

Childhood Abuse and Mental Health Indicators Among Ethnically Diverse Lesbian, Gay, and Bisexual Adults

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Objective: Prior research has established that lesbian, gay, and bisexual (LGB) people experience higher rates of childhood abuse than heterosexuals. However, there has been little research on the mental health impact of these experiences or how race/ethnicity might influence prevalence and mental health impact of childhood abuse in this population. The study's objective was to examine the relationships between race/ethnicity, childhood abuse, and mental health indicators in a national sample of LGB adults. **Method:** Participants were recruited via the Internet through snowball and targeted sampling methods. Six hundred and sixty-nine LGB adults, 21% of whom were people of color, participated in an online survey. Participants completed the Childhood Trauma Questionnaire–Short Form, the Center for Epidemiologic Studies Depression Scale, the Patient Health Questionnaire Generalized Anxiety Disorder Scale, the Posttraumatic Stress Disorder (PTSD) Checklist–Civilian Version, and the Perceived Stress Scale–Short Form. **Results:** Latina/o and Asian American participants reported the highest levels of physical abuse ($p < .01$), and Latina/o and African American participants reported the highest levels of sexual abuse ($p < .01$). Childhood emotional abuse was the strongest predictor of psychopathology symptoms for all participants ($ps < .01$). Relative to White participants, emotional abuse showed a stronger relationship with PTSD and anxiety symptoms for African American participants ($ps < .01$), and physical abuse showed a stronger relationship with PTSD and anxiety symptoms for Latina/o participants ($ps < .05$). **Conclusions:** Race/ethnicity may be an important factor when examining childhood abuse and mental health correlates among LGB populations.

Keywords: sexual orientation, race, child abuse, gay, lesbian

Childhood abuse is a common problem in U.S. society. According to the National Child Abuse and Neglect Data System, an estimated 905,000 children were found to be victims of child maltreatment in 2006 (U.S. Department of Health and Human Services, 2006). Risk for childhood abuse can vary according to a number of social and cultural factors. In particular, one disadvantaged social status that has been examined with respect to child abuse is sexual orientation. Indeed, higher risk of child maltreatment, including emotional, physical, and sexual abuse, among lesbian, gay, and bisexual (LGB) individuals relative to heterosexuals has been consistently found across research studies with a wide range of sampling methodologies (e.g., Austin et al., 2008; Balsam, Rothblum, & Beauchaine, 2005; Corliss, Cochran, & Mays, 2002; Tjaden, Thoennes, & Allison, 1999).

Although there has been relatively little research on LGB people who are also racial/ethnic minorities, the literature to date indicates that this is a population subject to multiple minority and life stressors, including stigma associated with their sexual orientation, rejection by their cultural or ethnic community, and prejudice and

discrimination associated with their race/ethnicity (Cochran & Mays, 1994; Díaz, Ayala, Bein, Jenne, & Marin, 2001; Greene, 1997). Only a handful of studies have examined childhood abuse among LGB people of color. Morris and Balsam (2003), in a large national survey, found higher rates of childhood physical and sexual abuse among lesbian and bisexual women of color compared with White lesbian and bisexual women. Similarly, two studies of gay and bisexual men have found higher prevalence rates of childhood sexual abuse among African American and Latino men compared with White men (Doll et al., 1992; Feldman & Meyer, 2007). LGB people of color may experience elevated risk compared not only with White LGB people but also with their ethnic heterosexual counterparts. For example, Balsam, Huang, Fieland, Simoni, and Walters (2004) found higher rates of childhood physical abuse among LGB Native Americans compared with heterosexual Native Americans.

There are several potential explanations for why one might hypothesize elevated rates of child abuse among LGB people of color compared with their White LGB counterparts. Some of these reasons parallel reasons for childhood abuse in the general population, such as additional stress on families and economic disadvantage (Freisthler, Bruce, & Needell, 2007). Additionally, cultural or religious beliefs within ethnic minority families may include strong prohibitions against homosexuality (e.g., Chung & Katayama, 1998). Although ethnic minority youth may be less likely to disclose their sexual orientation to their families (Dubé & Savin-Williams, 1999; Pilkington & D'Augelli, 1995), gender atypicality may elevate their risk for abuse (Grossman, D'Augelli,

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This research was supported by National Institute of Mental Health Grants F32MH69002 and T32MH20010.

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Howell, & Hubbard, 2006). Indeed, two studies of Latina/o LGB adults (Finlinson et al., 2003; Guarnero, 2007) found that these participants linked their childhood physical and sexual abuse experiences to homophobia among family members.

Childhood Abuse and Mental Health Among Diverse LGB People

Research on mental health of LGB populations indicates that this group is at elevated risk for mental health disorders compared with heterosexual populations (see Cochran, 2001, for a review). Although relatively little LGB mental health research has examined the role of race/ethnicity, findings from two recent studies indicate that some LGB people of color may experience elevated risk for suicidality and depressive disorders relative to heterosexual people of color (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007) and elevated risk for suicidality compared with White LGB people (Meyer, Dietrich, & Schwartz, 2008). However, despite evidence that LGB people are at elevated risk for both childhood abuse and mental health problems in adulthood, very little research has examined the linkage between these two constructs within this population. In the general population, a vast body of literature documents the adverse adult mental health outcomes associated with a history of childhood abuse, including posttraumatic stress disorder (PTSD), depression, anxiety, and increased stress (Arias, 2004; Edwards, Holden, Felitti, & Anda, 2003; Gibb, Chelminski, & Zimmerman, 2007; Hyman, Paliwal, & Sinha, 2007; Kaplow, Dodge, Amaya-Jackson, & Saxe, 2005). A few studies of LGB people have examined adult health correlates of childhood sexual abuse, yielding similar results (Descamps, Rothblum, Bradford, & Ryan, 2000; Hughes, Johnson, Wilsnack, & Szalacha, 2007; Ratner et al., 2003); however, little is known about correlates of childhood emotional and physical abuse among LGB people.

