Syracuse University

SURFACE at Syracuse University

Theses - ALL

Spring 5-22-2021

The Association Between Experiences Of Relational Injustice And Psychological Distress In People With Marginalized Sexual Orientation And Gender Identities

Khoi Nguyen Anh Le
Syracuse University

Follow this and additional works at: https://surface.syr.edu/thesis

Part of the Clinical Psychology Commons, and the Gender and Sexuality Commons

Recommended Citation

Le, Khoi Nguyen Anh, "The Association Between Experiences Of Relational Injustice And Psychological Distress In People With Marginalized Sexual Orientation And Gender Identities" (2021). *Theses - ALL*. 484.
https://surface.syr.edu/thesis/484

This Thesis is brought to you for free and open access by SURFACE at Syracuse University. It has been accepted for inclusion in Theses - ALL by an authorized administrator of SURFACE at Syracuse University. For more information, please contact surface@syr.edu.

Abstract

The current study explored correlations between experiences of relational injustice with psychological distress in people with marginalized sexual orientation and gender identity (MSOGI). Based on the Contextual Therapy theory, it was hypothesized that experiences of relational injustice are associated with psychological distress of people with MSOGI. Also, people with both marginalized identities were assumed to have greater distress than people with only one marginalized identity. Data were collected from clients self-identifying as MSOGI at the Syracuse University Couple and Family Therapy Center. Both self-reported and standardized instruments, including the Everyday Discrimination Scale (EDS) and Brief Symptoms Inventory (BSI-18), were used to gather information. Findings indicated moderate associations between some forms of relational injustice and aspects of psychological distress, as well as interconnections between those forms. There were no statistically significant differences in psychological distress between the groups, even though there were some differences in the forms of relational injustices experienced. Given the results, it is necessary to explore multiple forms of relational injustices in working with people with MSOGI. Further limitations and implications are discussed.

THE ASSOCIATION BETWEEN EXPERIENCES OF RELATIONAL INJUSTICE AND PSYCHOLOGICAL DISTRESS IN PEOPLE WITH MARGINALIZED SEXUAL ORIENTATION AND GENDER IDENTITIES

by

Khoi Nguyen Anh Le

B.A., University of Van Hien, 2012

M.A., Ecole De Psychologues Praticiens, 2014

Thesis

Submitted in partial fulfillment of the requirements for the degree of

Master of Arts in Marriage and Family Therapy.

Syracuse University

May 2021

Copyright © Khoi Nguyen Anh Le, 2021
All Rights Reserved

Table of Contents

Introduction..1

Literature review..3

Study questions...15

Methods..16

Results..21

Discussion...28

Appendix A...35

References...41

Lists of illustrative materials

Figure	Page
Figure 1: Hypothesized relationships between variables in the study	16
Table 1: Demographic information of each marginalized group	17
Table 2: Descriptive of main variables	23
Table 3: Correlations between main variables	26

Introduction

This study investigated associations between experiences of relational injustice with psychological distress in people with marginalized sexual orientation and gender identities (MSOGI). While researchers usually examine relational injustice via self-report of perception of how fair people are treated in their family of origin and couple relationships (Hargrave et al., 1991), this study explored a new way of testing relational injustices through self-report of unjust actions that occur to persons. Also, contextual therapy and its considerations for relational fairness and justice are adopted to conceptualize lived experiences of other populations (Gangamma et al., 2012, 2015; Leibig & Green, 1999; McPhee et al., 2019; Patton & Weigold, 2020; Schmidt et al., 2016), but they are almost absent in the MSOGI literature. Thus, the study aimed to generate insights and clinical implications in using relational injustice in practice with MSOGI clients.

Sexual orientation reflects one or more of three sexual characteristics: attraction, behavior, and identity. Social sciences researchers usually ask for participants' sexual orientation based on their self-identity of the third characteristic (Savin-Williams, 2006). Gender identity concerns people's internal schema of their gender features and perceived gender expectations. People may or may not match their gender identity with their assigned sex at birth (Haas et al., 2010). People who identify themselves with a marginalized sexual orientation (SO) or gender identity (GI) frequently report significant levels of psychological distress in studies and clinical work. Compared to their heterosexual, cisgender counterparts, MSOGI people have higher risks and prevalence of substance use, suicidal ideation and attempts, unsafe sexual behaviors, and mental disorders (Bostwick et al., 2014; Haas et al., 2010; Phan et al., 2020; Storholm et al., 2019).

Within the framework of contextual therapy, relational injustice can be defined as an imbalance of fairness in relationships between people (Boszormenyi-Nagy & Krasner, 1986).

In general, experiences of relational injustice may emerge when one party in close relationships with others gains benefits without returning support to other parties or stops the others from accessing resources to develop. Typically, motivations for such unfair interactions are not intentional or at the level of consciousness. Studies suggest that specifically in MSOGI people, discrimination, bullying, and unfair treatment in families are common and that these types of actions are significantly associated with a wide range of psychological distress among MSOGI individuals (D'Amico & Julien, 2012; Earnshaw et al., 2016; Valente et al., 2020).

This study has two objectives. Firstly, it was hypothesized that each type of unjust actions is correlated with psychological distress. In the second hypothesis, it was assumed that people with both marginalized sexual orientation and gender identities would score higher on psychological distress and experience greater relational injustice, in comparison with people with only one marginalized identity. Discriminatory experiences were measured using the Everyday Discrimination Scale (EDS, Williams et al., 1997), and information relating to bullying and unfair treatment was collected by self-reported questions. Psychological distress was considered as internalizing (anxiety and depression) and externalizing (suicidality and substance use) problems. The former was measured using the Brief Symptoms Inventory (BSI-18; Kreutzer et al., 2011) while the latter was asked via self-reported questions, as well as using the Alcohol-CAGE and Substance-CAGE screening tools (O'Brien, 2008).

This study aims to bridge the gap in the literature of relational injustices and MSOGI and explore their connection. It may broaden the conceptualization of contextual therapy beyond its traditional realm of family relationships to address relational injustices in multiple relationships in the MSOGI population.

Literature review

Marginalized SOGI

A body of research over years has shown that people with marginalized sexual orientation and gender identities (MSOGI)—who identify themselves as sexual minority (gay, lesbian, bisexual, pansexual, etc.) and/or transgender or nonbinary—experienced greater negative psychological distress and riskier behavioral health (Bostwick et al., 2014; Coulter et al., 2018; Haas et al., 2010; Phan et al., 2020; Valente et al., 2020). Sexual orientation generally reflects one or more of three interconnected characteristics: sexual behavior, sexual attraction, and sexual identity (Haas et al., 2010; Savin-Williams, 2006). Most social science researchers define sexual orientation based on the last component. Although the prevalence of people who identify as gay, lesbian, and bisexual in the general population varied across different studies, the general estimation ranges from 3%–5% (Haas et al., 2010). On the other hand, gender diverse people may have gender identity and expression that are different with ascribed sex at birth or not exclusively male or female (Haas et al., 2010). It is difficult to estimate the prevalence of transgender and nonbinary people in the general population because of the lack of data. For instance, the estimated prevalence is 1/30,000 AMAB (assigned male at birth) people and 1/100,000 AFAB (assigned female at birth) people seeking reassignment surgery in the U.S. Latest data showed that the estimation of transgender adults is about 0.58% (Flores et al., 2016).

Meta-analytic results from 25 international studies suggested that the odds of depression, anxiety disorders, and substance use disorders occurred 1.5 times more frequently among lesbian, gay, and bisexual (LGB) individuals than their heterosexual counterparts (Haas et al., 2010). Within the American context, one study showed that LGB individuals tended to experience 0.5–1 times higher odds of mental disorders than their heterosexual counterparts in the past year (Bostwick et al., 2014). In particular, gay young men and

bisexual young women reported higher rates of eating disorders than heterosexual young men and heterosexual/lesbian women (Shearer et al., 2015). The rate of suicidal attempts is two times higher in lesbian and bisexual women than in heterosexual women, while it is four times higher for gay and bisexual men, compared to heterosexual men during their lifetimes (Mereish et al., 2014). Similarly, transgender individuals also reported one third higher rate of suicidal attempts than cisgender counterparts, and the higher rate was seen in adolescents and young adults, compared to older transgender persons (Haas et al., 2010). People with MSOGI also likely used drugs (Coulter et al., 2018; Lee et al., 2020; Phan et al., 2020; Storholm et al., 2019) and practiced sexual risk behaviors (Frye et al., 2015; Nadal et al., 2014; Storholm et al., 2019).

Despite these high risks, we still do not know much about complex associations rather than bivariate connections between single factors, such as sexual orientation or gender identity, with behavioral and health outcomes in this population (Valentine & Shipherd, 2018). We do not understand thoroughly potential mediators and mediating processes that increase or reduce the risk of negative outcomes as well. In particular, although there is increasing evidence of relational trust and fairness in different demographic groups (Gangamma et al., 2012, 2015; Kawar et al., 2019; Lee, 1995; Leibig & Green, 1999; McPhee et al., 2019; Patton & Weigold, 2020; Schmidt et al., 2016; Soyez et al., 2004) the role of relational injustices, as understood within contextual therapy, in the wellbeing of people with marginalized SOGIs has not been articulated well in research. Some case studies reported the therapeutic effectiveness with a focus on fairness and trustworthiness with same-sex couples (Belous, 2015; McPhee et al., 2019), and a recent phenomenological study explored the dynamics of emotional bonds and fairness with transgender-including couples (Coppola et al., 2021). Beyond that, it is unknown how holding experiences of relational injustices impact the group's psychological and relational wellbeing (Coppola et al., 2021).

