Summer 8-11-2020

Correlates And Predictors Of Life Satisfaction And Resilience Among Sexual Minority Persons Living With Disabilities

Tameeka L. Hunter

Recommended Citation

Hunter, Tameeka L., "Correlates And Predictors Of Life Satisfaction And Resilience Among Sexual Minority Persons Living With Disabilities." Dissertation, Georgia State University, 2020.
doi: https://doi.org/10.57709/18735371

ACCEPTANCE

This dissertation, CORRELATES AND PREDICTORS OF LIFE SATISFACTION AND RESILIENCE AMONG SEXUAL MINORITY PERSONS LIVING WITH DISABILITIES,

by TAMEEKA LASHAE HUNTER, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education & Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

Franco Dispenza, Ph.D.
Committee Chair

Catherine Y. Chang, Ph.D.
Committee Member

Erin C. M. Mason Ph.D.
Committee Member

Rafe McCullough, Ph.D.
Committee Member

Date

Brian Dew, Ph.D.
Chairperson, Department of Counseling and Psychological services

Paul A. Alberto, Ph.D.
Dean, College of Education &
Human Development

AUTHOR'S STATEMENT

By presenting this dissertation as a partial fulfillment of the requirements for the advanced degree from Georgia State University, I agree that the library of Georgia State University shall make it available for inspection and circulation in accordance with its regulations governing materials of this type. I agree that permission to quote, to copy from, or to publish this dissertation may be granted by the professor under whose direction it was written, by the College of Education and Human Development's Director of Graduate Studies, or by me. Such quoting, copying, or publishing must be solely for scholarly purposes and will not involve potential financial gain. It is understood that any copying from or publication of this dissertation which involves potential financial gain will not be allowed without my written permission.

____

Tameeka L. Hunter

NOTICE TO BORROWERS

All dissertations deposited in the Georgia State University library must be used in accordance with the stipulations prescribed by the author in the preceding statement. The author of this dissertation is:

Tameeka LaShae Hunter
Department of Counseling and Psychological Services
College of Education and Human Development
Georgia State University
Atlanta, GA 30303

The director of this dissertation is:

Franco Dispenza, Ph.D.
Department of Counseling and Psychological Services
College of Education and Human Development
Georgia State University
Atlanta, GA 30303

Tameeka L. Hunter, MS, LPC, NCC, CRC
Tameekah06@gmail.com 404-932-6887 (cell)

EDUCATION

Ph.D. Counselor Education, and Practice (CACREP Accredited) July 2020
Cognate: Multicultural Rehabilitation Counselor Education
Georgia State University, Atlanta, Georgia

M.S. Rehabilitation Counseling (formerly CORE, now CACREP Accredited) May 2007
Georgia State University, Atlanta, Georgia

B.A. Business Administration December 1998
Georgia State University, Atlanta, Georgia

PROFESSIONAL LICENSE AND CERTIFICATIONS

Licensed Professional Counselor, Georgia (LPC) #010501
Certified Rehabilitation Counselor (CRC) #00101934
National Certified Counselor (NCC) #742770

SCHOLARLY PUBLICATIONS AND RESEARCH

PUBLICATIONS (REFEREED)

Hunter, T., Dispenza, F., Huffstead, M., Suttles, M., & Bradley, Z. (2020). Queering Disability: Exploring the Resilience of Sexual and Gender Minority Persons Living With Disabilities. *Rehabilitation Counseling Bulletin.* https://doi.org/10.1177/0034355219895813

Massengale, M., Shebuski, K. M., Karaga, S., Choe, E., Hong, J., **Hunter, T. L.,** & Dispenza, F. (2019). Psychology of Working Theory With Refugee Persons: Applications for Career Counseling. *Journal of Career Development*. https://doi.org/10.1177/0894845319832670

Dispenza, F., & **Hunter, T**. (2015). Reported Use of and Satisfaction With Vocational Rehabilitation Services Among Lesbian, Gay, Bisexual, and Transgender Persons. *Rehabilitation Research, Policy, and Education, 29*(4), 421-424. https://doi.org/10.1891/2168-6653.29.4.421

BOOK CHAPTERS

Dispenza, F., & **Hunter, T.**, Kumar, A. (2017). The Needs of Gender and Sexual Minority Persons Living with Disabilities. In K. B. Smalley, J. C. Warren, N. Barefoot (Eds.), LGBT Heath. New York, NY: Springer Publishing Company.