Furthermore, little is known about whether childhood abuse differentially affects LGB people according to their race or ethnicity. Prior research indicates that traumatic events may more likely lead to PTSD among racial/ethnic minorities compared with Whites (Brewin, Andrews, & Valentine, 2000), although the link is stronger among military than civilian populations, the average effect size is small (0.29–0.37), and there is little research examining this question specifically among childhood abuse survivors.

The Current Study

The overall goal of the current study was to examine the relationships between race/ethnicity and childhood abuse and their effect on mental health indicators in a nonrandom national sample of LGB adults. Our first aim was to explore differences between African American, Latina/o, Asian American, and White LGB adults on self-reported emotional, physical, and sexual abuse in childhood using a standardized childhood abuse measure. We hypothesized that ethnic minority LGB adults would report higher rates of childhood abuse compared with their White LGB counterparts. Our second aim was to examine the relationship between childhood abuse history and current self-reported depression, anxiety, posttraumatic stress symptoms, and perceived stress. We hypothesized that childhood abuse would be associated with more negative self-reported mental health indicators for all participants. Finally, given the possibility that multiple minority status might

alter the impact of abuse, our third aim was to examine whether the relationships between childhood abuse and current self-reported mental health was moderated by race/ethnicity. Given that our study included participants from four racial/ethnic groups who were administered measures of multiple types of abuse and mental health indicators, this aim was included for hypothesis-generating purposes.

Method

Procedure

Recruitment for the study was conducted with a combination of snowball and targeted sampling methods. Announcements about the study were sent electronically to LGB listservs, websites, groups, organizations, and clubs in all 50 states, with specific targeted advertising sent to venues focused on LGB people of color. Examples of such venues include Yahoo! groups; lesbian, gay, bisexual, and transgender (LGBT) community centers; e-mail lists specifically for LGBT people of color; LGBT social clubs specifically for people of color; and Craigslist. All participants were asked to forward information about the study to other individuals and groups that might be eligible to participate. Potential participants who followed our link were taken to our web-based information statement, which explained that the study was being conducted in order to “understand how the unique experiences of LGBT people affect their health and well-being” as well as to “refine our survey questions about experiences of lesbian, gay, bisexual, and transgender (LGBT) adults.” The information statement also explained the criteria for participation (age 18 or older; identify as lesbian, gay, bisexual, transgender, queer, or two-spirit), purpose of the study, its risks and benefits, and our confidentiality agreement. Participants who agreed to participate then completed the questionnaire online using Survey Monkey data collection software (<http://www.surveymonkey.com>). The questionnaire was followed by a listing of LGB and mental health resources. Questionnaire completers could then voluntarily choose to enter a lottery to win one of three \$100 prizes.

Participants

One thousand two hundred and seventeen questionnaires were completed. To have sufficient statistical power for all racial/ethnic group comparisons, we included only participants who self-identified as African American, Latina/o, Asian American, or White, excluding those who selected more than one race/ethnicity or other races/ethnicities ($n = 207$). Similarly, we excluded those participants who identified as transgender ($n = 184$) or were missing data on gender ($n = 23$) due to insufficient representation within some of the four racial groups. Finally, we excluded 180 participants who did not finish the questionnaire. There was some overlap in reason for exclusion; for example, some participants were both transgender and multiracial, or missing data on gender and did not complete the questionnaire. We compared the 180 noncompleters with the 669 completers on demographic variables. Noncompleters were significantly more likely to be people of color (31.1% vs. 21.8%), $\chi^2(1, N = 849) = 6.75, p < .01$, and had lower levels of education, $t(843) = 2.65, p < .01$, than completers. There were no significant ethnic differences in age or sexual identity.

Measures

The overall web-based questionnaire included a number of standardized and new measures of stressors and traumatic experiences, coping process, and mental health symptoms. For the current study, the following measures were used.

Demographics. Demographic questions were adapted from previous research by the investigative team (Balsam et al., 2005). These questions assessed gender, age, race/ethnicity, employment status, educational level, individual income, household income, and sexual orientation (lesbian, gay, bisexual, heterosexual, queer,¹ two-spirit, or other).

Childhood abuse. Childhood abuse was assessed with emotional, physical, and sexual abuse subscales of the Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein & Fink, 1998), a standardized, retrospective self-report questionnaire with strong internal consistency and test–retest reliability. In our sample, the internal consistency coefficients for each subscale were as follows: .87 for emotional abuse, .86 for physical abuse, and .94 for sexual abuse. Scores for each subscale range from 5 to 25. The CTQ scoring guidelines also indicate four abuse classifications for each scale: none or minimal, low to moderate, moderate to severe, and severe to extreme. To calculate prevalence rates for each of the three subscales in the current study, we classified any score above the none-or-minimal range as indicating abuse. This threshold is recommended by the authors of the CTQ for maximizing identification of any abuse while keeping specificity to an acceptable level (Bernstein & Fink, 1998).

Depression. Depression was assessed with the mean of the 10-item Center for Epidemiologic Studies Depression Scale (Radloff, 1977), a brief self-report measure with good reliability and validity characteristics (Andresen, Malmgren, Carter, & Patrick, 1994). Responses are recorded on a 4-point Likert scale ranging from 0 (*rarely*) to 3 (*most of the time*) during the past week, with higher scores representing greater depressive symptoms. In our sample, Cronbach's alpha was .91.