The following section will review existing literature on factors of psychological distress in this population and provide the theoretical framework guiding the study.

Factors influencing psychological distress in MSOGI individuals

Family dynamics

Existing literature on the psychological wellbeing of people with MSOGI shows that some particular actions will aggravate their internal distress and activate harmful ways of coping. They include discrimination, bullying, and family unfair treatment (D'Amico & Julien, 2012; Earnshaw et al., 2016; Valente et al., 2020). For children with MSOGI, this can occur after their sexual and gender identities are revealed by themselves or unexpectedly to family members, leading to rejection and unsupportive behaviors from them, especially the parents (Baiocco et al., 2015; D'Amico & Julien, 2012). Rejection from parents usually ranges from more explicit forms, such as demanding the child conceal the identity information from other family members and relatives, suggesting the minor to attempt to convert the minority sexual orientation, to subtler ones, including offering less affection as seen from some mothers to their gay children (Pachankis et al., 2018). Gay men reported more experiences of family rejection, which included psychological and physical abuse in its extreme forms, compared to their heterosexual peers and siblings (Pachankis et al., 2018). In their longitudinal study over seven years, Pachankis et al. (2018) discovered that parental rejection at early ages would lead to what was called unfinished business in the year when they conducted interviews with participants. The concept was associated significantly with concurrent conditions of depression and anxiety in college students with marginalized sexual orientation.

In another study, people with moderate or high family acceptance tended to report odds of suicidal thoughts and attempts at three times lower than those reporting low or no

family acceptance (Ryan et al., 2010). Findings from the study showed that participants with high and moderate levels of family acceptance reported higher self-esteem, social support, and general health compared to people with low family acceptance. Except for sexual behavior risks, rates of depression, suicidal thoughts, and suicidal attempts were negatively associated with the level of family acceptance.

According to contextual therapy, family rejection can be a manifestation of parentification and exploitation. It neglects developmental and emotional needs for support and safety of the child and prioritizes parents' vulnerabilities and beliefs. Indeed, in families where parents reject their child's sexual orientation identity, the adults usually hold strong conservative ideologies of religion and politics (Baiocco et al., 2015). The theory suggests that parental rejection likely damages the child's trustworthy relationship with the parents and leads the minor to accumulate destructive entitlements, which potentially results in further mental health issues and unhealthy coping mechanisms.

Discrimination and Bullying

Discrimination can occur under overt—calling name, insult, physical assaults—or subtle forms—microaggressions (Nadal, 2019). Regardless of its manifestations, researchers found links between discrimination and negative health outcomes for people with marginalized SOGI, such as anxiety, depression, sexual risk behaviors, substance use, suicidality, and trauma (Frye et al., 2015; Mereish et al. 2014; Nadal, 2019; Valentine & Shipherd, 2018).

Bostwick et al. (2014) explored the association between sexuality-based discrimination and mental health for about 693 lesbian, gay, and bisexual (LGB) adults among a national sample of the general population in the U.S. Compared to heterosexual individuals, participants self-identifying as LGB reported significantly higher rates of mood disorders and anxiety disorders. LGB persons with discriminatory experiences showed

greater odds of mental disorders than the ones who did not possess such experiences. In the comparing different types of discrimination, it is also worthy to consider that with racism, people tend to access and gain support easier from their community whose experiences are compatible; in contrast, people with marginalized sexual orientation struggle to gain similar support because their familial and communal members do not share their sexual identity (Bostwick et al., 2014).

In their review article on suicide and suicide risks in LGBT groups, Haas et al. (2010) claimed that LGBT individuals, overall, show significantly higher rates of suicide and mental distress than heterosexual people. The collection of research data in the U.S. and other countries indicated a clear association between different forms of SOGI-based discrimination, such as harassment, bullying, and violence, with suicidal behaviors for the marginalized groups. Experiencing interpersonal violence also contributed to their high odds of anxiety, substance use, and post-traumatic stress disorders. It is in line with findings from the study of Mereish et al. (2014) that showed experiences of being verbally and physically attacked led to higher chances of substance use, suicidal ideation, and suicidal attempts for LGBT participants than the ones without similar experiences.

Bullying is usually seen as a behavioral type where a perpetrator or a group intentionally inflicts injuries or distresses to a victim repeatedly over time. These harmful actions occur when the victim is in a weaker position than the perpetrator(s) in relation to both parties' power scale, and certain characteristics of social locations of the victim are targeted, such as sexual orientation, gender, race, class, etc. (Moran et al., 2018). Nevertheless, research showed that MSOGIs are the most frequent targets (Earnshaw et al., 2016). Researchers often categorize bullying into four main forms: verbal, physical, relational, and property damaging/ or cyberbullying. They also aim to explore victimized experiences in adolescents and young adults with peers and outsiders beyond the family

system. Among these populations, LGB youth reported a double rate of peer bullying in comparison with their heterosexual counterparts; similarly, 83% of transgender adolescents experienced victimization in the past year while the rate was 58% for cisgender young individuals (Earnshaw et al., 2016). Bullied experiences were significantly associated with greater negative health outcomes, such as depression, anxiety, low quality of life, and behavioral outcomes, such as suicidality, sexual risk behaviors, substance use, school absenteeism, low school performance (Earnshaw et al., 2016; Moran et al., 2018).

Among young adults, over 50% of respondents in a sample of college students with MSOGI, for example, reported one to two occasions of being bullied during the past three months (Moran et al., 2018). Although the rate was low, victimized experiences in general and in each specific form were positively associated with depressive symptoms. For lesbian participants, verbal and relational forms were significantly linked with their depression while for gay students, only the latter showed a statistically significant association with their depressive symptoms. Cyberbullying was significantly associated with bisexual individuals' depression, and verbal victimization related to depression in transgender students. Interestingly, there was no association between depression and any form of bullying in people with questioning SOGI. In terms of supportive factors, peer support served as the greatest buffer for college students with MSOGI, compared to family support and campus support. Nevertheless, deeper analyses showed that the protective effects were limited to LGB students who faced verbal and relational bullying, but it did not help to protect gender diverse individuals against depression (Moran et al., 2018).

Studies provided evidence for the combined effects of multiple forms of unfair treatments on marginalized SOGI individuals' health. The effects of sexual orientation-based discrimination in conjunction with any other forms of racism or sexism on the mental health of LGB people become significantly higher (Bostwick et al., 2014). Logistic regressions data

from a study on suicidality among gay young men in Taiwan revealed that early disclosure, low family support, and traditional homophobic bullying (verbal, relational, and physical attacks) increased their risks of suicidal ideation and attempts (Wang et al., 2019).

On the other hand, it was not clear from research if mental and behavioral problems can occur at a higher rate for people who self-identify with both marginalized sexual orientation and gender identity. Researchers agreed that people who self-identify with certain sexual and gender identities tend to report different intensity levels at psychological distress and risk behaviors (Balsam & Mohr, 2007; Bostwick et al., 2014; Haas et al., 2010; Lee et al., 2020; Mereish et al., 2014; Ryan et al., 2010). In general, data obtained from bisexual and transgender individuals usually demonstrates discrepancies in mental health from their gay and lesbian peers. For example, subgroup data showed that bisexual individuals had suicidal ideations more frequently than gay and lesbian people (Mereish et al., 2014); However, transgender groups exhibited the highest rate of suicidal attempts among different LGBT samples (Haas et al., 2010). The conflict in research data may emerge from differences in methodologies and demographical characteristics. Bostwick et al. (2014) also suggested that it may come from different levels of importance that people pay to their identities, which lead to divergences of consequences from being rejected, discriminated against, or attacked. Moreover, the conjunction of unjust experiences from both marginalized sexual orientation and gender identity can result in negative consequences at different intensities, depending on the combination.

To the best of my knowledge, there was only one study that contributed to examine how both marginalized sexual orientation and gender identity play roles in vaping, smoking, and drinking behaviors for LGBT adolescents (Coulter et al., 2018). The prevalence of electronic cigarette use, traditional cigarette use, alcohol drinking, and heavy drinking is highest for adolescents who self-identified as transgender and LGB. It was likely that when

they had to deal with both sexuality-based harassment and gender-based harassment at school, those adolescents became exhausted and began regulating their distress through substance use more frequently and excessively (Coulter et al., 2018). In this study, I examined associations between relational injustices in family and social relationships and psychological distress in participants who identified with one or more MSOGI. The study is informed by contextual therapy theory as described in the next section.

