The Impact of Caregiver-Child Relationships During Development on the Coming out Process, Perceived Support, and Mental Health in Sexual Minority Adults

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Abstract

The purpose of this study was to examine the relationship of caregiver-child relationships (attachment and closeness) to the coming out experience and perceived support of sexual minority individuals. Mental health issues as they relate to caregiver-child relationships were also examined as previous research has indicated that this community is at an increased risk for developing poor mental health outcomes. The sample included 72 LGB+ adults who had disclosed their sexual orientation to at least one of their caregivers. There was a moderate correlation between caregiver-child relationships and mental health issues. Additionally, the level of caregiver support received was moderately correlated to caregiver closeness while growing up. Lastly, the bond that caregiver two and the sexual minority individual shared was moderately correlated with their coming out experience. Study limitations and strengths, practice implications, and recommendations for future research are discussed.

Introduction

Caregivers of sexual minority children play a vital role in helping reduce the likelihood and severity of mental health problems in their children. The term "sexual minority" refers to individuals who identify as lesbian, gay, bisexual, or other nonheterosexual identities. Caregiver support is crucial due to the strong bond that forms between a caregiver and their child as a child develops. The attachment formed between a caregiver and their child can never be fully supplemented or replaced by another individual. From birth, children seek their caregiver(s) guidance to help navigate the world which will impact how they view themselves and those around them. Therefore, if a caregiver consistently has a negative reaction to their child's sexual orientation, then the child may internalize these feelings, impacting how they view themselves (Ryan et al., 2010). The same may also occur if a caregiver has a negative reaction to other sexual minority individuals (Ryan et al, 2010). Specifically, the youth may translate their caregiver(s) negative reaction to sexual minority individuals as what would happen if they came out as a member of the LGB+ community. Additionally, the nature of the relationship between a caregiver and child can impact the likelihood that the child wishes to disclose their sexual orientation (Bergen et al., 2020). If a sexual minority child does not feel safe or supported by their caregiver, then they may take longer to share their sexual orientation or may hide it entirely (Bergen et al., 2020). In this study caregiver-child attachment and caregiver-child closeness were examined in relation to the coming out process, perceived support, and mental health of sexual minority adults.

To begin it is first important to understand some background information on the LGB+ community and how prevalent mental health problems are among members. LGB

stands for lesbian, gay, and bisexual, and other nonheterosexual orientations. Traditionally “T” referring to transgender individuals would be at the end of this acronym but for this research sexual orientation was the focus rather than gender identity, as sexual orientation and gender identity are different topics. Sexual orientation refers to an individual’s attraction to another in a romantic, emotional, or sexual manner whereas gender identity refers to one’s own internal sense of self and their gender. Throughout this research study, the terms sexual minority and LGB+ were used interchangeably.

Caregiver Attachment

The impact caregivers have on the lives of their children, beginning at birth and following well into adulthood, is undeniably important. Caregiver-child relationships will impact how the child forms and develops relationships with other people as well as how they view themselves. Attachment occurs when a child is in a distressing situation and is impacted by how accessible and attentive the caregiver is to their child’s emotional needs and the potential danger at hand (Katz-Wise, Rosario, & Tsappis, 2016). This attachment is formed due to an accumulation of interactions between the caregiver and child, not just one experience. According to Mohr and Fassinger (2003), an individual’s attachment style can be characterized as either insecure or secure. Individuals with a secure attachment have a positive model of the self and others as their caregivers have been accessible when in need and responsive in an attentive manner (Katz-Wise, Rosario, & Tsappis, 2016). In contrast, insecure attachment forms when an individual’s caregiver is unresponsive and inaccessible to the needs of their child (Katz-Wise, Rosario, & Tsappis, 2016). The attachment style that is formed between a caregiver and child will determine

how the child learns to regulate their emotions, explore their environment, and become independent.

One reason secure attachment is so important when looking at sexual minority individuals' mental health is that such individuals will need to have skills to cope with various emotions associated with the coming out process. The coming out process can be a challenging time for many sexual minority individuals so being able to regulate and cope with potential stressors is vital. Additionally, an individual's attachment style with their caregiver(s) could predict how the caregiver will react to their child's sexual orientation disclosure. Sexual minority individuals with a secure attachment were more likely to have a positive coming out experience as they were encouraged to explore their identity and were valued as unique individuals growing up (Katz-Wise, Rosario, & Tsappis, 2016). Furthermore, caregivers of securely attached children who had feelings of concern and shock when their child disclosed their sexual orientation were more likely to work through their negative emotions over time and remain accessible and responsive to their child's needs. In contrast, children who have an insecure attachment to their caregiver were more likely to experience a negative coming-out experience (Katz-Wise, Rosario, & Tsappis, 2016). This is likely due to the child going against their caregiver's expectations of them in addition to potentially negative attitudes towards the LGB+ community.

Caregiver Closeness

As a child grows, they will develop a bond or closeness with their caregivers. This bond can have a profound impact on how comfortable the child feels about disclosing personal information about themselves to their caregivers, including their sexual

orientation. Closeness refers to the bond that forms between two people. Individuals who have a close relationship will like each other, be knowledgeable about the other person, and want to spend time together. Research has shown that having a positive relationship with one's caregivers will impact how and when a child chooses to disclose their sexual orientation (Grafsky, 2017). Grafsky goes on to say that-sexual minority individuals who reported having a very close relationship with their caregivers were more likely to seek out their caregivers for support regarding their same-sex attractions. In contrast, individuals who reported low levels of closeness were more hesitant to disclose their sexual orientation to their caregivers. Additionally, individuals who reported a high level of closeness with their caregiver were more likely to make a planned decision to disclose their sexual orientation to their caregiver. Planned disclosure decision meant that the sexual minority individual consciously considered whether to disclose their sexual orientation while unplanned disclosure decision occurred without a preplanned or expected disclosure. Grafsky's research is important in showing how sexual minority individuals' level of closeness with their caregivers influences when and how they choose to disclose their sexual orientation.