Hunter, T. (2004). Independence: Lessons from My Mom. In S. D. Klein & J. D. Kemp (Eds.), *Reflections from a Different Journey: Personal Stories for Parents by Adults with Disabilities* (pp. 101-104). New York, NY: McGraw Hill.

EDITED BOOKS

Weed, R.O. & Hill, J. A. (2008) **Hunter, T.** (Text Ed.). *CRC Exam Guide to Success, 9th Edition*. Athens, GA: Elliot & Fitzpatrick, Inc.

PEER-REVIEWED PRESENTATIONS

Huffstead, M., **Hunter, T**., Williams, N., & Placeres**,** V**.** (2019, October). *What biracial individuals really need: Counselor education and supervision implications*. Association for Counselor Education and Supervision. Seattle, WA.

Varney, M., Chang, C., Zeligman, M., Huffstead, M., **Hunter, T**., Placeres, V**.**, Williams, N. (2019, March). *Predictors for vicarious trauma for black college students in the current sociopolitical climate.* American Counseling Association Conference. New Orleans, LA.

Glosoff, H., McCullough, R., Paige Band, M., Holcomb-McCoy, C., **Hunter, T.**, Watts, R., & Christian, A. (2018, April). *Practicing Cultural Encounters: Responding with Competence*. American Counseling Association Conference, Atlanta, GA.

Hunter, T. & McCullough, R. (2018, September). *Rainbow Colored Butterflies, A Metaphor for Resilience: Working With LGBTQ+ Clients Experiencing Chronic Illness & Disability (CID).* ALGBTIC Conference: Portland, OR.

Hunter, T., Huffstead, M., Suttles, M., Bradley, Z., & Dispenza, F. (2017, October). *Exploring Resilience of LGBTQ Individuals with Chronic Illness/Disability.* Association for Counselor Education and Supervision (ACES) 2017 Conference, Chicago, IL.

Huffstead, M., **Hunter, T.**, Placeres, V., & Williams, N. (2017, October). *Counseling/Training Implications: Multiracial Individuals Experience and Perception of Counseling.* ACES Conference: Chicago, IL.

Murphy, T., Pierce, L., **Hunter, T.** (2017, October). *Service Dogs: Ethical and Legal Issues in the Counseling Environment.* Presented at the Association for Counselor Education and Supervision ACES Conference, Chicago, IL.

Hunter, T. & Temple, M. (2014) LPCA 26th Annual Convention and Regional Conference. Is Disability Really a Form of Diversity and Does It Matter? Legal and Ethical Implications Explored. Atlanta, Georgia.

CLINICAL SUPERVISON EXPERIENCE

Spring 2020	**Internship I Rehabilitation Counseling** Group, Triadic, and Dyadic Supervisor,
Fall 2019	**Practicum I Rehabilitation Counseling** Group, Triadic, and Dyadic
Fall 2018	**Practicum I Rehabilitation Counseling** Group, Triadic, and Dyadic Supervisor,
Spring 2017	**Advanced Mental Health Counseling Group Supervisor**
Fall 2015	**Dyadic Rehabilitation Counseling Supervisor**, Georgia State University
Spring 2016	**Dyadic Rehabilitation Counseling Supervisor**, Georgia State University

Director/ Department Head (Professional, Full-time)

05/2008-08/2017 *Director, Disability Resource Center*
Supervised 2 Master's- Level Rehabilitation Counselors
Assistant Director, Disability Resource Center
Supervised 2 Master's- Level Rehabilitation Counselors
Clayton State University, Morrow, Georgia

CORRELATES AND PREDICTORS OF LIFE SATISFACTION AND RESILIENCE AMONG SEXUAL MINORITY PERSONS LIVING WITH DISABILITIES

by

TAMEEKA L. HUNTER

Under the Direction of Franco Dispenza, Ph.D.