Theoretical framework

The concept of relational injustice stemmed from the scholarly work of Ivan Boszormenyi-Nagy (henceforth: Nagy) and contextual therapy. Relational injustice is the violated status of trust and fairness among people within their close relationships (Boszormenyi-Nagy & Krasner, 1986; van der Meiden et al., 2020). Trust and fairness are two hallmark concepts of the dimension of relational ethics that Nagy claimed as the most influential factor on human relationships, beyond other psychological and systematic dimensions (Boszormenyi-Nagy & Krasner, 1986). Based on clinical observations and treatments, Nagy postulated that trust and fairness are first applied to relationships between children and their parents; subsequently, other theorists and researchers also saw that they might apply to human relationships at larger systemic levels (Dankoski & Deacon, 2000; Meulink-Korf & Noorlander, 2012; van der Meiden et al., 2020). Many studies showed that relational ethics associated significantly with marital satisfaction, depression, and other health problems in couples (Gangamma et al., 2015; Grames et al., 2008), alcohol drinking in college students (Patton & Weigold, 2020), and interpersonal behaviors towards non-family people in youths in delinquent centers (Lee, 1995).

Relational justice, Nagy believed, is the fundamental foundation of human connectedness through its two features: interconnectedness and justice-based fairness (Boszormenyi-Nagy & Krasner, 1986; Leibig & Green, 1999; Soyez et al., 2004; van der

Meiden et al., 2020). People whose being is important to each other connect through their reciprocal giving-and-receiving support. Everyone owns an ethical entitlement to receive help when they are in need; in turn, they also hold accountability to offer support to in-need persons (Boszormenyi-Nagy & Krasner, 1986; Soyez et al., 2004; van der Meiden et al., 2020). When people can balance the giving-and-receiving, they create relational fairness in their mutual relationships. Fairness relies on just actions between people that require them to actively maintain the balance of what they earn and what they give. If people experience relational injustices with no attempts to restore them, they can become incapable of continuing to maintain the connectedness and balance fairness. Consequently, they own destructive entitlements that lead to relational stagnation among them (Boszormenyi-Nagy & Krasner, 1986; Gangamma et al., 2012; McPhee et al., 2019; van der Meiden et al., 2020).

Relational stagnation is the status in which people suffer from unjust actions and are unable to give or receive (Boszormenyi-Nagy & Krasner, 1986). Such conditions can result from people's current just circumstances – horizontal dimension - or their inherited ledger – vertical dimension (Hargrave & Pfitzer, 2003; Kawar et al., 2019). In the state of relational stagnation, people cannot nurture their kinship and potentially develop pathologies and difficulties, such as depression, anxiety, or relational dissatisfaction.

Exploitation and parentification are two major actions that account for relational injustice (Boszormenyi-Nagy & Krasner, 1986). The latter usually occurs in filial relationships when parents rely excessively on their partners or children for their benefits (Boszormenyi-Nagy & Krasner, 1986; Soyez et al., 2004; Sude & Eubanks Gambrel, 2017). The parent initially experienced unjust circumstances from previous relationships, especially with their parents during childhood, without any attempts from other adults to support them. Consequently, the parent is encumbered with destructive entitlements and cannot invest in the next relationships but likely demands people around them to take care of themselves.

Exploitation usually displays itself in how parents delegate to children. Nagy saw delegation as a means to "describe the consequence of a transaction between parent and child that is solely determined by the parents' self-serving needs." (Boszormenyi-Nagy & Krasner, 1986, p.179). Also, the collusion between family traditions and social norms may potentially intensify it. When outsiders and a father see that his only duty is earning money, they may largely accept his one-way demand of emotion and trust from his wife and children (Boszormenyi-Nagy & Ulrich, 1992). A family may similarly struggle to support a child with LGB or gender diverse identities if its members uphold resolutely cisgender-heteronormative beliefs.

Considering the foundation of relational justice as the balanced account of giving and receiving between people, there are certain kinds of actions that can unbalance the account and lead individuals and groups to act on destructive entitlements. Thus, within this particular study, relational injustice is defined as experiencing unfair treatment occurring to an individual. Such treatment usually carries on the essence of parentification and exploitation, which is about unfairly yielding benefits for one side while neglecting or even damaging the other side. They may stem from both family and social dynamics (Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy & Ulrich, 1992).

Taking this notion into the specific context of sexuality and gender identity-based injustices, there is more than just one kind of action that may deteriorate the perception of trust and fairness for people with marginalized SOGI. Researchers mentioned the impact of several interactions that may activate unjust experiences on their mental well-being, such as family rejection, bullying, sexual and gender-based discrimination and violence, and unfair treatment (Coulter et al., 2018; Earnshaw et al., 2016; Frye et al., 2015; Mereish et al., 2014; Pachankis et al., 2018; Ryan et al., 2010; Valente et al., 2020). It is congruent with the major principle of contextual therapy, in which the concept of relational injustice is grounded. Thus,

exploring relational injustices through examining such actions should be considered feasible to research.

This approach is different from the traditional way of measuring relational ethics using the Relational Ethics Scale (RES; Hargrave et al., 1991). RES is a measurement developed to capture the concurrent perception of loyalty, entitlement, and fairness in relationships with families of origin and current coupled partners of individuals. It does not survey how the experience of relational justice and injustice is potentially developed or mediated from possibly unfair actions. Hence, data collected from RES cannot identify where the experience comes from and how people address it with what particular strategies or supports. In fact, the approach in this thesis follows previous studies in which researchers investigated experiences of justice in samples of people who went through adverse circumstances that may create the perception of being unfairly treated. For instance, there were investigations of the impact of parental infidelity on relational ethics between adult children with their parents (Kawar et al., 2019; Schmidt et al., 2016) and romantic partners (Schmidt et al., 2016; Schmidt et al., 2016). This path can help to identify distinct behaviors that facilitate experiences of relational injustices and evaluating how unjust behaviors, marginalized identities, and experiencing injustices in relationships influence the wellbeing of people with MSOGI.

This expansion to more explicitly include social dynamics where relational injustices can occur is also in line with the extensive literature on minority stress. This explicit inclusion of social dynamic of relational injustice allows for incorporating aspects of minority stress theory and intersectionality framework. Developed to conceptualize how social stressors operate unique stress experiences of minority sexual individuals, the minority stress theory has been extensively applied with minority sexual populations (Meyer, 2003). Subsequently, the theory was expanded to include the experiences of transgender people

(Coppola et al., 2021; Mereish et al., 2014; Meyer, 2015). Under the framework, minority stress is considered unique, chronic, and social-based. It is originally categorized as distal and proximal stress. While the former relates to stressors from external environment and recur independently with one's perception and expectation, the latter happens inside oneself and reflects psychological processes connecting to self-identifying as a minority sexual or gender individual. Some authors see proximal minority stress as internalized stigma or discrimination (Pachankis et al., 2018), which is associated with a wide range of psychological distress and risk behaviors, such as depression, anxiety, low self-esteem, substance use, alcohol drinking, and suicidality (Mereish et al., 2014; Pachankis et al., 2018). As the minority stress theory articulates the impact of social stressors on psychological distress of MSOGI individuals, it is a helpful expansion to contextual therapy. The latter theory already conceptualizes potential effects from family factors, such as parentification, exploitation, destructive entitlement, and relational stagnation, to family members' distressed states.

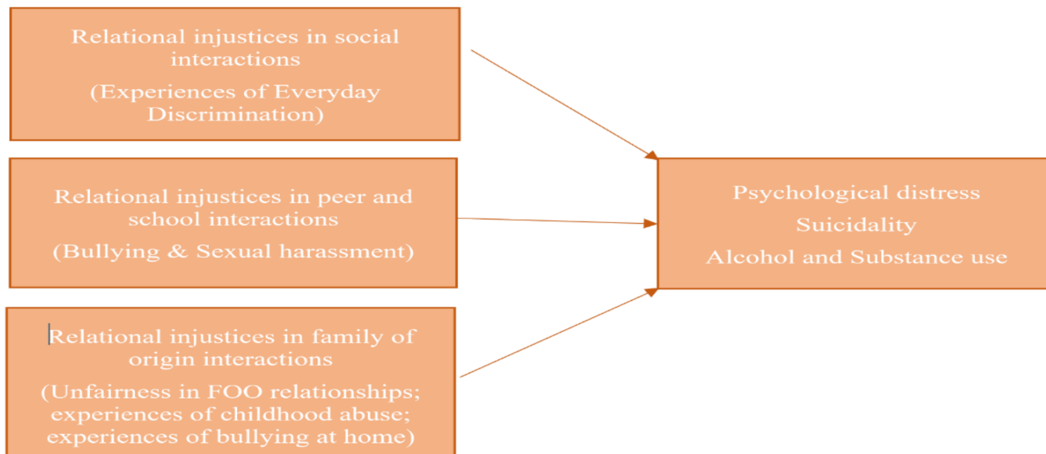
Similarly, this expansion would also bring contextual therapy theory closer to integrating with the framework of intersectionality (Addison & Coolhart, 2015; McDowell et al., 2017). Within the perspective, there is no single identity at the centred focus. Instead, multiple identities, such as race, gender, and sexual orientation, are placed together and examined for their inter-influences over each other and over lived expereriences of their holders. Although MSOGI persons experience unique stress relating to their sexual and/or gender identities, these are only parts of their whole identity, and many of them may carry other marginalized characteristics, concerning race, class, age, disability, etc. Thus, they may suffer from experiences of relational injustice beyond their SOGI. The relational intersectional framework calls for attention to the intersect of multiple identity aspects of an individual, rather than just fixing focus on one or two features (Addison & Coolhart, 2015). It

is compatible with contextual therapy, as the theory also demands a therapist explores comprehensively one's living context and events containing merits or unfairness (the first dimension), as well as one's perception and feelings towards those (the second dimension) (Boszormenyi-Nagy & Krasner, 1986). Overall, the minority stress theory serves as a base for an expansion of contextual therapy to social dynamics, and the relational intersectional framework contributes to the importance of interconnection between marginalized aspects.