Coming Out Experience

The coming out experience is the process of identifying and disclosing one's sexual minority attraction to others including family, friends, coworkers, and acquaintances (Bergen et al., 2020). There are many factors that come into play when sexual minority individuals chose to disclose their sexual orientation, especially with one's caregivers. Motivation for disclosing one's sexual orientation varies. Regardless, sexual minority individuals report having a strong desire to disclose their sexual

orientation to their families so that they can live their life authentically (D'Augelli, 2002). Disclosure can also result in more emotional, physical, and social resources becoming available for LGB+ individuals. Nevertheless, many sexual minority individuals fear and worry about how their caregivers will react to their disclosure even if they have a close, positive relationship (D'Augelli, 2002). On average, LGB+ individuals are aware of their sexual orientation for three years before disclosing their sexual orientation to their caregivers (Bergen et al., 2020). The reason individuals may take this long to come out to their caregivers is rooted in the idea that their caregivers will reject them due to their sexual orientation. This fear is warranted as research has shown that non-affirming reactions are common during the period immediately following disclosure. Furthermore, how caregivers discuss, react, and feel about the LGB+ community can impact when sexual minority individuals disclose their sexual orientation. For example, D'Augelli (2002) found that, individuals whose caregivers did not give clear messages regarding how they felt about the LGB+ community were more hesitant to disclose their sexual orientation than those who knew how their caregiver would react positively. Caregivers displaying negative messages about the LGB+ community resulted in their children taking longer to disclose their sexual orientation.

The reason caregiver reaction has such a profound effect is that children's self-perception of the world is influenced by how they believe their caregivers evaluate and view them. Youth who experienced high rates of caregiver rejection were 8.4 times more likely to report attempting suicide at some point in their lives, 5.9 times more likely to report experiencing depressive symptoms, and 3.4 times more likely to report using illegal drugs and engage in unprotected sexual intercourse (Ryan et al., 2009). In contrast,

sexual minority individuals who had a positive coming out experience with their caregivers had more feelings of wholeness and a sense of coherence (Bergen et al., 2020).

Caregiver Support

Following the coming out process caregivers play a key role in helping reduce the likelihood of mental health problems developing in their child by being supportive of their child's sexual orientation. There are many ways that caregivers can show their support for their child's sexual orientation including advocating for their child when they are being mistreated due to their sexual orientation, bringing the youth to LGB+ organizations and events, requiring others to be respectful of the youth's sexual orientation, and welcoming LGB+ friends and partners (Ryan et al., 2010). For example, caregiver support has been found to protect against the development of depression, substance abuse, sexual risk behavior, and suicidal ideation in sexual minority individuals (Ryan et al., 2010). The research Ryan et al. (2010) completed provides important information about the impact caregiver support has on sexual minority individuals' physical and mental health. Additionally, based on research conducted by Roe (2016), sexual minority individuals reported that it was important for them to be given explicit verbal support for their sexual orientation from their caregivers. By verbally displaying support for the LGB+ community and children's expression of their sexual orientation caregivers will help reduce the likelihood of negative psychological issues developing as well as help maintain a positive caregiver-child relationship.

During the coming out process, caregiver rejection is a common experience among sexual minority individuals. Caregiver rejection can be due to a multitude of factors, including religious beliefs. There is a relationship between the level of religiosity

and negative attitudes towards homosexuality (Gibbs & Goldbach, 2015). Specifically, individuals who experienced a conservative religious upbringing and were having religious conflicts due to their sexual orientation were more likely to have suicidal thoughts. Participants who experienced religious conflict were more likely to have caregivers who were not supportive of homosexuality due to their conservative religious beliefs. This research shows how experiencing a religious upbringing that is unsupportive of the LGB+ community can put sexual minority individuals at a higher risk for developing internalized homophobia and mental health problems. Additionally, sexual minority individuals who raised in religious households are more likely to have a negative coming out experience and face discrimination within their family unit.

Mental Health

The LGB+ community has a greater risk of developing mental health problems when compared to the general population. Russell & Fish (2016) found that nearly one-third of sexual minority participants met the criteria for a mental illness and/or reported that they had a suicidal attempt at some point in their lifetime. Specifically, 18% of sexual minority members met the criteria for major depression while only 8.2% of the general population did. Additionally, 11.3% of sexual minority youth showed signs of PTSD and 31% reported some form of suicidal tendencies at some point in their life compared to just 3.9% and 4.1% respectively for the general population. This is a stark reality for the LGB+ community and has led many researchers to search for factors that can help prevent or reduce mental health problems from developing, particularly the relationship between mental health issues and caregiver characteristics.

Older members of the LGB+ community may be at higher risk for experiencing mental health problems. Yarns et al. (2016) found that older members of the LGB+ community might be at an even higher risk for experiencing mental health problems than others in the community. Older generations of sexual minority individuals lived through a time period where being LGB+ was considered immoral, illegal, and a mental disorder for a large period of history. For example, it was not until 1960 that the first state, Illinois, removed its anti-sodomy law, essentially decriminalizing homosexual behavior. It then took over fifty years for all sodomy laws to be considered unconstitutional in the United States with the ruling *in Lawrence V. Texas* in 2003 (Spindelman, 2004). Additionally, it was not until 1973 that the American Psychiatric Association (APA) asked all members attending their convention to vote on whether homosexuality should be considered a mental disorder (Burton, 2015). A majority of voters decided that homosexuality should be removed from the Diagnostic Statistical Manual (DSM). However, it was replaced by sexual orientation disturbance until 1987 when the APA decided to completely remove homosexuality from the DSM. The examples previously discussed show how, despite society's progression in its acceptance and treatment of sexual minority individuals, there was a time period when individuals feared showing homosexual behaviors publicly due to society's perception of the community. Older sexual minority adults likely experienced some form of mistreatment and discrimination for their sexual orientation at some point in their life. For example, D'Augelli (2002) found that 81% of LGB+ individuals have reported being verbally abused based on their sexual orientation, 38% have been threatened with a physical attack, 22% have had objects thrown at them, 15% have been physically assaulted, 6% have been assaulted

with a weapon, and 16% have been sexually assaulted. These negative experiences can have a profound effect on a sexual minority individual's mental health.

When looking at the relationship between caregiver-child attachment and mental health issues, there was no existing research found. This relationship needs to be examined further as there is a potential that the type of attachment a child forms with their caregiver will have a later impact on their mental health outcomes. However, research has shown that there is a relationship between mental health and closeness. Sexual minority individuals who have a more positive relationship with their caregivers reported having lower levels of mental health problems (D'Augelli, 2002). In contrast, when children have a more distant or negative bond with their caregivers, they may choose to hide their identity out of fear of rejection and have a higher sense of anxiety surrounding the coming out process. Ultimately, this can lead to higher levels of mental health problems, as sexual minority individuals are hiding a part of their identity.

Additionally, research has shown that there is a relationship between mental health and the coming out experience between a caregiver and their sexual minority child. For example, rejection by a caregiver following sexual orientation disclosure has been shown to have a negative impact on sexual minority individuals' mental health (Bergen et al., 2020) including a higher likelihood of suicide attempts and substance use. Furthermore, research has also shown a relationship between individuals mental health and the level of perceived support from their caregivers. For example, when sexual minority individuals experience a positive support system from their caregivers, they are more likely to have a greater self-esteem, social support, and general health (Ryan et al, 2010).