ABSTRACT

Life satisfaction and resilience are understudied, but important psychosocial constructs in the lives of sexual minority persons with disabilities(SMPWDs; Hunter et al., 2020). This study examined the influence of multiple minority stressors on the life satisfaction and resilience of SMPWDs. This study also examined whether social support bolsters life satisfaction and resilience in relation to minority stress. This study sought to answer the following questions: (a) What are the associations between ableist microaggressions, sexual orientation microaggressions, self-stigma, perceived social support, resilience, and life satisfaction? (b) To what degree do ableist microaggressions, sexual orientation microaggressions, self-stigma, perceived social support, resilience, and perceived support uniquely predict life satisfaction and resilience? (c) To what degree does perceived social support moderate the relationship between minority stress and resilience? (d) To what degree does perceived social support moderate the relationship between minority stress and life satisfaction?

Approximately 257 SMPWD were recruited through social media sites to complete an online Qualtrics survey. The Ableist Microaggressions Scale (Conover et al., 2017), the Sexual Orientation Microaggressions Scale (Nadal, 2019), the Self-Stigma Scale (Mak, & Cheung, 2010), and the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) were used to examine study constructs. Additionally, the Brief Resilience Scale (Smith et al., 2008) and the Satisfaction with Life Scale (Diener et al., 1985) were used to assess study outcomes. Responses of 257 participants were analyzed using bivariate correlations, two separate blockwise hierarchical regressions, and Haye’s moderation PROCESS macro in SPSS. To varying degrees, ableist microaggressions, sexual orientation microaggressions, self-stigma, and social support were significant correlates and predictors of life satisfaction and resilience. Hierarchical linear regression analyses indicate that while social support does not uniquely predict resilience, social support does uniquely predict life satisfaction. Social support did not moderate the relationship between minority stress and resilience or minority stress and life satisfaction among sexual minority persons living with disabilities. Implications for counselor education, clinical practice, and research are discussed.

INDEX WORDS: sexual minority, LGB, resilience, counseling, social support, mental health, disability, chronic illness, minority stress, homophobia, ableism

CORRELATES AND PREDICTORS OF LIFE SATISFACTION AND RESILIENCE AMONG SEXUAL MINORITY PERSONS LIVING WITH DISABILITIES

by

TAMEEKA LASHAE HUNTER

A Dissertation

Presented in Partial Fulfillment of Requirements for the

Degree of

Doctor of Philosophy

in

Counselor Education & Practice

in

Counseling & Psychological Services

in

the College of Education and Human Development
Georgia State University

Atlanta, GA
2020

DEDICATION

This dissertation is dedicated to my Mama, Peggy Drake Hunter, my wife, Rebecca Kay Glatzer, and my father-in-law (and in love), Lawrence Glatzer. Mama, thank you for telling me that as an African American woman, who was born with a physical disability, there would be limitations, but that I should decide them for myself. Thank you for believing in me when I decided the sky was my only limit. As you always say, “It’s my time to shine!” Beck, I am still convinced that a significant reason why I was admitted was they liked you so much, and I completely understand why. There is no way I could have done this without you. Your tireless support and encouragement kept me going throughout this process. I cannot thank you enough for your love and support. I love you with all my heart. “ Daddy G,” your entire life was the embodiment of resiliency. You are sorely missed. We will hold you in our hearts forever.

ACKNOWLEDGMENTS

I am deeply grateful for my committee chair, Dr. Franco Dispenza. “Dr. D,” thank you for the many ways that you have supported my growth and development. Your commitment to students and the intentionality shown within your roles as scholar, teacher, and mentor, inspires. It is something I hope to emulate. Thank you for taking a chance on me. You changed the trajectory of my entire life, and I am forever thankful.