Study questions

Although many studies tried to establish associations between certain types of actions, such as discrimination, bullying, unfair treatment, with health outcomes of people with MSOGI, potential connections between experiences of relational injustices and psychological distress for people with marginalized SOGI are still unexplored. This study, therefore, aims to examine such associations in a clinical population as there are limited or unknown studies in such populations. It may be one of the first to look at the association of relational injustice and unfair experiences with the group's distress. The study will attempt to explore a different route to measure relational injustices via interpersonal unjust behaviors and the perception of unfairness. I propose two hypotheses: a. the experience of relational injustice will be correlated with symptoms of psychological distress (Figure 1); and b. there will be a stronger association with the outcomes in participants with both marginalized sexual and gender identities compared to those with only one or none.

Figure 1: Hypothesized relationships between variables in the study



Methods

Participants

This study used a secondary dataset of information gathered from clients who sought therapy services at a University-based Couple and Family Therapy Center. The Center provides support for individuals, couples, and families from a wide range of ages with different difficulties, such as psychological and relational distress. At the beginning of therapy, new clients above the age of 18 years were introduced and invited to participate in ongoing research by their assigned therapist. Their participation was voluntary and did not impact their therapy. If they consented to partake, their assessment questionnaires were included in the research dataset.

Data for this study were collected between early 2018 to early 2020. To be selected to participate in this study, individuals had to fulfill two criteria: i. they had to be over 18 years old; and ii. they had to identify with at least one identity of marginalized sexual orientation or gender identity. The final sample included a total of 73 adult individuals. The majority of participants were younger than 40 years old (80%) and identified as White (73%), cisgender (63%), and sexual minority or questioning (92%) Most of them also completed some high

school or some college education (73%). Although their income varied on a wide range, about 75% reported household income with less than $40,000 while some participants (12.3%) reported household income greater than $60,000. In terms of relationship status, most of them were single (34.2%), living together (26%), or married (15%). Participants sought therapy for various initial reasons, among which, main ones were: support for gender transition (52%), anxiety (37%), depression (29%) improving couple communication (26%), and other individual concerns (25%).

In this study, I created three groups based on their marginalized SOGI. "Sexual minority" included participants who identified only with a marginalized sexual orientation; "Gender diverse" as those who identified with only a marginalized gender diverse identity (such as transgender and non-binary); and "SOGI" as those who identified with both marginalized gender diverse and sexual identities. Among these participants, 46 identified as Sexual minority, 6 as Gender diverse, and 21 with both marginalized SOGI. The demographic details of each of these groups are presented in Table 1.

Table 1 - Demographic information of each marginalized group

		Sexual minority		Gender diverse		SOGI	
		Count	%	Count	%	Count	%
Age	18-25	16	35.6%	3	50.0%	13	61.9%
	26-32	9	20.0%	2	33.3%	2	9.5%
	33-40	10	22.2%	0	0.0%	2	9.5%
	41-48	5	11.1%	0	0.0%	0	0.0%
	49-56	2	4.4%	1	16.7%	3	14.3%
	>57	3	6.7%	0	0.0%	1	4.8%
	Total	45	100.0%	6	100.0%	21	100.0%
Race	White	35	79.5%	4	66.7%	13	61.9%
	Person of Color	9	20.5%	2	33.3%	8	38.1%
	Total	44	100.0%	6	100.0%	21	100.0%
Education	Elementary	0		0		0	

	Some high school/high school	12	26.1%	4	66.7%	5	23.8%
	Some college/ Associate degree	24	52.2%	1	16.7%	7	33.3%
	Bachelor's degree	6	13.0%	1	16.7%	5	23.8%
	Graduate degree	4	8.7%	0	0.0%	4	19.0%
	Total	46	100.0%	6	100.0%	21	100.0%
Income	<10,000	10	23.8%	3	60%	5	27.8%
	10,000 - 19,999	5	11.9%	0		3	16.7%
	20,000 - 29,999	6	14.3%	0		4	22.2%
	30,000 - 39,999	10	23.8%	2	40%	1	5.6%
	40,000 - 49,999	3	7.1%	0		2	11.1%
	50,000 - 59,999	2	4.8%	0		1	5.6%
	>60,000	6	14.3%	0		2	11.1%
	Total	42	100%	5	100.0%	18	100.0%

Measurements

Independent variables - Experiences of relational injustice

Discrimination. Data on discrimination were collected using the modified Everyday Discrimination Scale (EDS; Williams et al., 1997). The original scale contained 9 items, and scores range from 1 (Almost never) to 6 (Very often), followed by a follow-up question to examine which identity characteristics are discriminatory targets. Those ones include gender, race, nationality, sexual orientation, socio-economic status, disability, or others. Examples of its items are “you are treated with less courtesy than other people”, or “you are threatened or harassed”. EDS showed a high Cronbach Alpha score in research with gay and bisexual young adult men (α = .84, Pachankis et al., 2018).

Within this study, participants were asked a close-ended question about whether they have been discriminated against because of their identity characteristics based on a list of features drawn from the original scale's follow-up questions. Then, the main question of the EDS scale was used to investigate the frequency and specific discriminatory types they have gone through. The internal consistency for the modified EDS version was .863.

Bullying. Participants' encounters with bullying were assessed with five questions. In the beginning, they were asked if they were bullied at grade K-12, at home, and were sexual harassed in grades K-12. Two more questions were used to explore whether they attributed those incidents to their gender identity or sexual orientation. These questions showed an acceptable Cronbach Alpha score ($\alpha = .695$).

Unfair tretatment in family. Participants gave their judgment of how they were treated in family via a one-item question of "to the best of your ability, how were you treated in the family you grew up in?" The scores range from 1 ("I was never treated unfair") to 5 ("I was always treated unfairly").

Abusive experiences in childhood. In this study, experiences of verbal, physical, and sexual abuse were investigated using some items from the questionnaire of Adverse Childhood Experiences (ACEs; CDC, 2009). The questionnaire is usually based on the ten-item Behavioral Risk Factor Surveillance Systems measurement that explores hardships and abuses in households of people before their age of eighteen. In this study, only the three items on experiences of abuse were used as they were considered as direct indicators of relational injustice in family of origin ("Did an adult in your home ever swear at you, insult you, or put you down?" "Did an adult in your home ever hit, beat, kick, or physically hurt you in any way" "Did anyone ever forcibly touch you sexually, try to make you touch sexually, or force you to have sex?"). Each of these items had a "Yes" or "No" response option.

Dependent variables - Psychological distress

Psychological distress. The main dependent variable of psychological distress was measured using the 18-item Brief Symptom Inventory (BSI-18; Kreutzer et al., 2011). The BSI-18 questionnaire was developed based on the 90-item Symptom Checklist (SCL-90), assessing anxiety, depression, and somatization via three 6-item subscales and a Global Severity Index (GSI) (Franke et al., 2017). Its scores are calculated by summing scores; scores of each item range from 0-4. The scale demonstrated high internal consistency in studies with individuals with marginalized SOGI (α = .91-.94; Reuter et al., 2017). Within this study, the BSI-18 scale also showed high reliability, α = .928 for the global scale, and.771, .928, .872 for somatization, depression, and anxiety subscales, respectively.

Alcohol and substance abuse. Participants' dependence on alcohol and substances was screened through the CAGE questionnaire (CAGE is an acronym for Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers; O'Brien, 2008) and its modified version for substance use. Each of them is a four-item screening questionnaire, asking clients about their guilty feeling on the behavior, their judgment of the necessity of reducing it, their urge of drinking or using in the morning, and criticism from other people of their behavior. CAGE is an easy-to-use and reliable screening tool to detect alcoholism in the first place (O'Brien, 2008), but it is not good to identify binge drinking (Chen et al., 2016). Its modified version can help to detect substance use disorders as well (Dezman et al., 2018). The alcohol CAGE (α = .719) and the substance CAGE (α = .826) scales showed good internal consistencies in this study.

Suicidality. Two one-item questions were used to ask about suicidal ideation and suicidal attempt of participants. While they were asked about any current ideation, their attempts across lifetime were considered. The questions included: "Do you have current thoughts of suicide?" and "Have you ever attempted suicide?"

Data analysis

I used the Statistical Package for the Social Sciences (SPSS 25.0) to conduct bivariate and multivariate analyses. Initially, I combined variables of gender and sexual orientation to one new SOGI variable including three values: Sexual minority, Gender diverse, and SOGI as explained above. Descriptive analysis was run for demographic parameters. Subsequently, Chi-square tests were applied to investigate potential differences between the SOGI variable's values in experiences of relational injustices, suicidality, alcohol, and substance use. One-way ANOVA analysis was used to assess differences in anxiety, depression, somatization, and participants' everyday discrimination scale scores based on their marginalized SOGI.