Thesis statement

This project examined the relationship between caregiver-child attachment and closeness during development on the coming out process and perceived support of sexual minority individuals. Further, this study also examined the relationship of mental health to caregiver attachment and closeness. This research is important due to the high likelihood of individuals in the LGB+ community developing mental health problems when compared to the general population. However, previous research has shown that caregiver support can be an essential protective factor in alleviating such mental health problems (Mills-Koonce, Rehder, & McCurdy, 2018). Caregivers play a vital role in how their child views themselves and explore their sexual orientation. Therefore, how a caregiver chooses to allow their child to explore their identity will influence their child's mental health, coming out process, and support system following disclosure of their sexual orientation (Ryan et al., 2010).

The research hypotheses are as follows:

(1) There is an inverse relationship between sexual minority individuals' mental health issues and their attachment to their caregiver(s) during their development. Specifically, greater mental health issues will be related to lower attachment to caregiver(s).

(2) There is an inverse relationship between sexual minority individuals' mental health issues and their closeness to their caregiver(s) during their development. Specifically, fewer mental health problems will be related to greater closeness to caregiver(s).

(3) There is an inverse relationship between sexual minority individuals' mental health issues and their level of perceived support from their caregiver(s) during their

development. Specifically, greater mental health issues will be related to lower levels of perceived support from participants' caregiver(s).

(4) There is an inverse relationship between sexual minority individuals' mental health issues and their coming out experience. Specifically, fewer mental health problems will be related to a more positive coming out experience.

(5) There is a direct relationship between caregiver-child attachment during development and the coming out process. Specifically, experiencing a negative caregiver-child attachment during development will be correlated with a negative coming-out process.

(6) There is a direct relationship between caregiver-child closeness during development and the coming out process. Specifically, experiencing a negative caregiver-child relationship during development will be correlated with a negative coming-out process.

(7) There is a direct relationship between caregiver-child closeness during development and caregiver support following sexual orientation disclosure. Specifically, positive caregiver-child closeness during development will be correlated with positive support following disclosure.

(8) There is a direct relationship between caregiver-child attachment during development and caregiver support following sexual orientation disclosure. Specifically, positive caregiver-child attachment during development will be correlated with positive support following disclosure.

Methods

The methods section includes a description of the research participants, a description of the survey, how participants were recruited, and data analytic strategies. This research was approved by the MTSU Office of Research Compliance.

Participants

This study examined sexual minority adults who had previously disclosed their sexual orientation to their caregiver(s). For the purposes of this study, the term sexual minority referred to lesbian, gay, bisexual, and other nonheterosexual identities. Individuals who identify as transgender and/or heterosexual were excluded from this study due to the different nature of the coming out process for people who identify as transgender as compared to sexual minority (LGB+) individuals.

Individuals who did not disclose their sexual orientation were also excluded from the study since the study focused on the relationship between the caregiver-child relationship and the coming out process for LGB+ people.

The initial sample consisted of 133 individuals who were recruited using snowballing and purposive sampling techniques to complete an online questionnaire. Snowball sampling occurs when research participants help recruit future participants for the study such as by word of mouth (Simkus, 2022). Purposive sampling occurs when researchers select participants based on predetermined criteria (Palinkas, 2016) which, in this study were as follows: 18 years or older, identify as a sexual minority, and had previously disclosed their sexual orientation to their caregiver(s). The final sample was composed of 72 individuals because of the 133 individuals who completed the survey,

only 72 met the criteria for the survey. All remaining data are presented in the final sample (n = 72).

Demographic information collected included age, gender, sexual orientation, and race. More individuals were in the younger age brackets as follows: 18-24 years (39%, n = 28), 25-34 years (36%, n = 26), 34-44 years (19%, n = 14), 45-54 years (4%, n = 3), 55-64 years (1%, n = 1), and no individuals older than 65 years of age. Most identified as female (60%, n = 43), followed by males (21%, n = 15), non-binary (15%, n = 11), and other (4%, n = 3). Sexual orientations were reported as lesbian (31%, n = 22), gay (21%, n = 15), bisexual (21%, n = 15), queer (15%, n =11), pansexual (8%, n = 6), and other (4%, n = 3) The majority of participants identified as White (n = 57), followed by 2 identifying as Black/African American, 4 identifying as Hispanic/Latino, and 8 identifying as Biracial/Multiracial. Only 1 participant identified as Native American or Alaskan Native; White, Biracial, or Multiracial; White, African American/Black, Native Hawaiian, or Other Pacific Islander; White, Hispanic/Latino; and White, African American/Black, Biracial or Multiracial.

Measure

This anonymous survey consisted of 78 items (Appendix). Participants were first asked a series of demographic questions (age, gender, sexual orientation, and race). Next, participants identified who they consider to be their primary and secondary caregivers. Then participants disclosed if they had experienced any mental health problems (yes or no). The survey explained to respondents that the term “mental health problems” was not limited to diagnosed mental health disorder but “any mental or emotional struggles.”

Participants who stated they experienced mental health problems were then asked to rate the severity on a scale of 1 (not at all) to 7 (a great deal).

The first scale in the survey examined sexual minority individuals' relationship with their caregiver(s) while growing up based on their level of attachment. To evaluate the level of caregiver attachment, a portion of the Inventory of Parent and Peer Attachment (IPPA) was utilized (Armsden & Greenberg, 1987). Specifically, the Mother and Father Attachment subscales were combined to measure participants' level of attachment to both their primary and secondary caregivers. While this scale was combined to reduce the number of questions, participants were still required to answer their level of attachment for both their caregivers. Additionally, language referring to mother and father were changed to caregiver 1 and caregiver 2 to be more inclusive. If individuals only grew up with one caregiver, they could click "N/A" for all statements referencing caregiver 2. At the end of the scale, an open-ended item was given to participants stating, "Please feel free to share anything else you would like to about regarding your attachment to your parent(s) growing up." This attachment scale has a total of 25 questions on a 5-point Likert scale, ranging from 1 (almost never or never true) to 5 (almost always or always true). The IPPA attachment subscale measures three concepts: degree of mutual trust, quality of communication, and level of anger and alienation between the caregiver and their child. At the end of the scale, participants had an open-ended item where they could describe their answers regarding caregiver attachment. When analyzing this scale, reverse coding was utilized for negatively worded statements including items: 3, 6, 8, 9, 10, 11, 14, 17, 18, and 23. Attachment scores were

separate for primary and secondary caregiver and could range from 1 to 5 with higher scores indicating more positive attachment.