Dr. Rafe McCullough, you have the uncanny ability to provide meaningful support and advice in a way that allows people to maintain dignity. I am a better teacher, scholar, and ultimately, a person because of you. I adore you. Thank you from the bottom of my heart.

Dr. Erin Mason, you are always a source of warmth and kindness. You remind me never to lose my compassion for students. You are a beam of sunshine.

Dr. Catherine Chang, thank you for being an exemplary model of what it means to be of service to the profession.

To my entire committee, thank you for your ongoing feedback throughout this process.

To Vanessa, Melanie, Nic, Rafe, and Mary, thank you for the laughter, the tears, the venting sessions, and the celebrations. I could not have done this without you. I love you and the rest of my 9th-floor family. We did it!

To the National Board for Certified Counselors, thank you for establishing the Minority Fellowship Program. Without your support, completing my doctoral degree may not have been possible. Thank you for connecting me to a community of like-minded scholars, who are now family, to my “Oyate.” We are poised to take on the world.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

CORRELATES AND PREDICTORS OF LIFE SATISFACTION AND RESILIENCE AMONG SEXUAL MINORITY PERSONS LIVING WITH DISABILITIES: A LITERATURE REVIEW

The Centers for Disease Control (CDC, 2018) reported that one in four adults in the United States – approximately 61 million Americans – live with a chronic illness or disability. The Americans with Disabilities Act (ADA, 1990) defines a *person with a disability* as having a physical or mental impairment that substantially limits one or more major life activities. Major life activities include breathing, moving, grooming, performing manual tasks, learning, and working (ADA, 1990). Diagnoses that qualify as disabilities under the ADA include cerebral palsy, learning disabilities, chronic illnesses, and attention deficit, and psychiatric disabilities.

Due to a variety of stress-related factors, persons living with disabilities (PWDs) experience higher rates of anxiety, feelings of isolation depressive disorders, and suicidality than nondisabled persons (Fredriksen-Goldsen et al., 2012, 2014; Metzler et al, 2012). People living with disabilities are also more likely to face problems with substance abuse (Bernert et al, 2012; Smedema & Ebener, 2011) and to engage in risky sexual behaviors (Bernert et al., 2012) than their counterparts without disabilities. People living with intellectual disabilities also are exposed to disability-related microaggressions, such as taunting and bullying, and report poorer physical and mental health than their nondisabled peers (Emerson, 2010). Minority stress theory posits that nondominant group members (such as persons with disabilities and sexual minority persons [SMPs]; e.g., bisexual, gay, lesbian, pansexual, queer, questioning, same-sex/gender attracted) experience chronic stress related to the social stigma, marginalization, objectification, and discrimination related to their identity and that this stress leads to mental and physical health disparities (Hatzenbuehler, 2009; Meyer, 1995; 2003). Minority stress theory (Meyer, 1995, 2003) centers on the unique stressors faced due to minority identity, while Hatzenbuehler's psychological framework (2009), inclusive of mediation and moderation mechanisms, focuses on the general psychological processes that are shared to identify areas of possible intervention. For example, emotional regulation is a shared process between marginalized persons and the general population. The psychological mediation framework avows that: (a) SMPs contend with increased stress as a result of stigma when compared to heterosexual persons; (b) this stigma-related stress produces elevations in general coping/emotion regulation, social/interpersonal, and cognitive processes thereby, increasing risk of adverse health outcomes (Hatzenbuehler, 2009).

Both minority stress theory and the psychological framework are used in the current study. The benefit of integrating these two models is that several general psychological processes are amenable to intervention, including emotional dysregulation, pessimism, hopelessness, and substance use disorders (Hatzenbuehler, 2009). Thus, the aim is to test a theoretical framework that integrates insights from both perspectives, with the ultimate hope of improving physical and mental health outcomes for SMPWDs.

