granted herein is required, a separate permission would be required.

Thank you for your interest in our materials. If you need additional assistance, please contact me directly at the below email address, at 210 -339-5345, or toll free at 800-228-0752 ext. 5345.
Sincerely,
William H. Schryver
William H. Schryver
Permissions Specialist
Clinical Assessment
Pearson
pas.licensing@pearson.com

Appendix E: Permission to Use the Homosexuality Attitude Scale (HAS)

Subject : **RE: Permission to use tool**

Date : Sat, Feb 21, 2009 10:24 AM CST

From : "Kite, Mary E." <mkite@bsu.edu>

To : LaTonya Watters <lwatt001@waldenu.edu>

"Kite, Mary E." <mkite@bsu.edu>

LaTonya:

You are welcome to use the scale.

Best of luck in your research.

Mary

From: LaTonya Watters [lwatt001@waldenu.edu]

Sent: Thursday, February 19, 2009 7:12 PM

To: Kite, Mary E.; lwatt001@waldenu.edu

Subject: Permission to use tool

Hello Dr. Kite,

I would like to use your Homosexuality Attitude Scale in my research related to me completing my dissertation at Walden University. I was hoping that you would grant me permission to use this scale in my study. Please email me back if you approve of me using your scale in my dissertation.

Thanks in advance for your time, LaTonya Watters, LPC, NCC, MS

Appendix F: Permission to Use the Duke Social Support and Stress Scale (DUSOCS)

From: George R Parkerson <parke001@mc.duke.edu>

Date: 2008/01/11 Fri PM 09:22:13 CST

To: <lwatt001@waldenu.edu>

Subject: Re: Duke Social Support and Stress Scale

Thank you for your interest in the Duke Social Support and Stress Scale (DUSOCS). You are welcome to use it for your dissertation free of charge.

You can find more information on our website <http://healthmeasures.mc.duke.edu>. Also, you can use the website to order a User's Guide.

George Parkerson

01/11/2008 05:10

To: parke001@mc.duke.edu

From lwatt001@waldenu.edu

Subject: Duke Social Support and Stress Scale

Hello Dr. Parkerson,

I am a PhD psychology student working on my dissertation at Walden University. I was hoping and in need for you to would grant me permission to use the: The Duke Social Support and Stress Scale in my paper. Thank you for your time and have a blessed day.

LaTonya Watters

Appendix G: Data Analysis Tables and Figures

Table G1

Distribution of Raw Scores for the DUSOCS I: People Who Give Personal Support

How supportive are these people now?	0 = *none*	1 = *some*	2 = *a lot*
1. Your wife, husband, or significant other person	42 (21.0%)	66 (33.0%)	92 (46.0%)
2. Your children or grandchildren	45 (22.5%)	88 (44.0%)	67 (33.5%)
3. Your parents or grandparents	49 (24.5%)	97 (48.5%)	54 (27.0%)
4. Your brothers or sisters	56 (28.0%)	102 (51.0%)	42 (21.0%)
5. Your other blood relatives	75 (37.5%)	102 (51.0%)	23 (11.5%)
6. Your relatives by marriage	80 (40.0%)	89 (44.5%)	31 (15.5%)
7. Your neighbors	80 (40.0%)	94 (47.0%)	26 (13.0%)
8. Your coworkers	78 (39.0%)	95 (47.5%)	27 (13.5%)
9. Your church members	88 (44.0%)	82 (41.0%)	30 (15.0%)
10. Your other friends	99 (49.5%)	79 (39.5%)	22 (11.0%)

Table G2

Distribution of Raw Scores for the DUSOCS II: People Who Cause Personal Stress

How stressed do you feel by these people now?	0 = *none*	1 = *some*	2 = *a lot*
1. Your wife, husband, or significant other person	75 (37.5%)	59 (29.5%)	66 (33.0%)
2. Your children or grandchildren	96 (48.0%)	61 (30.5%)	43 (21.5%)
3. Your parents or grandparents	94 (47.0%)	77 (38.5%)	29 (14.5%)
4. Your brothers or sisters	75 (37.5%)	80 (40.0%)	45 (22.5%)
5. Your other blood relatives	103 (51.5%)	79 (39.5%)	18 (9.0%)
6. Your relatives by marriage	113 (56.5%)	65 (32.5%)	22 (11.0%)
7. Your neighbors	110 (55.0%)	71 (35.5%)	19 (9.5%)
8. Your co-workersy6io	102 (51.0%)	78 (39.0%)	20 (10.0%)
9. Your church members	110 (55.0%)	71 (35.5%)	19 (9.5%)
10. Your other friends	129 (64.5%)	62 (31.0%)	9 (4.5%)