The second scale on the survey assessed the level of closeness to participants caregiver(s) while growing up through the Parent-Child Relationship Survey (PCRS). The PCRS was developed to examine the bond between a child and their mother and father (Fine, 1981). This survey consists of 24 questions on a Likert scale ranging from 1 (not at all) to 7 (a great deal). For this study, the mother (or maternal figure) and father (or paternal figure) subscales were combined to measure participants' level of closeness with both their caregivers, caregiver 1 and caregiver 2. While this scale was combined to reduce the number of questions, participants were still required to answer their level of attachment to both their caregivers for each statement. If individuals only grew up with one caregiver, they could click "N/A" for all statements referencing caregiver two. At the end of the scale, an open-ended item was given to participants stating, "Please feel free to share anything else you would like about closeness (or lack thereof) to your parent(s)." When analyzing the PCRC scale reverse coding was utilized for negatively worded statements including items 9,13, and 14. Closeness scores were separate for primary and secondary caregiver and could range from 1 to 7 with higher scores indicating closer bond.

Survey items were also included to understand the impact that caregiver(s) had on the coming out process and individuals' perceived support following disclosure. There was no scale existing that evaluated what factors led sexual minority individuals to disclose their sexual orientation to their caregiver(s). Therefore, the author created a set of eight statements on a Likert scale ranging from 1 (disagree strongly) to 7 (agree

strongly). Each item allowed the participant to respond for both caregivers. If individuals only grew up with one caregiver, they could click "N/A" for all statements referencing caregiver two. At the end of the scale, an open-ended item was given to participants stating, "Please feel free to share anything else about your coming out process with your parent(s)."

The Parental Support for Sexual Orientation Scale (PSOS) was used to examine the extent that the participants perceived their caregiver(s) as being supportive of their sexual orientation. In the original scale (Mohr & Fassinger, 2003), there nine statements measuring participants' perceived support from their mother and nine identical statements assessing the participant's perceived level of support from their father. The items on the scale ranged from 1 (disagree strongly) to 7 (agree strongly). For this study, the two scales were combined to measure participants' level of perceived support from their primary and secondary caregivers. While this scale was combined to reduce the number of questions, participants were still required to answer for both caregivers. If individuals only grew up with one caregiver, they could click "N/A" for all statements referencing caregiver two. At the end of the scale, an open-ended item was given to participants stating, "Please feel free to share anything else about support from your parent(s)." When analyzing this scale reverse coding was utilized for negatively worded statements including items 1, 4, 6, 7, 8, and 9. Caregiver support scores were separate for primary and secondary caregiver and could range from 1 to 7 with higher scores indicating more positive support.

Participant Recruitment

Participants were recruited through various avenues including social media and word of mouth. Multiple recruitment strategies were utilized so that a large sample of sexual minority individuals would have the opportunity to complete the survey. The sample size ensured that the findings were more reliable. To participate in the study, participants clicked a link that sent them to the consent form to complete prior to beginning the survey. Following their consent to participate in the study, the individuals were directed to the survey.

Data Analytic Strategy

Most of the survey data was quantitative and using Excel. Descriptive statistics were created to analyze demographic information including age, race, sexual orientation, and gender. Univariate analyses were conducted as well as some bivariate analyses. Reverse coding was utilized for negatively worded items for the attachment, closeness, and perceived support scales. Additionally, since the coming out experience scale was created for this project, bivariate analyses were conducted to assess whether any of the individual coming out items correlated with any of the predictor variable scores (attachment, closeness, and perceived support).

Open-ended survey items were analyzed qualitatively, through open coding. Open coding does not assume an underlying theory beforehand but allows categories to be created from the data itself (Krysik, & Finn, 2013). Major themes from qualitative analyses are presented.

Results

The following section includes a summary of the demographic characteristics of the sample including race/ethnicity, age, gender identity, and sexual orientation. Most of the sample identified as White (79%), followed 6% of participants identifying as Biracial/Multiracial and Hispanic/Latino. Three percent of the sample identified as African American/Black. The remaining group accounted for 1% of the sample each (Table 1).

Table 1.

Race/Ethnicity

Race/Ethnicity	Frequency	Percentage
White	57	79%
African American/Black	2	3%
Biracial or Multiracial	4	6%
Native American or Alaskan Native	1	1%
Hispanic/Latino	4	6%
White, Biracial, or Multiracial	1	1%
White, African American/Black, Native Hawaiian or Other Pacific Islander	1	1%
White, Hispanic/Latino	1	1%
White, African American/Black, Biracial or Multiracial	1	1%
TOTAL	72	100%

The majority of the sample consisted of younger participants with 39% stating they were between the age of 18-24 years of age and 36% stating they were between 25-34 years of age. Only 1% of the sample that was between the age of 55-64 years of age and no participants that were 65+ years old (Table 2).

Table 2.

Age

Age (in years)	Frequency	Percentage
18-24	28	39%
25-34	26	36%
35-44	14	19%
45-54	3	4%
55-64	1	1%
65+	0	0%
TOTAL	72	100%

Most of the sample identified as female (60%), followed by 21% identifying as male, and 15% identifying as non-binary. Only 4% of participants identified stated that their gender identity did not fit under the categories provided (Table 3).

Table 3.

Gender Identity

Gender Identity	Frequency	Percentage
Non-Binary	11	15%
Female	43	60%
Male	15	21%
Other gender identity (please specify)	3	4%
TOTAL	72	100%

Individuals identified most frequently as lesbian (31%), followed by gay and bisexual (21%). Only 15% identified as queer, 7% identified as pansexual and the remaining sample (6%) stated their sexual orientation did not fit under the categories provided (Table 4).

Table 4.

Sexual Orientation

Sexual Orientation	Frequency	Percentage
Lesbian	22	31%
Gay	15	21%
Bisexual	15	21%
Queer	11	15%
Pansexual	5	7%
Other sexual orientation (please specify)	4	6%
TOTAL	72	100%

The following section presents statistical analysis for attachment, closeness, support and coming out experience for caregiver one and two.

Table 5 table describes the statistical analyses that were conducted for the attachment, closeness, and support scale. Based on the results for standard deviation, it can be observed that the data is clustered around the mean. Furthermore, the mean for each scale indicates that individuals had slightly higher level of attachment and closeness with both their caregivers compared to perceived support from their caregivers.

Table 5.