SMPs also experience greater negative health disparities as a result of their minority identity when compared to heterosexual persons. Approximately 4.1% of the United States population identifies as a sexual minority (Gates, 2017). Adolescent SMPs are at increased risk anxiety, depression, smoking, substance use and dependence, and suicidal behaviors (Institute of Medicine [IOM], 2011; Strutz et al., 2015). Additionally, SMPs report experiencing poorer health and greater physical health concerns than heterosexual persons, such as asthma, cardiovascular risk, and the risk of being overweight, or obese (Dispenza et al., 2016; Fredriksen-Goldsen et al., 2013). In addition to physical and mental health disparities, SMPs face an elevated risk of violence and victimization when compared to the heterosexual population (Centers for Disease Control [CDC] Okoro, 2018; Pyra et al., 2014).

The physical and mental health disparities encountered by SMPs are well-represented in the literature (Fredriksen-Goldsen et al., 2012; IOM, 2011; Meyer, 2015), and SMPs are more likely to report disabilities than their heterosexual counterparts (Lick et al., 2013). Fredriksen-Goldsen and colleagues (2012) examined the prevalence of disability among SMPs and determined that overall rates of disability were significantly higher among sexual minority adults as compared to their heterosexual counterparts.

Sexual minority persons living with disabilities (SMPWDs) face a multitude of heterosexist and ableist stereotypes that impact their mental and physical health, as well as day-to-day functioning (Conover & Israel, 2019). Prejudice, discrimination, and stigma contribute to minority stress and negatively influence areas such as employment, personal care services, transportation, medical care, and activities of daily living among SMPWDs (Conover et al., 2017). For example, SMPWDs may have difficulty acquiring or maintaining work as a result of discrimination based on disability (i.e., ableism). SMPWDs may also be terminated based on homophobia (i.e., discrimination based on sexual orientation).

Decreasing prejudice, discrimination, marginalization, and related chronic daily stressors have been posited as an important way to minimize health disparities among PWDs and SMPs by targeting their root cause (APA, 2012a, 2012b; Conover et al., 2017). Although research focused on how marginalization negatively impacts functioning has yielded essential information about how marginalization adversely impacts functioning it is equally important to recognize the strengths of minoritized communities and to identify ways to bolster positive psychology constructs, such as life satisfaction and resilience. Some scholars contributing to minority stress literature have shifted to examining how wellbeing outcomes, such as life satisfaction, are affected by discrimination (Douglass et al., 2017). A compelling finding of this shift is that increased distress is not synonymous with decreased well-being for sexual minority persons (Douglass et al., 2017; Kertzner et al., 2009). In this chapter, I will examine predictors of life satisfaction and resilience, as well as how social support may impact resilience and multiple minority stress. Current research on life satisfaction and resilience will be examined, along with implications for counselors and counselor educators.

Life Satisfaction and Resilience

Life satisfaction is a global, subjective valuation of an individual's well-being and overall quality of life (Diener, 1984; Douglass et al., 2017). Life satisfaction is especially valuable as an indicator of wellbeing in people living with chronic illness or disability (Amtmann et al., 2019; Smedema &Tansey, 2015). Meyer (2003) suggests that sexual minority persons are exposed to unique minority stressors, which increase the potential for negative mental health outcomes and decrease the potential for greater life satisfaction. Relatedly, life satisfaction is positively associated with perceived social support and mood in people with a variety of disability conditions, such as spinal cord injury and multiple sclerosis (Silverman et al., 2017). Researchers suggest that social support is an important factor in maintaining and promoting health and life satisfaction among individuals with disabilities (Kim et al., 2018). Since life satisfaction appears to be an important indicator of well-being, and potentially resilience, it is important to study.