Table G3

Descriptive Statistics of the Variables

	N	Minimum	Maximum	Mean	*SD*	Skewness	Kurtosis
Social support	200	21.43	100.00	61.5	13.62	-.544	.662
Social stress	200	.00	59.09	29.15	14.75	-.245	-.931
Hopelessness	200	19.00	56.00	30.57	7.16	.726	1.363
Suicidal ideation	200	19.00	57.00	21.74	6.76	3.242	11.213
Attitude toward homosexuality	200	42.00	103.00	69.80	13.79	1.140	.781

Table G4

Distribution of Raw Scores for the Beck Scale for Suicide Ideation (BSS)

Item	0 No suicidal ideation	1 Weak suicidal ideation	2 Moderately strong suicidal ideation
1. Wish to live	144 (72.0%)	44 (22.0%)	12 (6.0%)
2. Wish to die	151 (75.5%)	37 (18.5%)	12 (6.0%)
3. Reasons for dying	161 (80.5%)	31 (15.5%)	8 (4.0%)
4. Desire to kill myself	161 (80.5%)	31 (15.5%)	8 (4.0%)
5. Not take steps necessary to avoid death	172 (86.0%)	24 (12.0%)	4 (2.0%)
6. Long periods of thinking about suicide	166 (83.0%)	30 (15.0%)	4 (2.0%)
7. Continuously thinking about suicide	180 (90.0%)	16 (8.0%)	4 (2.0%)
8. Accept idea of suicide	177 (88.5%)	19 (9.5%)	4 (2.0%)
9. Cannot keep myself from suicide	189 (94.5%)	9 (4.5%)	2 (1.0%)
10. Concerned about suicide	177 (88.5%)	20 (10.0%)	3 (1.5%)
11. Reasons for suicide	180 (90.0%)	17 (8.5%)	3 (1.5%)
12. Specific plan for suicide	176 (88.0%)	19 (9.5%)	5 (2.5%)
13. Opportunity for suicide	188 (94.0%)	9 (4.5%)	3 (1.5%)
14. Courage/ability for suicide	178 (89.0%)	20 (10.0%)	2 (1.0%)
15. Sure to make suicide attempt	190 (95.0%)	6 (3.0%)	4 (2.0%)
16. Finished preparations for suicide	195 (97.5%)	3 (1.5%)	2 (1.0%)
17. Completed a suicide note	190 (95.0%)	7 (3.5%)	3 (1.5%)
18. Made arrangements after suicide	180 (90.0%)	17 (8.5%)	3 (1.5%)
19. Attempted to hide suicide ideation	188 (94.0%)	7 (3.5%)	5 (2.5%)

Table G5

Distribution of Raw Scores for the Beck Hopelessness Scale (BHS)

Item	0 – *False*	1 –*True*
1. I look forward to the future with hope and enthusiasm	89 (44.5%)	111 (55.5%)
2. I might as well give up because there is nothing I can do about making things better for myself	121 (60.5%)	79 (39.5%)
3. When things are going badly, I am helped by knowing that they cannot stay that way forever.	84 (42.0%)	116 (58.0%)
4. I can't imagine what my life would be like in 10 years.	128 (64.0%)	72 (36.0%)
5. I have enough time to accomplish the things I want to do.	67 (33.5%)	133 (66.5%)
6. In the future, I expect to succeed in what concerns me most.	53 (26.5%)	147 (73.5%)
7. My future seems dark to me.	167 (83.5%)	33 (16.5%)
8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	82 (41.0%)	118 (59.0%)
9. I just can't get the breaks, and there's no reason I will in the future.	173 (86.5%)	27 (13.5%)
10. My past experiences have prepared me well for the future.	41 (20.5%)	159 (79.5%)
11. All I can see ahead of me is unpleasantness rather than pleasantness.	172 (86.0%)	28 (14.0%)
12. I don't expect to get what I really want.	175 (87.5%)	25 (12.5%)
13. When I look ahead to the future, I expect that I will be happier than I am now.	61 (30.5%)	139 (69.5%)
14. Things just won't work out the way I want them to.	167 (83.5%)	33 (16.5%)
15. I have great faith in the future.	59 (29.5%)	141 (70.5%)
16. I never get what I want, so it's foolish to want anything.	181 (90.5%)	19 (9.5%)
17. It's very unlikely that I will get any real satisfaction in the future.	179 (89.5%)	21 (10.5%)
18. The future seems vague and uncertain to me.	161 (80.5%)	39 (19.5%)
19. I can look forward to more good times than bad times.	41 (20.5%)	159 (79.5%)
20. There's no use in really trying to get anything I want because I probably won't get it.	181 (90.5%)	19 (9.5%)