Attachment, Closeness, and Support

	Caregiver 1: Attachment	Caregiver 2: Attachment	Caregiver 1: Closeness	Caregiver 2: Closeness	Caregiver 1: Support	Caregiver 2: Support
Mean	3.19	2.94	3.56	3.56	2.53	2.41
SD	0.92	0.88	1.25	1.25	0.75	0.75
Range	1.39 - 4.84	1.24 - 5.00	1 - 5.67	1 – 5.67	1 – 4.50	1.00 – 4.00

Table 6 shows the statistical analysis that was conducted for each question on the coming out experience scale for caregiver one. Based on the results for standard deviation, we can assume that the data is somewhat dispersed around the mean. Furthermore, the mean suggests that participants likely had a neutral to somewhat positive coming out experience with their caregiver.

Table 6.

Caregiver 1: Coming Out Experience

	Average	SD	Range
My caregiver accepted my sexual orientation following disclosure	4.52	2.14	1 - 7
My caregiver reacted positively after disclosing my sexual identity	4.02	2.15	1 - 7
My caregiver’s religious beliefs impacted when I came out	3.90	2.51	1 - 7
My relationship with my caregiver worsened after coming out	3.09	2.25	1 - 7

My caregiver did not accept my sexual identity following disclosure	3.70	2.25	1 - 7
My caregiver tried to hide my sexual orientation from others	3.21	2.34	1 - 7
My caregiver made me feel like I could come out when I was ready	3.23	2.17	1 - 7
My sexual identity was disclosed to my caregiver without my consent	2.70	2.47	1 - 7

Table 7 shows the statistical analysis that was conducted for each question on the coming out experience scale for caregiver two. Based on the results for standard deviation, we can assume that the data is somewhat dispersed around the mean. Additionally, the mean suggests that participants had a slightly less positive coming out experience with caregiver two compared to caregiver one.

Table 7.

Caregiver 2: Coming Out Experience

	Average	Standard Deviation	Range
My caregiver accepted my sexual orientation following disclosure	4.25	2.19	1 - 7
My caregiver reacted positively after disclosing my sexual identity	3.93	2.16	1 - 7
My caregiver's religious beliefs impacted when I came out	3.98	2.60	1 - 7
My relationship with my caregiver worsened after coming out	3.33	2.20	1 - 7
My caregiver did not accept my sexual identity following disclosure	4.10	2.14	1 - 7
My caregiver tried to hide my sexual orientation from others	3.64	2.30	1 - 7
My caregiver made me feel like I could come out when I was ready	3.14	2.08	1 - 7

My sexual identity was disclosed to my caregiver without my consent	3.10	2.59	1 - 7

The following section presents descriptive statistics for attachment and closeness with perceived support from caregivers.

Table 8 presents the relationship between caregiver support and the level of attachment and closeness participants reported. It was found that there was a moderate correlation between the level of caregiver support and attachment for both caregiver one (r = 0.45) and caregiver two (r = 0.45). There is a weak correlation between perceived support and closeness to caregiver one.

Table 8.

Correlation of caregiver support with attachment and closeness

	Correlation
Caregiver 1: Attachment	0.45
Caregiver 2: Attachment	0.45
Caregiver 1: Closeness	0.26
Caregiver 2: Closeness	0.47

The final section presents bivariate correlations for attachment, closeness, and support with mental health issues and coming out experiences.

Table 9 shows the relationship between mental health issues and participants attachment, closeness, and perceived support from their caregivers. There was a moderate correlation between participants' level of attachment with caregiver two and their level of mental health issues. There was also a moderate relationship between the level of

closeness participants had with their caregivers and their level of mental health issues (r = 0.44 for both caregivers). Furthermore, there was a weak relationship between attachment with caregiver one and mental health issues and no correlation between the level of support from caregivers and mental health issues.

Table 9.

Correlation of mental health issues with attachment, closeness, and support

	Correlation
Caregiver 1: Attachment	-0.36
Caregiver 2: Attachment	-0.52
Caregiver 1: Closeness	-0.44
Caregiver 2: Closeness	-0.44
Caregiver 1: Support	-0.11
Caregiver 2: Support	0.16

Table 10 looks at the relationship between each item on the coming out experience scale and the level of attachment between caregiver one and two. Correlations for all items were very weak for all items. The strongest correlation (r = 0.22) was between caregiver 1 and "My sexual identity was disclosed to my caregiver without my consent." Even so, this is a very weak correlation.

Table 10.

Coming Out Experience and Attachment (Correlations)

	Caregiver 1	Caregiver 2
My caregiver accepted my sexual orientation following disclosure	-0.07	-0.03
My caregiver reacted positively after disclosing my sexual identity	-0.12	-0.03

My caregiver's religious beliefs impacted when I came out	0.12	0.08
My relationship with my caregiver worsened after coming out	-0.12	-0.07
My caregiver did not accept my sexual identity following disclosure	0.19	-0.06
My caregiver tried to hide my sexual orientation from others	0.04	0.05
My caregiver made me feel like I could come out when I was ready	-0.08	0.00
My sexual identity was disclosed to my caregiver without my consent	0.22	-0.08

Table 11 presents the correlation of each item on the coming out experience scale with individual's level of closeness to caregivers one and two. For caregiver one there was no relationship between the level of closeness and any item from the coming out experience scale. However, for caregiver two there was a moderate relationship between participants' level of closeness and their coming out experience for all scale items, ranging from r = 0.46 to r = 0.60. Correlations were weaker for "My caregiver's religious beliefs impacted when I came out" (r =-0.31), "My caregiver did not accept my sexual identity following disclosure" (r = -0.38), and "My sexual identity was disclosed to my caregiver without my consent" (r =-0.22).

Table 11.

Coming Out Experience and Closeness (Correlation)

	Caregiver 1	Caregiver 2
My caregiver accepted my sexual orientation following disclosure	0.15	0.54
My caregiver reacted positively after disclosing my sexual identity	0.01	0.50
My caregiver's religious beliefs impacted when I came out	-0.01	-0.31
My relationship with my caregiver worsened after coming out	-0.13	-0.60

My caregiver did not accept my sexual identity following disclosure	-0.06	-0.38
My caregiver tried to hide my sexual orientation from others	-0.16	-0.59
My caregiver made me feel like I could come out when I was ready	0.13	0.46
My sexual identity was disclosed to my caregiver without my consent	0.15	-0.22

Table 12 looks at the relationship between participants coming out experience and their level of mental health issues. There was a weak correlation between the level of mental health issues participants reported and the item "my caregivers religious beliefs impacted when I came out" for caregiver one (r = 0.25). There was also a weak correlation between mental health issues and the item "my relationship with my caregiver worsened after coming out" for caregiver two (r = 0.27). All correlations for the rest of the scale had no relationship with mental health issues.