Resilience is a positive adaption to adversarial conditions, ranging from everyday stressors, such as microaggressions, to significant life events, such as the loss of a spouse (Hunter et al., 2020; Levitt et al., 2016; McConnell et al., 2018). Resilience is further described as the quality of being able to survive and thrive in the face of adversity (Meyer, 2015), and the ability to navigate adversity in a manner that protects wellbeing (Hilliard et al., 2015). Resilience is also defined as triumphing over adversity and as the state of having positive mental and physical health outcomes despite serious threats to development (Frost & Meyer, 2013; Meyer, 2015). Meyer (2015) and Wheaton (1985) assert that resilience can only be inferred in the face of stress since resilience has no meaning in the absence of stress (Wheaton, 1985). According to stress theory, the impact of stress on health is determined by the countervailing effects of pathogenic (i.e. disease-causing) stress processes and the salutogenic (i.e. health and wellbeing promoting) processes, such as resilience (Meyer, 2015).

Resilience has been widely studied in relation to sexual minority persons and minority stress (Meyer 2003, 2015; McConnell et al., 2018). Facing minority stress, both SMPs and PWDs exhibited resilience by actively seeking social support from local communities (Corbett, 1994; Hunter et al., 2020; Matsuno et al., 2018; Puckett et al., 2019; Whitney, 2006). More specifically, participants who received social support from family members or peers (Bariola et al., 2015) had higher levels of resilience.

Resilience also has some legitimate critiques. A criticism of resilience is there is no consensus on the definitions and operationalization of the construct (Luthar et al., 2000). Resilience has been conceptualized as a personal trait, a stress-buffering process, and an outcome (Fletcher & Sarkar, 2013). Another critique of resilience is the focus on individual-level or personal resilience, which is rooted in Western ideology (Meyer, 2015). Resilience framed based on personal traits implies that resilience is an immutable, innate characteristic. At issue, is that emphasis on individual resilience shifts attention to *individual responses* to stress, rather than the core issue: *societal stressors* (Meyer, 2015). Resilience as an individual attribute or a solely personal responsibility is harmful to marginalized populations as the social environment is fraught with prejudice and discrimination (Hunter et al., 2020). Framing resilience exclusively at the individual-level fails to acknowledge that SMPWDs contend with intersecting oppression (i.e., simultaneously experiencing ableism, homophobia, and for some, racism; Hunter et al., 2020). Despite these valid critiques, resilience is important to study because it may mitigate the negative impact of minority stress on health outcomes.

Additionally, scholars have called for more intersectional research on SMPWDs with strength-based outcomes, for example, life satisfaction and resilience (Kwon, 2013; Meyer, 2015). The goal is to move away from examining single identities to incrementally increase resilience scholarship focused on populations that experience multiple minority stress (McConnell et al., 2018; Remedios & Snyder, 2015).

Minority Stress

Minority stress theory has been studied extensively with sexual and gender minority persons (Balsam et al., 2011; Hilliard et al., 2015; Nadal et al., 2011; Woodford et al., 2014). SMPs experience forms of minority stress that are shared with other minority groups, such as prejudice, discrimination, expectations of rejection, and possible hate crimes. In addition, SMPs also experience unique stressors related to their sexual minority identity, such as identity management, stigma consciousness, and self-stigma (Frost et al., 2015). Minority stress has been studied to a lesser degree on persons living with disabilities (Brotha & Frost, 2018; Conover & Israel, 2019; Emerson 2010; Keller & Galgay, 2010). The well-documented negative impact of minority stress on sexual minority persons (Hatzenbuehler, 2009; Meyer 1995, 2003) and the limited research on minority stress among PWDs compel researchers to examine the impact of multiple minority stress on SMPWDs. Additionally, scholars have called for a shift in focus from pathogenic outcomes (example, depression, and anxiety) to examining strength-based constructs like life satisfaction and resilience among marginalized persons (Hunter et al., 2020; Kwon, 2013; Meyer, 2015; Riggle, et al., 2008)