Table G6

Distribution of Raw and Reversed Scores for the Homosexuality Attitude Scale (HAS)

Item	1 *SD*	2 *D*	3 *N*	4 *A*	5 *SA*
1. I would not mind having a homosexual friend.	0 (0.0%)	0 (0.0%)	2 (1.0%)	19 (9.5%)	179 (89.5%)
2. Finding out that an artist was gay would have no effect on my appreciation of his/her work.	0 (0.0%)	0 (0.0%)	1 (0.5%)	8 (4.0%)	191 (95.5%)
3. I won't associate with known homosexuals if I can help it.	95(47.5%)	75 (37.5%)	0 (0.0%)	12 (6.0%)	18 (9.0%)
4. I would not look for a new place to live if I found out my roommate was gay.	0 (0.0%)	0 (0.0%)	1 (0.5%)	74 (37.0%)	125 (62.5%)
5. Homosexuality is a mental illness.	164 (82.0%)	34 (17.0%)	2 (1.0%)	0 (0.0%)	0 (0.0%)
6. I would not be afraid for my child to have a homosexual teacher.	31 (15.5%)	1 (0.5%)	7 (3.5%)	81 (40.5%)	80 (40.0%)
7. Gays dislike members of the opposite sex.	89 (44.5%)	63 (31.5%)	3 (1.5%)	4 (2.0%)	41 (20.5%)
8. I do not really find the thought of homosexual acts disgusting.	0 (0.0%)	2 (1.0%)	3 (1.5%)	79 (39.5%)	116 (58.0%)
9. Homosexuals are more likely to commit deviant sexual acts, such as child molestation, rape, and voyeurism than are heterosexuals.	111 (55.5%)	71 (35.5%)	0 (0.0%)	0 (0.0%)	18 (9.0%)
10. Homosexuals should be kept separate from the rest of society.	173(86.5%)	27 (13.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
11. Two individual of the same sex holding hands or displaying affection in public is revolting.	127 (63.5%)	56 (28.0%)	0 (0.0%)	0 (0.0%)	17 (8.5%)
12. The love between two males or two females is quite different from the love between two persons of the opposite sex.	53 (26.5%)	102 (51.0%)	4 (2.0%)	24 (12.0%)	17 (8.5%)
13. I see the gay movement as a positive thing.	111 (55.5%)	71 (35.5%)	3 (1.5%)	4 (2.0%)	11 (5.5%)
14. Homosexuality is not sinful.	120 (60.0%)	73 (36.5%)	4 (2.0%)	3 (1.5%)	0 (0.0%)

(*table continues*)

Item	1 *SD*	2 *D*	3 *N*	4 *A*	5 *SA*
15. I would not mind being employed by a homosexual.	2 (1.0%)	2 (1.0%)	4 (2.0%)	89 (44.5%)	103 (51.5%)
16. Homosexuals should be forced to have psychological treatment.	94 (47.0%)	82 (41.0%)	0 (0.0%)	1 (0.5%)	23 (11.5%)
17. The increasing acceptance of homosexuality in our society is aiding in the deterioration of morals.	90 (45.0%)	86 (43.0%)	0 (0.0%)	0 (0.0%)	24(12.0%)
18. I would decline membership in an organization just because it had homosexual members	89(44.5%)	87 (43.5%)	0 (0.0%)	0 (0.0%)	24(12.0%)
19. I would vote for a homosexual in an election for public office.	0 (0.0%)	1 (0.5%)	1 (0.5%)	78 (39.0%)	120 (60.0%)
20. If I knew someone were gay, I would still go ahead and form a friendship.	0 (0.0%)	1 (0.5%)	3 (1.5%)	59 (29.5%)	137 (68.5%)
21. If I were a parent, I could accept my son or daughter being gay.	5 (2.5%)	9 (4.5%)	3 (1.5%)	81 (40.5%)	102 (51.0%)

Note. SD = *strongly disagree*. D = *disagree*. N = *neutral*. A = *agree*. SA = *strongly agree*.