Anxiety. Anxiety was assessed as the mean of the seven-item Patient Health Questionnaire Generalized Anxiety Disorder Scale (Spitzer, Kroenke, Williams, & Löwe, 2006), which has strong reliability and validity as a measure of general anxiety (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007; Löwe et al., 2008; Spitzer et al., 2006). On the Generalized Anxiety Disorder Scale, participants are asked how often, over the last 2 weeks, they have been bothered by each of seven anxiety symptoms (e.g., feeling nervous, anxious, or on edge; trouble relaxing). Response options are *not at all*, *several days*, *more than half the days*, and *nearly every day*, scored as 0, 1, 2, and 3, respectively. In our sample, Cronbach's alpha was .86.

Posttraumatic stress symptoms. Posttraumatic stress symptoms were assessed with the mean of the items from the PTSD Checklist–Civilian Version (Weathers, Litz, Herman, Huska, & Keane, 1993), a self-report measure with strong reliability and validity as a screen for PTSD (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers et al., 1993). The measure consists of 17 items corresponding to each symptom of PTSD occurring in the past month in Criteria B, C, and D of the *Diagnostic and Statistical Manual of Mental Disorders*. Symptoms are rated from 1 (*not at all*) to 5 (*extremely*), reflecting the extent to which each

symptom bothered the individual in the last month. In the current study, Cronbach's alpha was .95.

Perceived stress. Perceived stress was assessed with the Perceived Stress Scale–Short Form, a four-item self-report questionnaire with strong reliability and validity (Cohen, Kamarck, & Mermelstein, 1983). Respondents are asked to indicate how often they have felt or thought a certain way in the past month (e.g., “In the last month, how often have you been upset because of something that happened unexpectedly?”) on a 5-point scale that ranges from 0 (*never*) to 4 (*very often*). Responses are then summed to indicate the level of perceived (subjective) stress. In the current study, Cronbach's alpha was .83.

Analytic Strategy

Analyses were performed in SPSS (Version 15.0) and Mplus (Version 5.2). Preliminary analyses compared race/ethnicity groups on CTQ abuse scores (analysis of variance) and experience or nonexperience of abuse (chi-square).

The main analyses were conducted separately for each mental health outcome and used a two-step regression approach. These analyses controlled for age, education, and gender. The first step tested the effects of emotional, physical, and sexual abuse on the outcome. Predictors were the CTQ scores for each type of abuse—in effect testing the unique effects of each, controlling for the others. Race/ethnicity was also included as a predictor in the form of dummy-coded variables representing being African American, Asian American, and Latina/o (hence White participants served as the reference group). The second step added the interaction of the race/ethnicity dummy codes with each type of abuse to test whether race/ethnicity moderated their effects on current mental health symptoms. In other words, a significant interaction would mean that experiencing a particular type of abuse was associated with either better or worse scores on the outcome for a particular race/ethnicity (compared with Whites).

The change in explained variance (R^2) between the first and second steps was then calculated, and how results are reported depends on the results of this and the regression estimates. If the variance change and the interaction terms were not statistically significant, this was considered an indication that race/ethnicity did not moderate the effect of abuse (given that the addition of the interaction terms did not explain anymore of the variance in the outcome, nor were they significant). In this case, the Step 1 regression results are reported. However, if the change in variance was significant, this reflected that some moderation was likely (because more variance in the outcome was being explained), and the Step 2 results are reported.

Maximum likelihood regression using robust standard errors was used in these, an appropriate statistic when there is some skew in variables. As implemented in Mplus, this approach also allowed the inclusion in the analyses of cases missing one but not all of the variables in a particular analysis. This was considered optimal for

¹ The term *queer* is used by some LGB people as a more broad and inclusive term for LGB identity. This study aimed to be inclusive of diverse individuals within the LGB community; thus, we allowed people to use the “queer” label rather than force them to choose “lesbian, gay, or bisexual.” However, this means that we cannot infer whether they have only same-sex partners or both same- and opposite-sex partners.

these analyses given that maximum likelihood is considered a state-of-the-art approach for allowing the inclusion of individuals with some missing data, thereby reducing the amount of bias in results (Schafer & Graham, 2002).

Results

Sample Description

The 669 participants included in the current study consisted of 256 (38.3%) men and 413 (61.7%) women. According to the self-rating of sexual orientation, 234 (35.0%) identified as lesbian, 204 (30.5%) as gay, 152 (22.7%) as bisexual, 47 (7.0%) as queer, and 32 (4.8%) as other. Participants ranged in age from 18 to 74, with a mean age of 36.5 years ($SD = 11.4$). The race/ethnicity of the participants was 523 (78.2%) European American/White, 49 (7.3%) African American/Black, 52 (7.8%) Latina/o/Hispanic, and 45 (6.7%) Asian/Asian American. Participants were generally highly educated, with 79.0% reporting at least a college degree and 42.1% reporting a graduate or professional degree. With respect to employment status, 59.2% were employed full-time and 15.2% part-time, and 30.2% were students. The mean reported annual individual income fell in the \$30,000–\$39,000 range, and the mean annual household income fell in the \$40,000–\$59,000 range.

Preliminary Analyses: Race/Ethnicity Comparisons

Abuse histories. Using the CTQ cutoff scores, we found gender differences for emotional abuse (50.2% men vs. 60.8% women), $\chi^2(1) = 7.19, p < .01$, and sexual abuse (32.0% vs. 42.4%), $\chi^2(1) = 7.07, p < .01$, but not for physical abuse (35.3% vs. 37.5%), $\chi^2(1) = 0.32, ns$.

Racial/ethnic differences in the percentage reporting any of each type of abuse are shown in Table 1. No significant racial/ethnic differences were seen for emotional abuse. A greater proportion of Latina/o and African American participants reported physical abuse compared with White participants and sexual abuse compared with both Asian American and White participants.