Results

Descriptives of independent variables

Table 2 contains detailed information relating to the percentage and/or the mean of the main variables of the study. In terms of abuse experiences, no participant reported physical abuse incidents during early development. Cisgender and sexual minority individuals tended to have the highest percentage of experiencing emotional and sexual abuse among the three subgroups. About 72% of them reported emotional abuse experiences while the percentage of gender diverse and SOGI people were 50% and 61.9%, respectively. About 16% of SOGI individuals reported sexual abuse experiences compared to 30% of sexual minority individuals. No participant identifying as gender diverse reported experiences of sexual abuse growing up.

Results showed that being bullied at school was the most common experience for all participants with 80% of SOGI participants and 67% of gender diverse and 70% of sexual minority participants acknowledging their victimization. While only 17% gender diverse

individuals experienced bullying at home, 67% suffered from sexual harassment at school, which is the highest percentage compared to people in the other subgroups. Among the sexual minority subgroup, the percentage was 36% (bullying at home) and 37% (sexual harassment at school), and they were 29% and 24%, respectively, among the SOGI subgroup. Furthermore, while about a third of sexual minority participants (30%) attributed bullying experiences to their sexual orientation, more than two-thirds of gender diverse participants (67%) thought the reason was their gender identity. For SOGI people who were bullied, they attributed it equally to either sexual orientation and gender identity (48% each). Importantly, the highest reported rate of being bullied because of their marginalized SO and SGI (38%) was for those who identified as MSOGI.

Relating to the other two unjust experiences, the average score of unfair treatment in family of origin was 2.49 (SD = 1.33) for people in the sexual minority subgroup and 1.67 (SD = 1.21) and 2.14 (SD = .11) for the gender diverse and SOGI subgroups, respectively. . It indicated that that the sexual minority subgroup reported the most unfair treatment in their family of origin in this sample. Besides, in this subgroup, 28% reported being discriminated against because of their sexual orientation or gender identities. Their mean score on EDS was 17.70 (SD =11.23). Among gender diverse participants, one-third attributed it to their sexual orientation, and 83% to their gender identities. Their mean score on EDS was 17.33 (SD =7.69). Finally, among SOGI participants, 73% and 57% believed that such experiences were due to their sexual orientation and gender identities, respectively. Their mean score on EDS was 18.10 (SD = 9.81). Although it is a slight difference, people who identified with both MSOGIs reported a higher score of discriminatory experiences in their daily life.

Descriptives of dependent variables

Descriptive analysis was run for dependent variables as well (Table 2). In previous studies in which researchers used the CAGE questionnaires to screen alcohol drinking and

substance using behaviors, the cutoff scores were 3 for males and 2 for females. Scores above these cut-offs indicated problematic alcohol and substance use. Since cut-off scores for gender diverse individuals are not yet established, I report the number of participants above both cut-off scores for all sub-groups in this sample. Using those indicators for this sample, no gender diverse participants reported above either cut-off. Among SOGI participants, none of them were above the cut-offs for alcohol use, while with the substance use, 5% scored higher than 3. Among the sexual minority subgroup, 13% and 2% of people scored above 2 and 3, respectively in the Alcohol-CAGE questionnaire. Their results were similar for substance use with 12% and 7%, respectively reporting above 2 and 3 respectively. Overall, sexual minority people had higher CAGE scores in comparison with the others.

On the other hand, greater percentages of gender diverse people tended to have current suicidal ideation and past suicidal attempts than sexual minority and SOGI people. Particularly, 33% of gender diverse participants thought about suicide and 50% attempted suicide before, in comparison with 14 % and 9% among SOGI people, and 15% and 41% among sexual minority people, respectively. However, the mean scores of BSI subscales and its global index for gender diverse participants were lowest between the three subgroups (more specific details can be found in Table 2).

Table 2: Descriptive of main variables

	Cisgender & Sexual minority	Gender diverse & Heterosexual	SOGI
Experiences of Bullying			
• K-12	69.6%	66.7%	80.0%

• Home	36.4%	16.7%	28.6%
• Sexual harassment K-12	37.0%	66.7%	23.8%
• Bullying due to Gender identity	15.2%	66.7%	47.6%
• Bullying due to Sexual Orientation	30.4%	33.3%	47.6%
Abuse experiences at home before age of 18 years			
• Physical abuse	0.0%	0.0%	0.0%
• Emotional abuse	71.7%	50%	61.9%
• Sexual abuse	30.4%	0.0%	15.8%
Alcohol use			
• % above 2	13.3%	0.0%	0.0%
• % above 3	2.2%	0.0%	0.0%
Substance use			
• % above 2	11.6%	0.0%	4.8%
• % above 3	6.9%	0.0%	4.8%
Current Suicidality	15.2%	33.3%	14.3%
% attempted suicide	41.3%	50%	28.6%

Unfairness in FOO (M; SD)	2.49; 1.33	1.67; 1.21	2.14; .011
Experiences of everyday discrimination (M; SD)	17.70; 11.23	17.33; 7.69	18.10; 9.81
Anxiety (M; SD)	7.50; 6.41	3.00; 3.10	7.43; 4.51
Depression (M; SD)	7.72; 7.05	3.50; 3.51	8.10; 6.71
Somatization (M; SD)	4.09; 4.27	2.33; 5.24	3.30; 3.93
Total BSI (M; SD)	19.36; 14.84	8.83; 11.09	18.80; 14.20

Correlations

Chi-square analysis was applied to examine differences between nominal independent and dependent variables. Chi-square effect sizes were also calculated to explore the variance of each independent variable in dependent variables. Overall, statistically significant associations were found between sexual abuse in childhood and sexual harassment, χ^2 (1) = 11,112, p = .001. The association was of moderate strength: Cramer's V = .396, and the occurrence of sexual abuse in childhood accounted for 15.68% of the variance in suicidal attempts. Similar effect occurred between the experience of being sexually harassed at school and suicidal attempts, χ^2 (1) = 12.477, p = .000. The association was of moderate strength: Cramer's V = .413, and the occurrence of sexual harassment in K-12 accounted for 17.06% of the variance in suicidal attempts. Furthermore, participants with marginalized SOGI showed statistically significant associations in their attribution of being bullied to gender identity, χ^2 (2) = 11.969, p = .003. The association was of moderate strength: Cramer's V = .405, and the different identities of SOGI accounted for 16.40% of the variance in the perception of being bullied based on gender.

Pearson correlations (see Table 3) showed moderate and statistically significant associations between everyday discriminatory experiences and somatization (.412, $p < .01$), depression (.412, $p < .01$), anxiety (.536, $p < .01$), and global scores on psychological distress (.528, $p < .01$). There was no statistically significant link between reports of unfairness in family of origin and psychological distress outcomes; however, there were weak and statistically significant correlations with everyday experiences of discrimination (.247, $p < .05$).

Taken together, findings from Chi-square analysis and Pearson correlations showed that while discrimination and bullying were associated with most psychological distress outcomes, they also interconnected with other relationally unjust interactions.

Table 3: Correlations between main variables

	1	2	3	4	5	6
EDS	_					
Unfairness in FOO	.247*	_				
Anxiety	.536**	.192	_			
Depression	.412**	.201	.676**	_		
Somatization	.414**	.155	.469**	.572**	_	
Total BSI	.528**	.217	.866**	.917**	.751**	_

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

* Correlation is significant at the 0.05 level (2-tailed).

ANOVA

One-way ANOVA was used to compare mean differences in BSI-18 scale between participants who identified themselves as sexual minority, gender diverse, and both. ANOVA size effect ($\eta 2$) was also calculated to explore the magnitude of the group differences. The effect size is considered small if $\eta 2$ scores around .01, medium if $\eta 2$ scores around .06, and large if the $\eta 2$ score is around .14 (Aron et al., 2014). ANOVA results yielded no statistically significant effect for self-identities with one or both marginalized SOGI on the scores for somatization, $F(2, 68) = 0.584$, $p = .560$, $\eta 2 = .017$; depression, $F(2, 70) = 1.156$, $p = .321$, $\eta 2 = .032$; anxiety, $F (2, 70) = 1.678$, $p = .194$, $\eta 2 = .046$; and GSI, $F (2, 68) = 1.425$, $p = .247$, $\eta 2 = .040$.

Besides, ANOVA analysis indicated no statistically significant difference between subgroups in everyday discriminatory experiences, $F (2, 68) = 0.016$, $p = .984$, $\eta 2 = .000$; and unfair treatment in family of origin, $F(2, 69) = 2.252$, $p = .235$, $\eta 2 = .041$. The effect sizes for most group differences were small. The largest group differences were in global psychological distress scores and unfairness in family of origin.

Overall, study findings showed that:

- Being bullied at school, especially sexual harassment, and being emotionally abused at home, as well as everyday experiences of discrimination were common experiences of relational injustice among participants in general.
- Gender diverse individuals showed higher prevalence of suicidal ideation and suicidal attempts than the others, while sexual minority people scored higher in alcohol drinking and substance use. In terms of psychological distress, gender diverse participants had the lowest scores, and sexual minority and SOGI people scored higher. When the sexual minority subgroup showed the highest scores in most areas, the SOGI one scored the highest in depression.