Meyer (2015) described the minority stress process as one along a continuum of proximal and distal stressors. *Proximal stressors* are internal stressors instituted through socialization and experienced through cognitive processes. For example, *self-stigma* is a proximal stressor that refers to an individual's internalization of negative societal attitudes directed toward minority individuals (Ramirez & Galupo, 2019). Self-stigma is self-directed prejudice. For SMPs, self-stigma has also been termed internalized homophobia, internalized heterosexism, and internalized homonegativity (Herek et al., 2015). By contrast, *distal stressors* are external everyday stressors, hassles, and recurring strains. Microaggressions are a type of distal stressor that includes statements, actions, or incidents of indirect, subtle, or unintentional discrimination against members of marginalized groups (Pierce et al., 1978; Sue et al., 2007). Microaggressions based on disability status are termed *ableist microaggressions* (Conover et al., 2017). *Sexual orientation microaggressions* are microaggressions based on sexual minority identity (Nadal, 2019).

There is extensive evidence that microaggressions are harmful minority stressors that result in poor mental and physical outcomes among marginalized communities (Keller & Galgay, 2010; Nadal, 2013; Sue et al., 2007; Wright &Wegner, 2012). For example, in a national sample of 7,091 eleventh grade SMPWDs, 61.4% reported being bullied by and hearing microaggressions from a peer within the last 30 days as compared to a rate of only 30.6% in the general student population (McGee, 2014). Further, sexual minority male youth with disabilities reported the highest rates of peer victimization at 75% when compared to heterosexual students without disabilities (McGee, 2014). The ill-effects of minority stress are likely exacerbated among multiple minority populations, like SMPWDs. Therefore, examining psychological mechanisms that could curb the damaging effects of microaggressions and self-stigma on SMPWDs is vital.

Meyer's (2003) minority stress theory offers a lens to explore the connections between minority stress, resilience, and life satisfaction, including factors that are believed to buffer against minority stressors, such as social support. Social support is information leading a person to believe that he or she is: (a) cared for and loved; (b) esteemed and valued, and/or (c.) belonging to a network of communication and mutual obligation (Sarason & Sarason, 2009). Research has provided extensive evidence for the positive impact of social support on physical health (Uchino, 2006) mental health (Froland et al., 2000; Kool et al., 2013), as well as the negative effects of a lack of social support (Barth et al. 2010). Social support can lead to feelings of connection with the sexual minority community, which can contribute to psychological health (Kwon, 2013). Further, Meyer (2003) highlights the role of social support in bolstering resilience and attenuating the adverse impact of minority stress to promote greater life satisfaction among multiple marginalized communities.

Microaggressions

Microaggressions are brief, commonplace verbal, behavioral, or environmental indignities that intentionally or unintentionally communicate negative slights or insults toward particular social groups (Sue et al., 2007). Microaggressions are insidious and harmful as they are subtle or covert forms of prejudice that leave recipients wondering about the veracity of their perceptions of the interaction (Sue et al., 2010). Sheldon and Delgado (2011) described the adverse effect of sexual identity microaggressions on sexual minority persons in therapy. Study results indicated that clients felt pathologized, harmed, invalidated, and rejected by mental health professionals. These negative experiences resulted in the premature termination of therapy.

Relatedly, a qualitative sample of 25 lesbians with physical disabilities reported that when seeking mental health services, counselors appeared uncomfortable, unaware, uneducated about issues related to disability and sexual identity, and had even less knowledge about the needs of clients at the intersection of disability and sexual identities (Hunt et al., 2006). As a result of these negative experiences, including microaggressions, SMPWD clients may seek support from friends and social networks instead of family members. Conover and colleagues (2017) published a development and validation study of the Ableist Microaggression Scale, based on Keller and Galgay's taxonomy. That study resulted in 99% of participants reporting at least one physical disability microaggression in their lifetime. Given the pervasive nature of microaggressions, the potential health risks posed by minority stress, and limited research on minority stress, microaggressions among SMPWDs, it is important to understand how microaggressions impact the development of resilience and impact the life satisfaction of SMPWDs.