After controlling for age, education, and gender, race/ethnicity was related to the continuously measured CTQ abuse scores in a multivariate analysis of variance, $F(9, 1962) = 4.06, p < .001$. Similar to the findings with the dichotomized measures, univariate follow-up analyses of variance showed that these differences were significant for physical and sexual abuse but not for emotional

abuse. Table 2 shows the mean of each variable after adjusting for control variables (hence the means reflect scores for people of average age and education and the average across genders). Post hoc tests showed that White participants had lower scores on physical abuse than Asian American and Latina/o participants and lower scores on sexual abuse than African American and Latina/o participants. Asian Americans had lower mean sexual abuse scores than Latina/os.

Current mental health symptoms. Race/ethnicity was not associated with any of the four mental health symptoms in the study (controlling for age, education, and gender).

Preliminary Analysis: Interrelationship of Abuse Types and Mental Health Symptoms

Examined via zero-order correlations, the three types of abuse were positively and significantly correlated with one another (r s ranged from .37 to .65; p s < .001). Additionally, zero-order correlations between emotional, physical, and sexual abuse were positive and statistically significant with PTSD (r s = .45, .37, and .25, respectively; all p s < .001), anxiety (r s = .33, .23, and .13; all p s < .001), depression (r s = .33, .24, and .08; p s < .001 for first two and $p < .05$ for last), and perceived stress (r s = .22, .17, and .09; p s < .001 for first two and $p < .05$ for last).

Main Analyses Predicting Current Mental Health Symptoms

Perceived stress and depression. For the perceived stress and depression outcomes, there was not a significant change in variance between the regression with only main effects ($R^2 = .128$ and .168, respectively) and the second regression in which the interactions of abuse by race were added ($R^2 = .143$ and .179, respectively), $F(9, 669) = 1.264$ and $0.968, p = .25$ and $.47$, respectively. Because no interaction terms were significant, and the second step did not explain more variance than the first, Table 3 shows the simpler Step 1 regression results. Among the three childhood abuse variables, emotional abuse was the only significant predictor of either symptom. Overall, these findings imply two things: (a) the effects of abuse did not differ due to race/ethnicity, and (b) physical and sexual abuse, despite having the significant zero-order correlations with these outcomes that are reported above, did not have any additive effects above and beyond the effects of

Table 1
Sample Proportions for Childhood Abuse Variables by Race/Ethnicity

Abuse type	African American ($N = 49$)		Latina/o ($N = 52$)		Asian American ($N = 45$)		White ($N = 523$)		$\chi^2(3)$	p
	Sample proportion (%)	95% CI	Sample proportion (%)	95% CI	Sample proportion (%)	95% CI	Sample proportion (%)	95% CI		
Emotional	59.2	[45.2, 72.8]	52.9	[38.4, 65.6]	57.8	[43.6, 72.4]	56.8	[52.8, 61.2]	0.50	<i>ns</i>
Physical	51.1 _a	[37.0, 65.0]	56.9 _a	[43.5, 70.5]	46.7 _{a,b}	[32.4, 61.6]	32.5 _b	[28.0, 36.0]	26.43	$\leq .001$
Sexual	52.2 _a	[39.0, 66.9]	62.7 _a	[49.9, 76.1]	29.5 _b	[16.6, 43.4]	35.5 _b	[30.9, 39.0]	25.99	$\leq .001$

Note. N indicates the sample size for the variable with the highest number of responses. Means in a row that do not share the same subscripts differ at $p < .05$. CI = confidence interval.

Table 2
Means and Standard Deviations for Childhood Trauma Questionnaire Scores by Race/Ethnicity

Abuse type	African American (<i>N</i> = 49)		Latina/o (<i>N</i> = 52)		Asian American (<i>N</i> = 45)		White (<i>N</i> = 523)		<i>F</i> (3, 654) ^a	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Emotional	10.50	0.79	11.52	0.76	12.42	0.81	10.72	0.23	1.67	<i>ns</i>
Physical	8.87 _{a,b}	0.63	9.29 _a	0.61	9.78 _a	0.65	7.67 _b	0.19	5.44	≤.001
Sexual	10.25 _{a,b}	0.83	10.97 _a	0.80	8.00 _{b,c}	0.85	7.96 _c	0.25	6.26	≤.001

Note. Means are adjusted for gender, age, and education. *N* indicates the sample size for the variable with the highest number of responses. Means in a row that do not share the same subscripts differ at $p < .05$.

^a *F* tests controlled for gender, age, and education.

emotional abuse when all three are included in a regression (and, hence, controlling for one another's effects).

Anxiety and PTSD symptoms. Results from these analyses are shown in Table 4. In analysis of both outcomes, there was a significant change in explained variance in the second step in which the interaction terms were added, and some interaction terms were significant. Anxiety variance changed from .169 to .205, $F(9, 669) = 3.270$, $p < .001$, and PTSD symptoms variance changed from .274 to .307, $F(9, 669) = 3.44$, $p < .001$. Positive and significant interaction coefficients showed similar findings for both outcomes. Specifically, relative to White participants, emotional abuse showed a stronger relationship with current PTSD and anxiety symptoms for African American participants (the African American \times Emotional Abuse interaction), and physical abuse showed a stronger relationship with current PTSD and anxiety symptoms for Latina/o participants (the Latina/o \times Physical Abuse interaction).