Table 12.

Coming Out Experience and Mental Health Issues (Correlation)

	Caregiver 1	Caregiver 2
My caregiver accepted my sexual orientation following disclosure	-0.15	-0.08
My caregiver reacted positively after disclosing my sexual identity	0.02	-0.01
My caregiver's religious beliefs impacted when I came out	0.25	0.14
My relationship with my caregiver worsened after coming out	0.09	0.27
My caregiver did not accept my sexual identity following disclosure	0.19	0.16
My caregiver tried to hide my sexual orientation from others	0.10	0.19
My caregiver made me feel like I could come out when I was ready	-0.07	-0.13
My sexual identity was disclosed to my caregiver without my consent	0.10	0.20

Qualitative data on attachment

When analyzing the qualitative data from the survey, 20 of the 72 participants (28%) chose to expand on their attachment with their caregivers. Multiple participants had a negative attachment with their caregivers. For example, one participant reported that they had a "Poor attachment with parents growing up overall. Parents were not personable and never encouraged us to verbalize or share feelings." Another participant stated that they had "alcoholic parents, a narcissistic mother, a suicidal father, and angry siblings." Other participants reported that their caregivers' religious beliefs impacted their attachment style with them. Some responses discussed how caregiver religiosity impacted attachment. One person stated that they "grew up in an extremely Southern Baptist environment. My parents were amazing except for accepting me for being gay. They care about me in every other aspect except for me and my partners or our problems." Another stated that they "grew up Catholic (Catholic school and church) so leaving this environment was hard for them to accept. Especially being viewed as 'pure and innocent.' However, some respondents did report that they had a positive attachment style with their caregivers. One person stated "I have two moms. They've always been supportive, and they try their best to be understanding. They're not perfect but they've been incredible parents."

Qualitative data on closeness

Seven of the 72 participants (10%) chose to expand their answers about their closeness with their caregivers. Multiple participants did not feel like they had a close bond with their caregivers. One participant stated that "my mom has severe depression and anxiety (and probably ADHD) while my dad is most likely on the autism spectrum. It

was a big family of undiagnosed neurodivergences... love and closeness was lacking." Another stated "I trust them with my life but opening up and being vulnerable is hard." In comparison, there was only one participant who discussed their close bond with their caregivers. They stated, "Mom was a single parent all of my growing up years, so we have been very close."

Qualitative data on coming out experience

Seventeen of the 72 participants (24%) chose to expand their answers about their coming out experience with their caregivers. Only one participant had a positive coming out experience. However, they state that they did not feel like they ever had a true coming out, because their mom also dated women and assumed their child was always "bi-curious." All other participants stated that their caregivers had a negative reaction to their coming out experience, with some caregivers stating that it was a phase, some reacting negatively due to their religious beliefs, and some outright denying it. For example, one participant stated that their caregiver had a "Typical 'it's a phase' response." Another participant stated, Caregiver 1 "found out but was able to rationalize it away using the relationship I was in at the time." Lastly, one participant stated that their caregivers had an extremely negative response to their coming out and choosing to send them to conversion therapy and living on the streets due to their caregivers' religious beliefs.

Qualitative data on support

When analyzing the qualitative data from the survey, 11 of the 72 participants (15%) chose to expand their answers about the level their caregivers are supportive of their sexual orientation. Based on the responses, participants reported that their caregivers were either unsupportive, supportive, or had become supportive through time. One

participant who reported a positive support system from their caregivers stated, "I've only ever dated men, but I know my mom would be STOKED if I brought home a girlfriend and my dad would simply not act any different than if I brought home a boy." While another whose caregivers were not supportive stated, "My mother very adamantly condemns my sexuality, and I am fearful of the day she finds out about my partner." Lastly another participant whose caregivers came to be more supportive of their sexual orientation stated, "My mother has improved greatly, going so far as to buy me a pride flag during pride month. Great progress."

Discussion

The discussion section begins with a summary of research findings for each hypothesis, followed by study limitations and strengths. The discussion concludes with practice implications and future research.

1. **Greater mental health issues will be related to lower attachment to caregiver(s).** There was a moderate correlation between caregiver-child attachment for caregiver two and mental health issues, while there was a weak correlation between the two variables for caregiver one. There is no known research that has examined whether there is a relationship between mental health issues and caregiver-child attachment.

2. **Fewer mental health problems will be related to greater closeness to caregiver(s).** There was only a moderate relationship between mental health problems and closeness to caregiver one and two. The findings relate to previous research conducted by D'Augelli (2002). He found that individuals who have a positive, close bond with their caregivers were more likely to report lower levels of mental health problems.

3. **Greater mental health problems will be related to lower levels of support from caregiver(s).** There was no correlation between mental health problems and perceived support for caregiver one and two. This contradicts previous research which suggested that experiencing a positive support system from caregivers was related to greater self-esteem, social support, and general health (Ryan et al., 2010).

4. **Fewer mental health problems will be related to a more positive coming out experience.** There was a weak correlation between mental health problems and some items on the coming out experience scale. However, most mental health items did not correlate with coming out experiences which contradicts previous research by Bergen et al. (2020) in which rejection by a caregiver following the coming out experience was shown to have a negative impact on sexual minority individuals' mental health.

5. **Negative caregiver-child attachment will be related to a negative coming out experience.** There was one item on the scale that showed a weak correlation between attachment and coming out experience with caregiver one. The remaining items on the scale showed no correlation with caregiver-child attachment. This contradicts research conducted by Katz-Wise, Rosario, & Tsappis (2016) which found that sexual minority individuals with a secure attachment were more likely to have a positive coming out experience.

6. **Experiencing a negative caregiver-child bond will be related to a negative coming out experience.** There was no correlation between closeness and coming out experience for caregiver one. However, all items for coming out experience showed either a moderate or weak correlations for caregiver 2. It is unknown why there was a correlation between the two variables for caregiver two but not caregiver one.

7. **Experiencing a positive caregiver-child bond will be related to positive caregiver support.** There was a moderate correlation between caregiver-child closeness and level of perceived support for caregiver two. There was a weak correlation between caregiver-child closeness and perceived support for caregiver one. Previous research has not examined how support differs by primary and secondary caregivers.