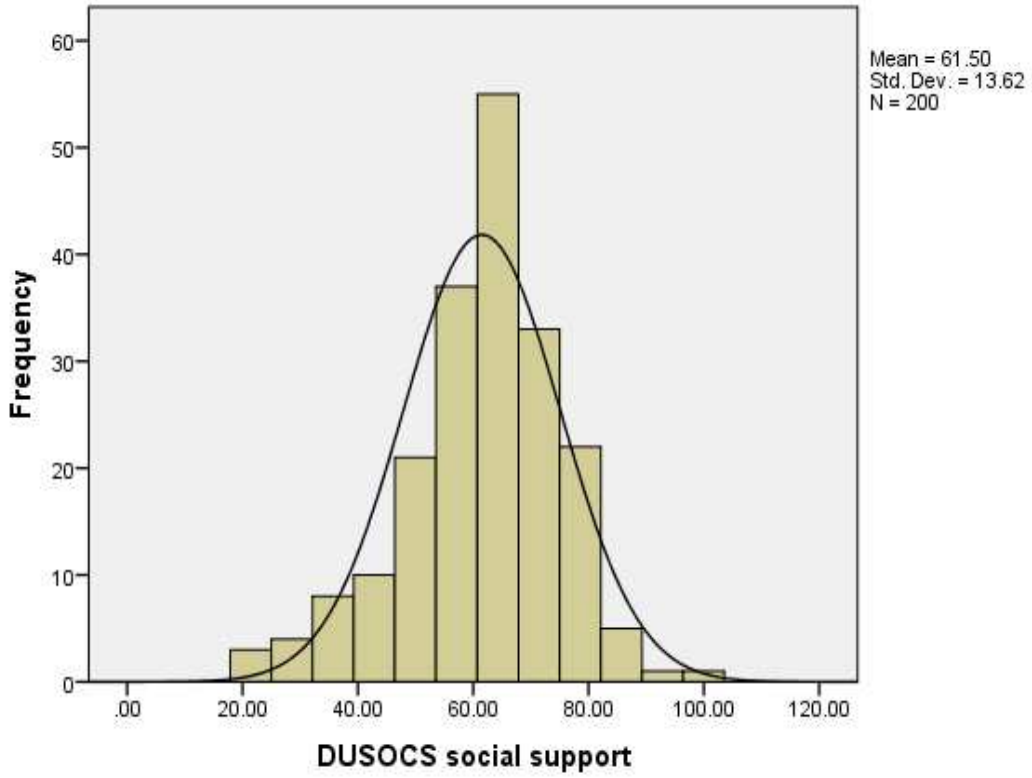

Figure G1. Histogram of DUSOCS social-support distribution.

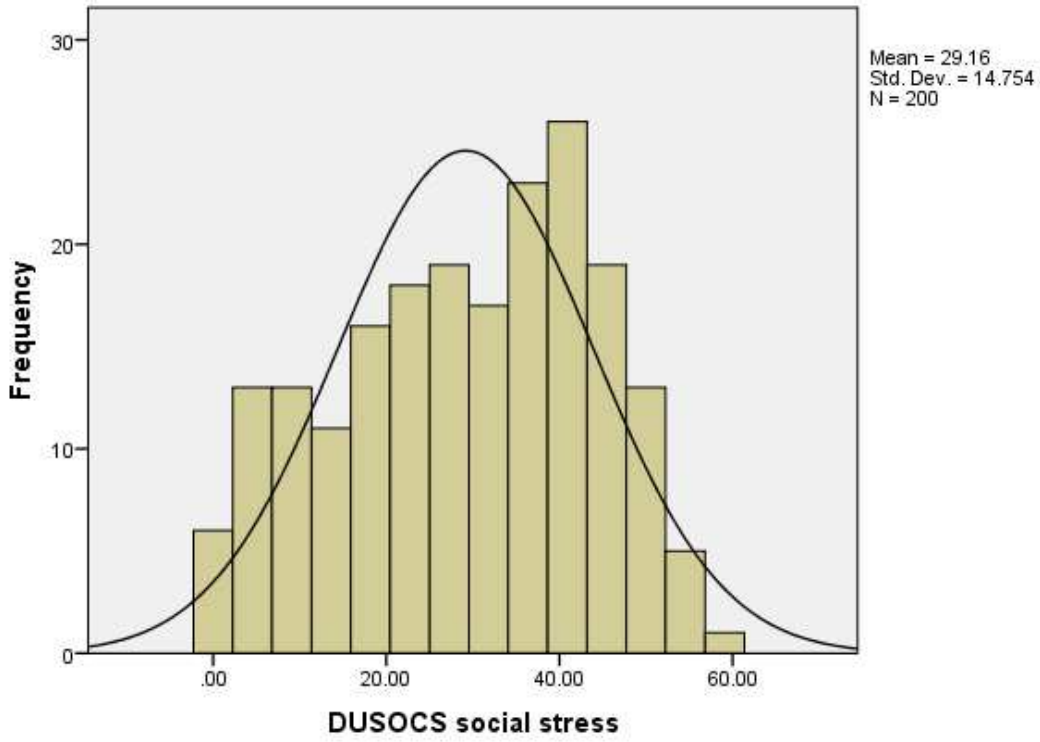

Figure G2. Histogram of DUSOCS social stress distribution.