Figures 1 and 2 illustrate the overall regression findings by charting the predicted values of PTSD symptoms and anxiety. The values are the predicted means for someone of average education and age in the sample and the average across genders. The predicted anxiety and PTSD symptoms associated with varying levels of physical abuse (Figure 1) and emotional abuse (Figure 2) are depicted separately for each race. Specifically, for each race the figure contrasts expected outcomes based on having no versus high scores on abuse (for illustrative purposes, high abuse was considered scores at the 95th percentile for that type of abuse in this sample). As can be seen for anxiety in Table 4, the significant interaction of emotional abuse with being African American reflected that emotional abuse had a greater effect on outcomes for African Americans compared with Whites. Indeed, follow-up regressions done separately for each race showed that the effect of emotional abuse was stronger for African Americans ($\beta = .71$ vs. $.31$).² Similarly, for Latina/os physical abuse had a larger association with anxiety than for Whites ($\beta = .25$ vs. $-.01$). Similar patterns were seen for PTSD. Emotional abuse was more strongly related to PTSD symptoms for African Americans than for Whites ($\beta = .73$ vs. $.30$). Physical abuse was more strongly related to PTSD symptoms among Latina/os than for Whites ($\beta = .41$ vs. $.08$).

Discussion

The current study is one of the first to examine childhood abuse and its relation to adult mental health indicators in an ethnically

diverse sample of LGB adults. Prior studies on race and childhood abuse have not generally assessed sexual orientation, and studies of LGB populations typically include very few ethnic minority participants. Our recruitment strategy using targeted sampling to increase our percentage of African American, Latina/o, and Asian American participants yielded a 21% ethnic minority LGB sample and allowed us to make comparisons across racial/ethnic groups.

Another unique feature of this study is the use of a standardized measure of emotional, physical, and sexual abuse. In the development of the CTQ, Bernstein and Fink (1998) studied the psychometric characteristics of the instrument across seven samples of both clinical and nonclinical adults. The representation of ethnic minorities among these samples ranged from 21.1% to 31.1%; sexual orientation of participants was not reported. Compared with the sample means reported by Bernstein and Fink for these validation samples, our sample means on emotional, physical, and sexual abuse for all participants generally fell between those reported for clinical and nonclinical populations (because of highly skewed distributions, difference of means testing was not performed; Blalock, 1979). This is consistent with the growing body of literature documenting a minority sexual orientation as a risk factor for various forms of childhood abuse (Balsam et al., 2005; Corliss et al., 2002). Indeed, the rates of abuse we found using the cutoff scores on the CTQ are similar to those found in studies of childhood abuse using other measures. For example, Balsam et al. (2005) found rates of childhood sexual abuse ranging from 31.6% to 47.6% among LGB women and men. In Corliss et al.'s (2002) study, rates of emotional maltreatment by a parent were 52.6% for gay and bisexual men and 45.5% for lesbian and bisexual women, and rates of physical maltreatment were 46.7% for gay and bisexual men and 43.6% for lesbian and bisexual women.

Racial/Ethnic Differences in Childhood Abuse

As predicted, the current study found racial/ethnic differences in self-reported experiences with physical and sexual abuse. Latina/o and Asian American participants reported the highest levels of physical abuse, and Latina/o and African American participants reported the highest levels of sexual abuse. In this regard, our

² Standardized beta coefficients allow the evaluation of the relative strength of associations. Here they reflect how much change in standard deviation there will be in the mental health outcome when there is a one standard deviation change in the emotional abuse predictor.

Table 3
 Linear Regression Testing Effects of Race and Abuse on Perceived Stress and Depression ($N = 669$)

Variable	Perceived stress ($R^2 = .128$)						Depression ($R^2 = .168$)					
	<i>B</i>	95% CI	<i>SE</i>	β^a	<i>t</i>	<i>p</i>	<i>B</i>	95% CI	<i>SE</i>	β^a	<i>t</i>	<i>p</i>
Intercept	4.69	[3.87, 5.51]	0.32		14.79	$\leq .001$	3.91	[2.26, 5.55]	0.64		6.11	$\leq .001$
Age	-0.06	[-0.92, -0.03]	0.01	-.21	-5.41	$\leq .001$	-0.10	[-0.16, -0.03]	0.02	-.16	-4.00	$\leq .001$
Female ^b	0.02	[-0.64, 0.68]	0.26	.00	0.10	$\leq .93$	0.15	[-1.08, 1.39]	0.48	.01	0.32	$\leq .75$
Education level ^c	-0.37	[-0.66, -0.08]	0.11	-.14	-3.30	$\leq .001$	-0.69	[-1.25, -0.12]	0.22	-.13	-3.12	$\leq .01$
Ethnicity ^d												
African American	0.28	[-1.24, 1.79]	0.59	.02	0.47	$\leq .64$	1.16	[-1.82, 4.14]	1.16	.04	1.01	$\leq .32$
Latina/o	-0.23	[-1.32, 0.85]	0.42	-.02	-0.55	$\leq .58$	-0.69	[-2.78, 1.41]	0.81	-.03	-0.85	$\leq .40$
Asian American	0.09	[-1.23, 1.40]	0.51	.01	0.17	$\leq .87$	-1.13	[-3.92, 1.66]	1.08	-.04	-1.04	$\leq .30$
Abuse type												
Emotional	0.12	[0.05, 0.20]	0.03	.20	4.06	$\leq .001$	0.40	[0.23, 0.57]	0.07	.32	6.01	$\leq .001$
Physical	0.02	[-0.09, 0.13]	0.04	.03	0.49	$\leq .62$	0.09	[-0.13, 0.31]	0.09	.06	1.02	$\leq .31$
Sexual	0.00	[-0.06, 0.07]	0.02	.01	0.11	$\leq .91$	-0.08	[-0.21, 0.05]	0.05	-.07	-1.59	$\leq .11$

Note. CI = confidence interval.