- Psychological distress, everyday experiences of discrimination, and unfair treatment in families were not statistically different between people in the three subgroups.
- For all participants, experiencing sexual abuse and sexual harassment were significantly related to participant's suicidal attempts. Similarly, everyday discriminatory experiences are associated moderately with psychological distress, including anxiety, depression, somatization, and general distress. There are also associations between experiences of relational injustices, such as discrimination and unfair treatment.

Discussion

This study explored a new route to examine associations between experiences of relational injustices with psychological distress outcomes in people with MSOGI. It also aimed to identify whether self-identifying with more marginalized sexual orientation and gender identities can impose greater effect on people's distress. The sample consisted of 73 participants of which 46 identified as sexual minority, 6 as gender diverse, and 21 as sexual minority and gender diverse. Pearson correlation, Chi-square, and one-way ANOVA were conducted to test two hypotheses: whether experiences of relational injustices are associated with psychological distress symptoms, and whether such associations are stronger for people with both marginalized SO and GI compared to those with either marginalized SO or GI.

For the first hypothesis, Pearson correlation results showed that experiences of relational injustice relating to discrimination were associated with various types of psychological distress, including somatization, anxiety, depression, and general distress. Besides, there were significant associations between being bullied with somatization, anxiety, and general distress. More particularly, the bullying form of sexual harassment was statistically associated with suicidal attempts in the past. Experiencing childhood abuse was linked with somatization, while experiences of sexual abuse were related to current suicidal intent and past attempts.

These findings are in line with previous studies. Using the Everyday Discrimination Scale to examine what was called enacted stigma in their longitudinal study, Pachankis et al. (2018) found that depression remained at the same level while anxiety increased 2.5 times over the period of eight years. Perceived discrimination among gay and bisexual young college students in the study was associated contemporaneously with depression and anxiety. It confirmed the important role of discrimination as a relational injustice factor on psychological distress of marginalized SOGI people. The systemic review of abusive experiences in childhood and their impact on health of people with MSOGI from Schneeberger et al. (2014) revealed strong links between sexual abuse in childhood with negative health outcomes and behavioral adjustments. Likewise, Moran et al. (2018) pointed out same associations between different forms of bullying with psychological distress, such as depression and anxiety. However, instead of those health outcomes, sexual harassment at school and sexual abuse in this study were strongly associated with anxiety, somatization, and suicide attempts among participants.

Moreover, experiences of relational injustices were not only associated with outcomes of psychological distress but also interconnected with each other. For instance, although being treated unfairly in family of origin was not significantly linked with any outcomes, its associations with the other relationally unjust experiences were statistically significant. Such similar links were found out between childhood abusive experiences with discrimination and bullying, and bullying with discrimination. This information may suggest that the experiences of relational injustices do not function separately from each other; rather, they are interconnected and impact the distress of people with MSOGI via unexplored pathways. A recent study by Gangamma et al. (2020) suggested a model in which adverse experiences in childhood indirectly influenced psychological distress via its direct effects on perceived

discrimination. Hence, further examinations are required to explore how experiences of relational injustices stand together and affect one's health outcomes.

ANOVA results did not confirm the second hypothesis, as differences in the psychological distress, everyday experiences of discrimination and unfair treatment in family of origin between the three subgroups were not statistically significant. Nevertheless, based on descriptive information, BSI-18 mean scores were different between the three subgroups. Taking the BSI Global Severity Index into consideration, gender diverse people had the lowest score, following by SOGI people's score, while sexual minority people had the highest. Although the number of participants in each subgroup is not approximately equal, there was a higher percentage of gender diverse people reporting current suicidal ideation and suicidal attempts, in comparison with the other subgroups. In terms of experiences of relational injustices, it was people in the SOGI subgroup with a higher mean score of everyday experiences of discrimination and higher percent of being bullied compared to the other two. These results suggest that people in each subgroup experienced some form of relational injustice, which was related to psychological distress in some way.

These findings also indicate that including multiple forms of relational injustices is important in further examination of experiences of distress. Rather than just limiting unfair experiences in the family of origin, experiences in violations of justice in societal interactions and peer relationships are equally necessary to explore. Although Nagy and other contextual therapy figures emphasized the social layer of justice and fairness in interpersonal and intergroup relationships (Boszormenyi-Nagy & Krasner, 1986; Meulink-Korf & Noorlander, 2012; van der Meiden et al., 2020), this feature of contextual therapy has not been well developed and explored. Nevertheless, there has been an emerging body of studies on contextual therapy application to marginalized populations such as resettled refugees (Gangamma, 2018) and trans-including couples (Coppola et al., 2021), which point to the

need to expand the contextual lens. This supports the need to include societal factors of injustice while working with marginalized SOGI within the contextual therapy framework.

Furthermore, analysis outcomes across the three subgroups suggest that gender diverse people in the sample reported the lowest scores in many areas of both relational injustices, such as discrimination, bullying (except sexual harassment at school), unfair treatment, and psychological distress, such as anxiety, depression, alcohol drinking, and substance use. These findings are uncommon, as gender diverse individuals in other studies usually reported higher mean scores on such issues (Earnshaw et al., 2016; Haas et al., 2010; Moran et al., 2018; Nadal et al., 2014). Some researchers even contended that gender diverse people tend to struggle more significantly than their sexual minority counterparts (Haas et al., 2010). Otherwise, the higher frequency of suicidal ideation and attempt of gender diverse participants in this study are consistent with findings from previous studies. Although the difference between groups is not statistically significant, sexual minority participants in this sample had the highest prevalence in most types of relational injustice and highest scores of most kinds of psychological distress.

When looking at demographic information, it is noticeable that sexual minority participants belong in various age groups, and over 44% are older than 33. Whereas the majority of gender diverse (83%) and SOGI (71%) participants are younger than 32 years. Only 22% of sexual minority people had a bachelor’s or graduate’s degree, while 43% for SOGI individuals did. Sexual minority people also reported greater religiosity and spirituality than their SOGI and gender diverse counterparts. These may suggest that when other non-sexual and non-gender “-isms”, such as ageism, classism, and religious oppression were not examined in this study, they might cause further living constraints and experiences of relational injustices to the participants.

On the other hand, the statistically nonsignificant differences may have some possible explanations. First, clients were screened before they went through the data collection to guarantee that their problem intensity would not exceed the master or doctoral level of student therapists in training. Thus, participants in this study possibly possessed a quite similar baseline of relational injustice and psychological distress. Another reason may relate to the inequivalent number of people in each subgroup. When there were 43 sexual minority participants, the number of SOGI people was mostly half of that, and only 6 individuals identified as gender diverse. Finally, according to the Relational Intersectional Lens (Addison & Coolhart, 2015), having more marginalized identities does not necessarily yield more or greater psychological distress to people. The authors discussed in depth the complexity of intersectional identities, such as gender, religion, ethnicity, race, etc. A privileged identity in the United States like Christianity can become more challenging in the case of an MSOGI person to navigate oppression and develop their identity. It may shed light on understanding reasons why sexual minority people in this sample expressed more signs of distress when they concurrently were more religious than their counterparts. Further research with sufficient sample sizes may lead to further unpacking of this interconnectedness of relational injustices, demographic factors, and psychological outcomes in marginalized SOGI.

Clinical Implications

The study findings indicate some clinical implications. Even though gender diverse individuals may come from similar baseline of psychological distress, their higher prevalence of suicidality requires clinicians to assess and monitor this issue in working with this population. Besides, they may consider addressing the connection between sexual harassment and sexual abuse with suicidal attempts, as they are associated together. When experiences of relational injustice potentially function together, it is worth placing them together and

connects them to help clients obtain a fuller narrative of their history and meanings of their experiences.

Furthermore, some findings in this study claim the necessity of addressing relational injustices in therapy with MSOGI clients. Unlike the minority stress theory's emphasis on an individual's internal distress as a result of external and internalized discrimination, within the contextual framework, a therapist should place focus on interpersonal relationships existing in the client's living context. Some authors (Dankoski & Deacon, 2000; van der Meiden et al., 2020) even suggested expanding the focus beyond family kinships to social and institutional connections between the client and other groups and institutions. Exploring actual unjust actions and experiences of relational injustices of clients is important, but a contextual therapist does not stop there. The therapist will attempt to identify relational resources which are people and connections that clients may rely on to deal with their challenges. Also, the therapist will try to help clients and other people in their circle credit the clients' giving support in their relationships. Efforts to support from the others, in turn, will need to gain acknowledgment as well. In short, the therapist strives in being multidirected partial to each party, balancing their account of giving and receiving, addressing unfairness and injustices, and uncovering relational resources between them.

Limitation and Research Implications

This study could not avoid its limitations. Its small sample and unequal proportion of participants in every subgroup reduced the value of found correlations between variables and likely prevented any significant difference between the three of them. The cross-sectional design does not allow for building causal associations. Moreover, the practice of initial screening in the clinic may yield a sample with not many differences between participants. Some independent and dependent variables were examined using unstandardized measurements, which led to less desirable results in data analysis. More specifically, for

example, when participants were asked for their experiences of being abused in the past, it was not possible to know if these experiences were related to the participants' expressed identities.