8. **Positive caregiver-child attachment will be related to positive caregiver support**. There was a moderate correlation between caregiver-child attachment and level of perceived support for caregiver one and two. In terms of perceived support, higher scores were related to more support from caregivers and lower scores was related to less support. Examples of support include caregivers advocating for their child when they are being mistreated due to their sexual orientation, attending LGB+ events and organizations, welcoming LGB+ friends and partners, and many others (Ryan et al., 2010).

Strengths

This research had several strengths as well. One strength was the number of responses received in a short period of time. Over approximately one month there were a total of 133 responses; of those 72 respondents (54%) met the qualifications for the study. Another strength of the study was the use of quantitative and qualitative survey items. Quantitative data involves a large sample size and data can be easily interpreted as it is in numeric form (Polit & Beck, 2010). In contrast, the goal of qualitative data is to provide a deeper understanding of aspects of human experience through open-ended questions. Both quantitative and qualitative data were useful when examining the relationships in this study.

Limitations

There were several study limitations. First, reliability and validity of the coming out experiences items is unknown. Reliability refers to the consistency of a while validity refers to the accuracy of a measure (Dudley, 2011). These items were created by the author for this study specifically, as there was no other known scale that measures the experiences individuals had when disclosing their sexual orientation to their caregivers. Second, this was a long survey. There were 78 items in total and participants had to answer for both caregiver one and two for each question. Research by Kost and de Rosa (2018) found that shortener surveys yield higher response and completion rates as well as increases a measure's reliability. The length of the survey may explain why many participants only completed part of the survey. Third, a few participants stated that there was some confusion regarding the difference between attachment and closeness when expanding their answers for those sections due to the similarity in questions.

Future Research

Future research should attempt to determine the reliability and validity of the items developed for the coming out experience portion of the study. Determining these items' reliability and validity will dictate whether they should be used for future use. Additionally, research should attempt to examine why there were instances when caregiver two yielded greater correlations than caregiver one. Future studies could also benefit from decreasing the length of the study which will help increase response rates. This is important as a larger sample is needed for future research. Lastly, future research should clarify the difference between attachment and closeness in order for participants to answer as accurately as possible.

Practice Implications

There are many real-world implications of this study despite there being no significant relationships between the variables examined. For example, the findings from this study show how the attachment and bond sexual minority individuals form with their caregivers at an early age could impact how supportive caregivers are of their child's sexual orientation. Professionals in the social service field could utilize these results to have a greater understanding of how early attachment formation and bonding might be a factor in how supportive caregivers are to their LGB+ child. Additionally, these results are significant for professionals as they show the importance of caregivers building a positive, close relationships with their children as that relationship will have lasting effects on their child's future mental health outcomes. Although there was only a moderate correlation found between mental health and the two variables attachment and closeness these areas should not be ignored as areas for intervention. Professionals should use these findings to help implement educational opportunities for caregivers to learn about their impact on their child's mental health.

Overall, this study examined the relationships between five variables: caregiver-child attachment, caregiver-child closeness, coming out experience, perceived support, and mental health issues in sexual minority individuals. While there were no significant findings, moderate correlations were found between several variables. Nevertheless, the correlations found between caregiver relationships and sexual minorities' mental health and perceived support should not be ignored. Future research and professionals should remain committed to learning what factors impact this vulnerable group in order to develop tools to help them.

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Appendix

<u>Informed Consent Form</u>

Purpose:

This research project is designed to help me evaluate how caregiver-child relationships during childhood and adolescence impact the coming out process and perceived support following disclosure for sexual minority adults. Furthermore, this study seeks to understand how the previously listed experiences impact sexual minority individuals' mental health.

Description:

There are several parts to this project. They are:

- Development of survey for participants
- Development of informed consent form for participants
- Create survey questions in Qualtrics for data collection -
- Distribute electronic survey to participants; The PI and FA will send email messages to participants, participants will scan QR code from IRB recruitment flyer, or participants will learn of survey through social media. When starting the survey participants will review the Informed Consent form which will provide the purpose of the study, the benefits and risks, their rights, a description of the study, confidentiality, compensation, and contact information. Participants will read the Informed Consent form and they will "agree" or "disagree" to voluntarily participate in the survey. Participants who select "agree" will proceed to the survey while the survey will terminate for participants will select "disagree."
- Analyze survey data.
- Summarize research findings as part of honors thesis Results section

IRB Approval Details:

- Protocol Title: The Impact of Caregiver-Child Relationships During Development on the Coming out Process, Perceived Support, and Mental Health in Sexual Minority Individuals
- Primary Investigator: Sarah Roberts
- PI Department & College: Social Work, College of Behavioral & Health Sciences
- Faculty Advisor: Ariana Postlethwait

- Protocol ID: 22-2162 7q Approval Date: 6/30/22 Expiration Date: 6/30/2023

Duration:

The whole activity should take about 20-30 minutes. The subjects must take at least 10 minutes to complete the study.

Here are your rights as a participant:

- Your participation in this research is voluntary.
- You may skip any item that you don't want to answer, and you may stop the experiment at any time (but see the note below)
- If you leave an item blank by either not clicking or entering a response, you may be warned that you missed one, just in case it was an accident. But you can continue the study without entering a response if you didn't want to answer any questions.
- Some items may require a response to accurately present the survey.

Risks & Discomforts:

The survey presents no more than minimal risk to participants. The foreseeable risks to participants include possible negative feelings due to sensitive topics being potentially discussed.

Benefits:

- Benefits to you that you may not receive outside this research: There are no direct benefits to you from this study
- Benefits to the field of science or the community: However, participants' responses can be useful in understanding the impact caregiver-child relationships have on the coming out process and perceived support of sexual minority individuals during the coming out process. Furthermore, participants' responses may show how the factors listed previously affect sexual minority mental health.

Identifiable Information:

You will NOT be asked to provide identifiable personal information.

Compensation:

There is no compensation for participating in this study

Confidentiality:

All efforts, within reason, will be made to keep your personal information private but

total privacy cannot be promised. Your information may be shared with MTSU or the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for Human Research Protections, if you or someone else is in danger or if we are required to do so by law.

Contact Information:

If you should have any questions about this research study or possibly injury, please feel free to contact Sarah Roberts by telephone 615-603-9720 or by email sar6g@mtmail.mtsu.edu OR my faculty advisor, Ariana Postlethwait, at 615-494-8633 or by email at Ariana.Postlethwait@mtsu.edu. You can also contact the MTSU Office of compliance via telephone (615 494 8918) or by email (compliance@mtsu.edu). This contact information will be presented again at the end of the experiment.

You are not required to do anything further if you decide not to enroll in this study. Just quit your browser. Please complete the response section below if you wish to learn more or you wish to part take in this study.