^a The standardized beta coefficients reflect how much change in standard deviation there will be in the mental health outcome when there is a one standard deviation change in the predictor. ^b Reference group was male. ^c Coded as 1 = some or no high school, 2 = high school degree, 3 = some college, 4 = college degree, 5 = some graduate/professional school, 6 = graduate/professional degree. ^d Reference group was White.

study parallels several other retrospective studies of presumably heterosexual adults that found higher levels of childhood abuse among racial/ethnic minorities (Hussey, Chang, & Kotch, 2006; Meston, Heiman, Trapnell, & Carlin, 1999; Ullman & Filipas, 2005). Our study adds to this body of literature by focusing specifically on ethnic/racial differences among LGB adults. Along

with a handful of other studies (e.g., Arreola, Neilands, Pollack, Paul, & Catania, 2005; Morris & Balsam, 2003), our results suggest that LGB people of color, who face prejudice and marginalization based on both race/ethnicity and sexual orientation, may also face unique risks for childhood abuse compared with their White counterparts. Identifying factors within ethnic minority

Table 4
 Linear Regression Testing Effects of Race and Abuse on Anxiety and Posttraumatic Stress Disorder (PTSD) Symptoms ($N = 669$)

Variable	Anxiety symptoms ($R^2 = .205$)						PTSD symptoms ($R^2 = .311$)					
	<i>B</i>	95% CI	<i>SE</i>	β^a	<i>t</i>	<i>p</i>	<i>B</i>	95% CI	<i>SE</i>	β^a	<i>t</i>	<i>p</i>
Intercept	9.71	[8.71, 10.72]	0.39		24.88	$\leq .001$	18.40	[15.33, 21.46]	1.19		15.46	$\leq .001$
Age	-0.04	[-0.07, -0.01]	0.01	-.12	-3.01	$\leq .01$	-0.14	[-0.24, -0.03]	0.04	-.12	-3.27	$\leq .001$
Female ^b	0.63	[-0.05, 1.31]	0.26	.09	2.40	$\leq .05$	1.09	[-1.27, 3.46]	0.92	.04	1.19	$\leq .23$
Education level ^c	-0.38	[-0.67, -0.09]	0.11	-.13	-3.38	$\leq .001$	-1.67	[-2.63, -0.72]	0.37	-.16	-4.51	$\leq .001$
Ethnicity ^d												
African American	-2.72	[-6.73, 1.29]	1.56	-.20	-1.75	$\leq .08$	-11.02	[-24.49, 2.45]	5.23	-.23	-2.11	$\leq .05$
Latina/o	-0.85	[-3.49, 1.79]	1.03	-.06	-0.83	$\leq .41$	-8.33	[-19.68, 3.02]	4.41	-.18	-1.89	$\leq .07$
Asian American	0.55	[-2.27, 3.37]	1.09	.04	0.50	$\leq .62$	-2.58	[-14.14, 8.97]	4.49	-.05	-0.58	$\leq .57$
Abuse type												
Emotional	0.20	[0.10, 0.29]	0.04	.30	5.39	$\leq .001$	0.72	[0.39, 1.04]	0.13	.31	5.72	$\leq .001$
Physical	-0.01	[-0.15, 0.14]	0.06	-.01	-0.12	$\leq .90$	0.18	[-0.24, 0.60]	0.16	.06	1.10	$\leq .27$
Sexual	0.01	[-0.07, 0.10]	0.03	.02	0.43	$\leq .67$	0.26	[0.00, 0.52]	0.10	.12	2.60	$\leq .01$
African American												
× Emotional Abuse	0.45	[0.06, 0.84]	0.15	.38	2.94	$\leq .01$	1.50	[0.32, 2.68]	0.46	.36	3.28	$\leq .001$
× Physical Abuse	0.02	[-0.55, 0.58]	0.22	.01	0.07	$\leq .95$	-0.03	[-1.56, 1.49]	0.59	-.01	-0.06	$\leq .95$
× Sexual Abuse	-0.17	[-0.41, 0.06]	0.09	-.16	-1.88	$\leq .67$	-0.54	[-1.31, 0.23]	0.30	-.14	-1.82	$\leq .07$
Latina/o												
× Emotional Abuse	-0.13	[-0.39, 0.14]	0.10	-.12	-1.23	$\leq .22$	-0.18	[-1.31, 0.95]	0.44	-.05	-0.41	$\leq .68$
× Physical Abuse	0.29	[-0.05, 0.63]	0.13	.23	2.21	$\leq .05$	1.19	[-0.20, 2.58]	0.54	.27	2.21	$\leq .05$
× Sexual Abuse	-0.08	[-0.27, 0.10]	0.07	-.08	-1.18	$\leq .24$	-0.16	[-0.89, 0.57]	0.28	-.04	-0.58	$\leq .56$
Asian American												
× Emotional Abuse	-0.05	[-0.35, 0.25]	0.12	-.05	-0.45	$\leq .66$	0.17	[-0.75, 1.10]	0.36	.05	0.48	$\leq .63$
× Physical Abuse	-0.03	[-0.34, 0.28]	0.12	-.02	-0.27	$\leq .79$	-0.10	[-1.15, 0.94]	0.41	-.02	-0.26	$\leq .80$
× Sexual Abuse	-0.11	[-0.29, 0.06]	0.07	-.07	-1.67	$\leq .10$	-0.23	[-1.16, 0.70]	0.36	-.04	-0.65	$\leq .52$

Note. CI = confidence interval.

^a The standardized beta coefficients reflect how much change in standard deviation there will be in the mental health outcome when there is a one standard deviation change in the predictor. ^b Reference group was male. ^c Coded as 1 = some or no high school, 2 = high school degree, 3 = some college, 4 = college degree, 5 = some graduate/professional school, 6 = graduate/professional degree. ^d Reference group was White.