Hence, future studies may consider applying standardized and more detailed measurements to expect more reliable outcomes. They can attempt to establish pathways of directions in which relational injustice impacts psychological distress of MSOGI people. Particularly, attention should be placed on potential interconnections between different types of relational injustice and how such interrelatedness relates to the distress. Another direction is looking for potential protective or resilient factors that are able to alleviate the effects of relational injustice on psychological distress. Future research on expanding the measurement of relational injustices in the domains of societal and peer relationships along with family relationships would benefit these explorations. Last but not least, researchers may try to build a new standardized measurement to investigate relational injustice, in which actually occurred unjust actions are taken into account instead of people's perception of how they are treated by others.

Appendix A

List of questions from the assessment 2018 will be used

		Categories	**Questions**
Demographics	Section A	Age	1. Age
		Race	3a. Your Race is 3b. Do you identify as Hispanic/ Latino(a)?
		Gender Identity	2. What is your gender?
		Sexual Orientation	4. What is your sexual orientation?
		Education	7. What is the highest level of education you have completed?
		Income	9. What is your current annual household income?
		Religiosity	5. What is your religious affiliation? 6a. Do you consider yourself
		Relationship Status	20. What is your relationship status?
Psychological Distress	Section A	Suicide	14. During the past six months, have you inflicted harm on yourself? If yes, how often?

			15. Have you ever been depressed for more than two weeks? If yes, when? 16. Do you have current thoughts of suicide? If yes, have you thought of acting on them? 16a. Do you have a plan? If yes, what is your plan? 17. Have you ever attempted suicide? If yes, how many times? If yes, when and how did the last attempt occur?
	Section B	Drinking Behavior	**II. Health: Drinking** 1. Have you ever felt you should cut down on your drinking? 2. Have people annoyed you by criticizing your drinking? 3. Have you felt bad or guilty about your drinking? 4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? **III. Health: Substances** 5. Have you ever felt you should cut down on your substance use?

			6. Have people annoyed you by criticizing your substance use? 7. Have you felt bad or guilty about your substance use? 8. Have you ever used substances first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? 9. Have you ever been in chemical dependency treatment?
		Depression	**I. BSI** 7. Feeling blue 8. Feeling no interest in thing 9. Feeling lonely 10. Feeling hopeless about future 11. Feeling of worthlessness 12. Suicidal thoughts
		Anxiety	**I. BSI** 13. Feeling tense 14. Nervousness 15. Feeling fearful 16. Spells of panic

<table>
<tr><td></td><td rowspan="3">Section A</td><td></td><td>17. Suddenly scared
18. Feeling restless</td></tr>
<tr><td>The experience of relational injustice</td><td>Unfairness in family relationship</td><td>IX. Relationship fairness
1. To the best of your ability, how were you treated in the family you grew up in?</td></tr>
<tr><td></td><td>Perceived discrimination

Identity-based discrimination</td><td>VIII. Discrimination
1. Have you ever been discriminated against/harassed/threatened/rejected/treated unfairly because of some aspect of your identity? Yes/No
If yes, what aspect if your identity was targeted? (check all that apply)
Gender
Race
Nationality
Sexual orientation
Socio-economic status
Disability
Other (specify)</td></tr>
</table>

			2. Has your family ever been discriminated against/harassed/threatened/rejected/treated unfairly because of some aspect of identity? Yes/No If yes, what aspect if your identity was targeted? (check all that apply) Gender Race Nationality Sexual orientation Socio-economic status Disability Other (specify) 4. How often did the following occur in the last 12 months: a. You are treated with less courtesy than other people b. You are treated with less respect than other people c. You receive poorer service than other people at restaurants or stores d. People act as if they think you are not smart e. People act as if they are afraid of you f. People act as if they think you are dishonest g. People act as if they are better than you are h. You or your family members are called names or insulted i. You are threatened or harassed

		Bullying	**VI. Bullying** 1. Were you bullied when you were in grades K-12? **Yes or No** o Do you think bullying had an impact on you? • If yes, what was the impact at the time? • What is the impact now? 2. Were you bullied at home? 2a. Who was the perpetrator of these acts? Do you think that bullying had an impact on you? o If yes, what was the impact at the time? o What is the impact now? 3. Were you sexually harassed in grades K-12? **Yes or No** o Do you think the sexual harassment had an impact on you? **Yes or No** ▪ If yes, what was the impact at that time? ▪ What is the impact now? 4. Do you think you were bullied based on your sexual orientation? **Yes or No** 5. Do you think you were bullied based on how you expressed your gender? **Yes or No** 6. Were you ever a bully? **Yes or No** If yes, can you give a brief example?

References

Addison, S. M., & Coolhart, D. (2015). Expanding the Therapy Paradigm with Queer Couples: A Relational Intersectional Lens. *Family Process*, *54*(3), 435–453. https://doi.org/10.1111/famp.12171

Aron, A., Coups, E. J., & Aron, E. (2014). *Statistics for the behavioral and social sciences: A brief course*. Pearson Education Limited.

Baiocco, R., Fontanesi, L., Santamaria, F., Ioverno, S., Marasco, B., Baumgartner, E., Willoughby, B. L. B., & Laghi, F. (2015). Negative Parental Responses to Coming Out and Family Functioning in a Sample of Lesbian and Gay Young Adults. *Journal of Child and Family Studies*, *24*(5), 1490–1500. https://doi.org/10.1007/s10826-014-9954-z

Belous, C. K. (2015). Couple Therapy With Lesbian Partners Using an Affirmative-Contextual Approach. *The American Journal of Family Therapy*, *43*(3), 269–281. https://doi.org/10.1080/01926187.2015.1012234

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry*, *84*(1), 35–45. https://doi.org/10.1037/h0098851

Boszormenyi-Nagy, I., & Krasner, B. R. (1986). *Between give and take: A clinical guide to contextual therapy*. Brunner/Mazel.

Boszormenyi-Nagy, I., Grunebaum, J., & Ulrich, D. (1991). Contextual Therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy: Vol. II* (pp. 200–239). Brunner/Mazel.

Bränström, R., & Pachankis, J. E. (2018). Sexual orientation disparities in the co-occurrence of substance use and psychological distress: A national population-based study (2008–2015). *Social Psychiatry and Psychiatric Epidemiology*, *53*(4), 403–412. https://doi.org/10.1007/s00127-018-1491-4

Chen, Y.-T., Ibragimov, U., Nehl, E. J., Zheng, T., He, N., & Wong, F. Y. (2016). Validity of the CAGE questionnaire for men who have sex with men (MSM) in China. *Drug and Alcohol Dependence*, *160*, 151–156. https://doi.org/10.1016/j.drugalcdep.2015.12.039

Coppola, J., Gangamma, R., & Hartwell, E. (2021). "We're just two people in a relationship": A qualitative exploration of emotional bond and fairness experiences between transgender women and their cisgender partners. *Journal of Marital and Family Therapy*, jmft.12467. https://doi.org/10.1111/jmft.12467

Coulter, R. W. S., Bersamin, M., Russell, S. T., & Mair, C. (2018). The Effects of Gender- and Sexuality-Based Harassment on Lesbian, Gay, Bisexual, and Transgender Substance Use Disparities. *Journal of Adolescent Health*, *62*(6), 688–700. https://doi.org/10.1016/j.jadohealth.2017.10.004

D'Amico, E., & Julien, D. (2012). Disclosure of Sexual Orientation and Gay, Lesbian, and Bisexual Youths' Adjustment: Associations with Past and Current Parental Acceptance and Rejection. *Journal of GLBT Family Studies*, *8*(3), 215–242. https://doi.org/10.1080/1550428X.2012.677232

Dankoski, M. E., & Deacon, S. A. (2000). Using a Feminist Lens in Contextual Therapy*. *Family Process*, *39*(1), 51–66. https://doi.org/10.1111/j.1545-5300.2000.39107.x

Dezman, Z. D. W., Gorelick, D. A., & Soderstrom, C. A. (2018). Test characteristics of a drug CAGE questionnaire for the detection of non-alcohol substance use disorders in

trauma inpatients. *Injury*, *49*(8), 1538–1545. https://doi.org/10.1016/j.injury.2018.06.019

Earnshaw, V. A., Bogart, L. M., Poteat, V. P., Reisner, S. L., & Schuster, M. A. (2016). Bullying Among Lesbian, Gay, Bisexual, and Transgender Youth. *Pediatric Clinics of North America*, *63*(6), 999–1010. https://doi.org/10.1016/j.pcl.2016.07.004

Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). *How Many Adults Identify as Transgender in the United States?* (p. 13). The Williams Institute.