- Yes, I have read this informed consent document pertaining to the above identified research
- Yes, the research procedures to be conducted are clear to me
- Yes, I confirm I am 18 years or older
- Yes, I am aware of the potential risks of the study

Q1 What is your gender?

- Male
- Female
- Non-binary
- Prefer not to say
- Other gender identity (please specify)

____

Q2 What is your race/ethnic background?

- White
- African American/Black
- Asian
- Native American or Alaskan Native
- Native Hawaiian or Other Pacific Islander
- Hispanic/Latino
- Biracial or Multiracial
- Other (Please Specify)

____

Q3 What is your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

Q4 What is your sexual orientation?

- Gay
- Lesbian
- Bisexual
- Pansexual
- Queer
- Other sexual orientation (please specify)

____

Q5 Who would you consider to be your primary caregiver growing up (Caregiver 1)?

- Mother
- Father
- Grandmother
- Grandfather
- Aunt
- Uncle
- Sibling
- Other (Please Specify)

____

Q6 Who would you consider to be your other primary caregiver (Caregiver 2)?

- Mother
- Father
- Grandmother
- Grandfather

- Aunt
- Uncle
- Sibling
- Other (please specify)

____

Q7 Do you experience mental health problems (Example: anxiety, depression, eating disorder, bipolar disorder, etc.)? Your response is not limited to diagnosed mental disorders but rather any mental or emotional struggles you face.

- Yes
- No

Q8 If you experience mental health problems, how would you rate the extent you struggle with them

	Never (1)	Rarely (2)	Occasionally (3)	A moderate amount (4)	A great deal (5)	N/A (6)
	-	-	-	-	-	-

Inventory of Parent and Peer Attachment (IPPA)

	Almost never or never true (1)	Not very often true (2)	Sometimes true (3)	Often true (4)	Almost always or always true (5)	N/A (6)
Caregiver 1	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-

Q9 My caregiver respects my feelings

Q10 I feel my caregiver does a good job as my caregiver

Q11 I wish I had a different caregiver

Q12 My caregiver accepts me as I am

Q13 I like to get my caregivers point of view on things I’m concerned about

Q14 I feel it’s no use letting my feelings show around my caregiver

Q15 My caregiver can tell when I’m upset about something

Q16 Talking over my problems with my caregiver makes me feel ashamed or foolish

Q17 My caregiver expects too much from me

Q18 I get upset easily around my caregiver

Q19 I get upset a lot more than my caregiver knows about

Q20 When we discuss things, my caregiver cares about my point of view

Q21 My caregiver trusts my judgment

Q22 My caregiver has their own problems, so I don’t bother them with mine

Q23 My caregiver helps me to understand myself better

Q24 I tell my caregiver about my problems and troubles

Q25 I feel angry with my caregiver

Q26 I don’t get much attention from my caregiver

Q27 My caregiver helps me to talk about my difficulties

Q28 My caregiver understands me

Q29 When I am angry about something, my caregiver tries to be understanding

Q30 I trust my caregiver

Q31 My caregiver doesn’t understand what I’m going through these days

Q32 I can count on my caregiver when I need to get something off my chest

Q33 If my caregiver knows something is bothering me, they ask me about it

Q34 Please feel free to share anything else you would like to about regarding your attachment to your parent(s) growing up.

____

Parent-Child Relationship Survey (PCRS)

	Never (1)	(2)	(3)	(4)	(5)	(6)	Always (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q36 How well do you feel you have been able to maintain a steady relationship with your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q37 How much do you trust your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q38 How confident are you that your caregiver would not ridicule or make fun of you if you were to talk about a problem?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q39 How confident are you that your caregiver would help you when you have a problem?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q40 How close do you feel to your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q41 How comfortable would you be approaching your caregiver about a romantic problem?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q42 How comfortable would you be talking to your caregiver about a problem at school?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q43 How confused are you about the exact role your caregiver is to have in your life?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q44 How accurately do you feel you understand your caregiver's feelings, thoughts, and behavior?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	7 Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q45 How easily do you accept the weaknesses in your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q46 To what extent do you think of your caregiver as an adult with a life of their own, as opposed to thinking of them only as your caregiver?

	Think of as only a caregiver (1)	(2)	(3)	(4)	(5)	(6)	See as an adult with their own life (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q47 How often do you get angry at your caregiver?

	Never (1)	(2)	(3)	(4)	(5)	(6)	Always (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q48 In general, how much do you resent your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q49 How well do you communicate with your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q50 How well does your caregiver understand your needs, feelings, and behavior?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q51 How well does your caregiver listen to you?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q52 How much do you care for your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q53 When you are away from home, how much do you typically miss your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q54 How much do you respect your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q55 How much do you value your caregiver's opinion?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q56 How much do you admire your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q57 How much would you like to be like your caregiver?

	Not at all (1)	(2)	(3)	(4)	(5)	(6)	Extremely (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q58 How much would you be satisfied with your caregiver's lifestyle as your own?

	Completely dissatisfied (1)	(2)	(3)	(4)	(5)	(6)	Completely satisfied (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q59 Please feel free to share anything else you would like about closeness (or lack thereof) to your parent(s).

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Coming Out Experience Survey

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q60 My caregiver accepted my sexual orientation following disclosure

Q61 My caregiver reacted positively after disclosing my sexual identity

Q62 My caregiver's religious beliefs impacted when I came out

Q63 My relationship with my caregiver worsened after coming out

Q64 My caregiver tried to hide my sexual orientation from others

Q65 My caregiver did not accept my sexual identity following disclosure

Q66 My caregiver made me feel like I could come out when I was ready

Q67 My sexual identity was disclosed to my caregiver without my consent

Q68 Please feel free to share anything else about your coming out process with your parent(s).

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Parental Support for Sexual Orientation Scale (PSOS)

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)	N/A (8)
Caregiver 1	-	-	-	-	-	-	-	-
Caregiver 2	-	-	-	-	-	-	-	-

Q69 Coming out to my caregiver has been a very painful process for me

Q70 My caregiver is very supportive of my current relationship

Q71 My caregiver has become a real support regarding my sexual orientation

Q72 My caregiver does not recognize my sexual orientation as legitimate

Q73 My caregiver has welcomed my partner as much as if she or he were of the opposite sex

Q74 I feel like I will never live up to my caregiver expectations of me because of my sexual orientation

Q75 I feel I have failed my caregiver because of my sexual orientation

Q76 I fear that my caregiver will never accept my sexual orientation

Q77 My sexual orientation has destroyed my relationship with caregiver

Q78 Please feel free to share anything else about support from your parent(s).

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