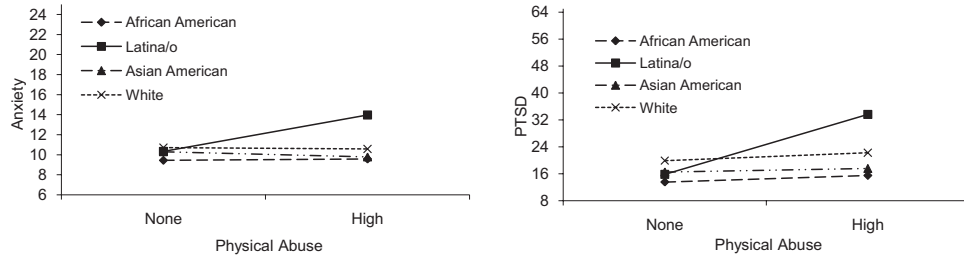


Figure 1. Relationship between physical abuse and outcomes, by race, controlling for age, gender, education, emotional abuse, and sexual abuse. PTSD = posttraumatic stress disorder symptoms.

families that may contribute to this risk, such as negative attitudes toward homosexuality (Finlinson et al., 2003; Greene, 1997; Guarnero, 2007), is an important area for future research.

Our study also adds to the literature in that it provides preliminary evidence that childhood emotional abuse is the strongest predictor of current mental health among LGB adults, regardless of their ethnic or racial background. Specifically, although physical and sexual abuse were bivariately related to mental health outcomes, this relationship was not significant when controlling for emotional abuse, suggesting that the emotional aspects of abuse were the most damaging. Childhood emotional abuse is an understudied topic compared with other forms of abuse and lacks a universal definition (Allen, 2008). Nonetheless, prior theory and research have addressed the unique properties of childhood emotional abuse that might contribute to adult mental health difficulties. For example, Rose and Abramson (1992) hypothesized that emotional abuse in childhood contributes to a cognitive style that might predispose an individual to developing a depressive disorder. Following up on this theory, Gibb et al. (2007), using the CTQ, found that the emotional abuse subscale correlated more strongly with both depressive and anxiety disorders among adult psychiatric outpatients than other forms of abuse. Similarly, a study comparing adults with treatment-resistant depression versus treatment-responsive adults, also using the CTQ, found that those who were treatment resistant reported significantly more emotional abuse but not sexual or physical abuse (Kaplan & Klinetob, 2000). Other empirical studies with presumably heterosexual populations have shown an association between childhood emotional abuse and increased levels of depression, anxiety, and somatic complaints (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006); worse overall emotional functioning (Higgins & McCabe, 2000);

and difficulties with interpersonal relationships in adulthood (Mullen, Marin, Anderson, Romans, & Herbison, 1996).

For LGB people, the negative messages internalized in response to childhood emotional abuse might be particularly salient because they occur against a backdrop of negative social and cultural messages about a sexual minority orientation. A growing body of literature documents that such internalized negative messages about homosexuality are associated with lower self-esteem and greater distress in LGB populations (Balsam & Mohr, 2007; Szymanski, Chung, & Balsam, 2001). Indeed, the items on the emotional abuse subscale of the CTQ (e.g., “I thought that my parents wished I had never been born” and “People in my family said hurtful or insulting things to me”) may potentially be tapping into some childhood experiences that are directly related to the child’s sexual orientation. Along these lines, Savin-Williams (2003) reviewed the results of literature on LGB youth and their parents, concluding that rejection, victimization, and verbal abuse are some consequences LGB youth may face when disclosing sexual orientation to parents. Nonetheless, he also stated that the prevalence of these consequences is difficult to assess because very few empirical studies have examined the relations that LGB youth have with their parents. Indeed, in a study with LGB adolescents, more than three quarters reported verbal abuse because of their sexual orientation (D’Augelli, 2002). In a study with LGB adults, 24% who experienced emotional abuse in childhood attributed this abuse directly to their sexual orientation (Balsam, 2002). A more recent study by Ryan, Huebner, Díaz, and Sanchez (2009) provides evidence that sexual-orientation-related family rejection in adolescence is associated with a number of negative health indicators among LGB adults, including depression and suicidality.

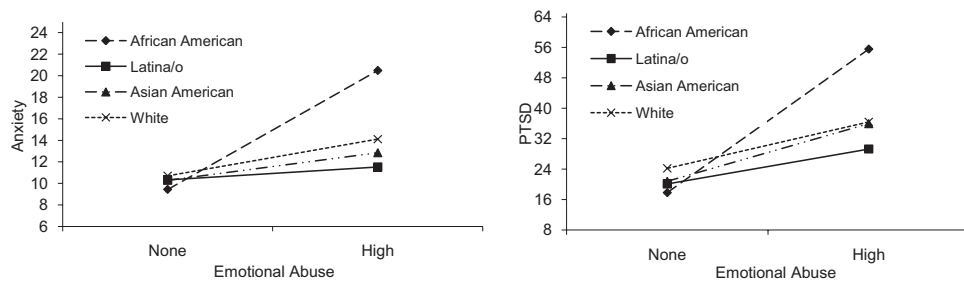


Figure 2. Relationship between emotional abuse and outcomes, by race, controlling for age, gender, education, physical abuse, and sexual abuse. PTSD = posttraumatic stress disorder symptoms.

Brown (2008) also noted that even in families with no overt abuse, generalized negative comments about homosexuality can be experienced as traumatic by children who will later grow up to be LGB. Thus, given the subjective nature of the experience of emotional abuse, it is possible that LGB adults may have a lower threshold for perceiving emotional abuse because they are particularly sensitized to such attitudes among family members. Furthermore, despite racial/ethnic differences in physical and sexual abuse, it is interesting that no significant differences were found in reported levels of emotional abuse. This may have been due to a ceiling effect, such that all participants reported high levels of this type of abuse. Our study did not assess whether child abuse in general and emotional child abuse in particular were perceived to be related to homophobia and sexual orientation; clearly, this is an important area for future research.