Franke, G. H., Jaeger, S., Glaesmer, H., Barkmann, C., Petrowski, K., & Braehler, E. (2017). Psychometric analysis of the brief symptom inventory 18 (BSI-18) in a representative German sample. *BMC Medical Research Methodology*, *17*(1), 14. https://doi.org/10.1186/s12874-016-0283-3

Frye, V., Nandi, V., Egan, J., Cerda, M., Greene, E., Van Tieu, H., Ompad, D. C., Hoover, D. R., Lucy, D., Baez, E., & Koblin, B. A. (2015). Sexual Orientation- and Race-Based Discrimination and Sexual HIV Risk Behavior Among Urban MSM. *AIDS and Behavior*, *19*(2), 257–269. https://doi.org/10.1007/s10461-014-0937-2

Gangamma, R., Bartle-Haring, S., & Glebova, T. (2012). A Study of Contextual Therapy Theory's Relational Ethics in Couples in Therapy. *Family Relations*, *61*(5), 825–835. https://doi.org/10.1111/j.1741-3729.2012.00732.x

Gangamma, R., Bartle-Haring, S., Holowacz, E., Hartwell, E. E., & Glebova, T. (2015). Relational Ethics, Depressive Symptoms, and Relationship Satisfaction in Couples in Therapy. *Journal of Marital and Family Therapy*, *41*(3), 354–366. https://doi.org/10.1111/jmft.12070

Gangamma, R., Tor, S., Whitt, V., Hollie, B., Gao, Q., Stephens, A., Hutchings, R., & Stone Fish, L. (2020). Perceived Discrimination as a Mediator of ACEs and Psychological

Distress. *The American Journal of Family Therapy*, 1–17. https://doi.org/10.1080/01926187.2020.1813656

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., … Clayton, P. J. (2010). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *Journal of Homosexuality*, *58*(1), 10–51. https://doi.org/10.1080/00918369.2011.534038

Hargrave, T. D. (2015). *New contextual therapy: Guiding the power of give and take.* Routledge.

Hargrave, T. D., Jennings, G., & Anderson, W. (1991). THE DEVELOPMENT OF A RELATIONAL ETHICS SCALE*. *Journal of Marital and Family Therapy*, *17*(2), 145–158. https://doi.org/10.1111/j.1752-0606.1991.tb00877.x

Kawar, C., Coppola, J., & Gangamma, R. (2019). A Contextual Perspective on Associations Between Reported Parental Infidelity and Relational Ethics of the Adult Children. *Journal of Marital and Family Therapy*, *45*(2), 354–363. https://doi.org/10.1111/jmft.12331

Kreutzer, J. S., DeLuca, J., & Caplan, B. (Eds.). (2011). BSI-18. In *Encyclopedia of Clinical Neuropsychology* (pp. 461–461). Springer New York. https://doi.org/10.1007/978-0-387-79948-3_5268

Lee, R. E. (1995). Availability to peer group treatment in residential care as a function of relational ethics. *Contemporary Family Therapy*, *17*(3), 343–348. https://doi.org/10.1007/BF02252671

Leibig, A. L., & Green, K. (1999). The Development of Family Loyalty and Relational Ethics in Children. *Contemporary Family Therapy*, *21*(1), 89–112. https://doi.org/10.1023/A:1021966705566

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2017). *Socioculturally Attuned Family Therapy: Guidelines for Equitable Theory and Practice* (1st ed.). Routledge. https://doi.org/10.4324/9781315559094

McPhee, D. P., Austin, K. L., & Eichenberger, L. R. (2019). Using Contextual Therapy to Treat Depression with Couples. *The American Journal of Family Therapy*, *47*(5), 275–292. https://doi.org/10.1080/01926187.2019.1673261

Mereish, E. H., O'Cleirigh, C., & Bradford, J. B. (2014). Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, Health & Medicine*, *19*(1), 1–13. https://doi.org/10.1080/13548506.2013.780129

Meulink-Korf, H., & Noorlander, W. (2012). Resourcing Trust in a Fragmenting World: The Social-Economic Dimension and Relational Ethics in the Track of Boszormenyi-Nagy. *European Journal of Mental Health*, *7*(2), 157–183. https://doi.org/10.5708/EJMH.7.2012.2.1

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2(3),* 209-213. doi: 10.1037/sgd0000132

Moran, T. E., Chen, C. Y.-C., & Tryon, G. S. (2018). Bully victimization, depression, and the role of protective factors among college LGBTQ students. *Journal of Community Psychology*, *46*(7), 871–884. https://doi.org/10.1002/jcop.21978

Nadal, K. L., Davidoff, K. C., & Fujii-Doe, W. (2014). Transgender Women and the Sex Work Industry: Roots in Systemic, Institutional, and Interpersonal Discrimination. *Journal of Trauma & Dissociation*, *15*(2), 169–183. https://doi.org/10.1080/15299732.2014.867572

O'Brien, C. P. (2008). The CAGE Questionnaire for Detection of Alcoholism. *JAMA*, *300*(17), 2054. https://doi.org/10.1001/jama.2008.570

Pachankis, J. E., Sullivan, T. J., & Moore, N. F. (2018). A 7-year longitudinal study of queer young men's parental relationships and mental health. *Journal of Family Psychology*, *32*(8), 1068–1077. https://doi.org/10.1037/fam0000427

Patton, R., & Weigold, I. K. (2020). Examining alcohol use and relational ethics in a college student sample. *Journal of American College Health*, 1–6. https://doi.org/10.1080/07448481.2020.1756824

Phan, J., Baronia, R., Ruiz, A., McGovern, T., & McMahon, T. (2020). Internalized Homophobia, Religious Affiliation, and Substance Use in Queer Women. *Alcoholism Treatment Quarterly*, *38*(4), 403–414. https://doi.org/10.1080/07347324.2019.1702486

Reuter, T. R., Newcomb, M. E., Whitton, S. W., & Mustanski, B. (2017). Intimate partner violence victimization in LGBT young adults: Demographic differences and associations with health behaviors. *Psychology of Violence*, *7*(1), 101–109. https://doi.org/10.1037/vio0000031

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family Acceptance in Adolescence and the Health of LGBT Young Adults: Family Acceptance in Adolescence and the Health of LGBT Young Adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

Savin-Williams, R. C. (2006). Who's Gay? Does It Matter? *Current Directions in Psychological Science*, *15*(1), 40–44. https://doi.org/10.1111/j.0963-7214.2006.00403.x

Schmidt, A. E., Green, M. S., Sibley, D. S., & Prouty, A. M. (2016). Effects of Parental Infidelity on Adult Children's Relational Ethics With Their Partners: A Contextual Perspective. *Journal of Couple & Relationship Therapy*, *15*(3), 193–212. https://doi.org/10.1080/15332691.2014.998848

Schneeberger, A. R., Dietl, M. F., Muenzenmaier, K. H., Huber, C. G., & Lang, U. E. (2014). Stressful childhood experiences and health outcomes in queer populations: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *49*(9), 1427–1445. https://doi.org/10.1007/s00127-014-0854-8

Shearer, A., Russon, J., Herres, J., Atte, T., Kodish, T., & Diamond, G. (2015). The relationship between disordered eating and sexuality amongst adolescents and young adults. *Eating Behaviors*, *19*, 115–119. https://doi.org/10.1016/j.eatbeh.2015.08.001

Soyez, V., Tatrai, H., Broekaert, E., & Bracke, R. (2004). The implementation of contextual therapy in the therapeutic community for substance abusers: A case study. *Journal of Family Therapy*, *26*(3), 286–305. https://doi.org/10.1111/j.1467-6427.2004.00284.x

Storholm, E. D., Huang, W., Siconolfi, D. E., Pollack, L. M., Carrico, A. W., Vincent, W., Rebchook, G. M., Huebner, D. M., Wagner, G. J., & Kegeles, S. M. (2019). Sources

of Resilience as Mediators of the Effect of Minority Stress on Stimulant Use and Sexual Risk Behavior Among Young Black Men who have Sex with Men. *AIDS and Behavior*, *23*(12), 3384–3395. https://doi.org/10.1007/s10461-019-02572-y

Sude, M. E., & Eubanks Gambrel, L. (2017). A Contextual Therapy Framework for MFT Educators: Facilitating Trustworthy Asymmetrical Training Relationships. *Journal of Marital and Family Therapy*, *43*(4), 617–630. https://doi.org/10.1111/jmft.12224

Valente, P. K., Schrimshaw, E. W., Dolezal, C., LeBlanc, A. J., Singh, A. A., & Bockting, W. O. (2020). Stigmatization, Resilience, and Mental Health Among a Diverse Community Sample of Transgender and Gender Nonbinary Individuals in the U.S. *Archives of Sexual Behavior*, *49*(7), 2649–2660. https://doi.org/10.1007/s10508-020-01761-4

Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review*, *66*, 24–38. https://doi.org/10.1016/j.cpr.2018.03.003

van der Meiden, J., Noordegraaf, M., & van Ewijk, H. (2020). Relational ethics as enrichment of social justice: Applying elements of contextual therapy to social work. *Qualitative Social Work*, *19*(1), 125–141. https://doi.org/10.1177/1473325018800383

Williams, D. R., Yan Yu, Jackson, J. S., & Anderson, N. B. (1997). Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination. *Journal of Health Psychology*, *2*(3), 335–351. https://doi.org/10.1177/135910539700200305

Biographical data

Khoi Nguyen Anh Le has an M.A. in Clinical Psychology from L'ecole De Psychologues Praticiens (France), and this thesis marks the completion of his M.A. in Marriage and Family Therapy at Syracuse University. During the MFT program, Khoi was a student therapist at the Syracuse University Couple and Family Therapy Center, and Vera House Inc. He will begin the doctoral program in MFT at Syracuse University in the fall of 2021. He was supervised during this thesis research by Dr. Rashmi Gangamma, Ph.D., LMFT, Associate Professor in the Marriage and Family Therapy Department atSyracuse University's David B. Falk College of Sport and Human Dynamics.