Overall, our findings suggest that the relationship between childhood abuse and adult mental health is similar for LGB people of diverse racial backgrounds. PTSD and anxiety symptoms did show a stronger relationship with emotional abuse for African American participants, and these same variables showed a stronger relationship with physical abuse for Latina/o participants. There is existing evidence from non-LGB research that Latina/os may be at elevated risk for PTSD following a range of other types of traumatic events (e.g., Galea et al., 2002); this has been linked to posttrauma factors such as differences in coping style and perceived racism (Pole, Best, Metzler, & Marmar, 2005). However, future research needs to determine whether these factors might affect symptom levels following childhood abuse.

For LGB people of color, family support can provide an important buffer against the negative health impact of homophobic and racist experiences (Greene, 1997). Conversely, abuse within the family of origin may be particularly anxiety provoking, as it signals the lack of such a buffer. For example, in one study of LGB adults, low levels of parental support for one's sexual orientation were associated with higher anxiety (Mohr & Fassinger, 2003). Additionally, such abuse may accompany a sense of self-blame for betraying one's cultural or ethnic heritage (Rutter & Estrada, 2006). It is also important to consider that there may be other unmeasured variables that confound the relationship between childhood abuse and adult mental health among African American and Latina/o participants, such as having a parent in jail and out-of-home placements, both of which occur at higher rates in these populations (Beck & Karberg, 2001). Future research should explore these potential explanations for differential effects of childhood abuse among ethnically diverse LGB populations.

Limitations of the Current Study

Although this study provides data on an understudied topic, some limitations must be considered in drawing conclusions. Participants were recruited in a nonrandom manner over the Internet. We cannot, therefore, generalize these results to all LGB individuals, nor do we know how the participants may differ in any systematic way from those who did not see our recruitment materials or who chose not to participate. It is possible that individuals who are less well connected to other LGB people, even via the Internet, and individuals who have fewer economic resources and thus less Internet access may have been less likely to participate in the study. The web-based format of our study may have resulted in

lower participation by ethnic minority participants, who may have less Internet access at home (Cheeseman, Janus, & Davis, 2005), although the extent to which ethnic minorities access the Internet at other locations relative to White individuals is not known. Another consideration is that despite our relative success in recruiting adequate numbers of ethnic minority participants, the sample sizes for our African American, Latina/o, and Asian American participants were relatively small, thereby reducing our power to be able to detect race differences and also precluding some potentially interesting analyses such as gender by race comparisons. Future research should continue inquiry on this topic by examining whether such findings are potentially moderated by gender.

Regarding measurement issues, our study was conducted on the Internet, and the measures we used were all normed with paper-based formats. Although there is little existing information about how web-based methodologies may impact psychometrics, there is some indication that participants may respond differently to items administered on the Internet than on paper (McCoy, Marks, Carr, & Mbarika, 2004). Finally, as with much other research on childhood abuse, this study relies exclusively upon adult retrospective reporting of such experiences and therefore may be subject to recall bias. It is possible that experiences in adulthood such as family reactions to disclosure of sexual orientation may influence recall and interpretation of adverse childhood events, or that adults who develop psychopathology symptoms may be more likely to recall or report past abuse than those who lack such symptoms. Moreover, it is possible that ethnic groups may systematically differ in their reporting style and/or sensitivity to reporting certain stigmatizing information (e.g., sexual abuse) even in a relatively anonymous forum such as the Internet. Finally, it is unknown the extent to which the racial/ethnic differences between completers and noncompleters may have biased these results, although it is difficult to ascertain whether this might magnify or minimize any race differences that we found.

Given these limitations, the results of our study should be viewed as preliminary and hypothesis generating and therefore subject to replication. Ideally, to replicate these findings with more confidence, we would need a population-based sample with higher numbers of ethnic minority LGB participants. That being said, accomplishing that is methodologically difficult. Although more population-based studies are now including measures of sexual orientation, these studies typically yield very small percentages of LGB participants (e.g., 2.5% in Corliss et al.'s, 2002, analysis of Midlife Development in the United States data; 4.8% in Cochran et al.'s, 2007, analysis of National Latino and Asian American Study data). Even among these LGB participants, only a small subset are ethnic minority (e.g., approximately 11 participants in Corliss et al.'s, 2002, analysis of 2,917 randomly sampled adults; 284 participants in Dilley, Simmons, Boyson, Pizacani, and Stark's, 2009, analysis of 79,500 randomly sampled adults). Additionally, with the exception of the Midlife Development in the United States, most epidemiologic studies do not include detailed measures of childhood abuse, if these variables are included at all. Clearly, future researchers who want to replicate these findings will need to take these challenges into account in designing their studies. Most important, oversampling ethnic minority LGB people will be necessary in order to have adequate statistical power to replicate the findings of our study.

Clinical Implications and Conclusions

The results of this study indicate that (a) African American and Latina/o LGB people may have elevated risk for childhood physical and sexual abuse compared with their White counterparts; (b) for all LGB people, childhood abuse (particularly emotional abuse) is associated with more current mental health symptoms; and (c) the association between childhood abuse and some mental health outcomes may differ according to race/ethnicity. Overall, these results highlight the importance for clinicians of considering the role that childhood trauma might play in the lives of LGB clients, even when this is not initially one of the presenting concerns. In particular, therapists working with LGB clients should conduct a thorough assessment of the emotional climate of the client's family of origin and the ways in which parents or other caregivers may have been emotionally abusive during the client's formative years. Additionally, clinicians working with parents and families of LGB youth might educate these families about the nature of emotional abuse and its potential long-term impact on their LGB family members. When working with LGB people of color, clinicians should be sensitive to the additional challenges faced by these clients and the ways in which trauma within the family of origin may be particularly deleterious in adulthood.

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Received October 24, 2008

Revision received December 1, 2009

Accepted December 2, 2009 ■