Social Support

Social support has been posited to buffer against the negative effects of minority stress (Meyer, 2003; Hatzenbuehler, 2009) and microaggressions (McCabe, 2009; Sue et al., 2007), such that adverse health outcomes are reduced or avoided (Meyer, 2003). Though social support and resilience have been equated in a few studies (e.g. Brockting et al, 2013; Grossman et al., 2011), social support may be more accurately characterized as a factor that promotes resilience (Hunter et al., 2020; Matsuno et al., 2018; Puckett et al., 2019). Higher levels of resilience are associated with receiving social support from family members, as well as sexual minority peers (Bariola et al., 2015).

Social support is defined as information leading people to believe they are: (a) cared for and loved, (b) esteemed and valued, and/or (c) belonging to a network (Cobb, 1976; Conover & Israel, 2019). Social support is a broad construct comprised of several sub-constructs (Barrera, 1986; Haber et al., 2007), including received and perceived social support (Haber et al., 2007; Prati & Pietrantoni, 2010; Uchino, 2009). Received support refers to receiving resources and support from others, and perceived support refers to the perception of access to or the availability of support (Haber et al., 2007; Uchino, 2009). However, study results consistently demonstrate that perceived support has a greater impact on physical and mental health than received support (Cohen & Wills, 1985; Moradi & Funderburk, 2006; Prati & Pietrantoni, 2010; Wethington & Kessler,1986).

Perceived social support is associated with positive psychological functioning and mood in people living with various disabilities (Silverman et al, 2017), and the negative effects of low or no social support (Barth et al., 2010). For example, Hunter and colleagues (2020) conducted a qualitative phenomenological resilience study of 13 sexual and gender minority persons living with disabilities (SGMPWDs). In that study, social support was identified as essential in reducing minority stress and bolstering resilience. Social support also appeared to diminish the negative impact of minority stress on sexual minority persons through a stress-buffering process (Sheets & Mohr, 2009) and on SGMPWDs (Hunter et al., 2020). However, some studies contradict the results (Burns et al., 2012; Conover & Israel, 2019; Szymanski, 2009). For example, Conover and Israel (2019) found that social support does *not* moderate (i.e., strengthen or weaken)the relationship between microaggressions and adverse mental health outcomes, a position asserted by Meyer (2003). Thus, Conover and Israel's results may suggest that social support fails to bolster resilience and wellbeing, nor does social support limit depression and anxiety for SMPWDs. Inconsistent study results related to minority stress and its association with social support necessitate further examination.

Implications for Counseling and Counselor Education

Widespread prejudice, discrimination, and stigma may predispose SMPWDs to poor physical and mental health outcomes (Hatzenbuehler, 2009; Meyer 2003). Therefore, counselors and other mental health professionals should engage in activities that help clients to develop critical consciousness (i.e., awareness aware of systemic inequities). The benefits of consciousness-raising include increased self-efficacy, self-esteem, and decreased depressive symptoms (Douglass et al. 2017), and ultimately, increased wellbeing.

Given the interlocking oppression SMPWDs contend with, and the complexities of navigating multiple marginalization, counselor educators and counselors and should avoid presuming which identities clients or students will endorse. Counselors and counselor educators should avoid and the assumption of which identities a most salient among SMPWDs, nor should mental health professionals assume a heterosexual identity. Instead, they should broach these topics early and with intention (Hunter et al, 2020), while recognizing that perceptions of identity salience may evolve based on sociocultural factors.

There are limited strength-based studies on resiliency and life satisfaction among SMPWDs, and those that exist there are inconsistent results regarding the role of social support. Given the well-known threats to mental and physical health as a result of minority stress and the likely increased risks imposed by multiple minority stress, it important to learn what contributes to life satisfaction and resilience among SMPWDs and whether social support is influential in this process. This review serves as an additional call following the recommendations from Kwon (2013) and Meyer (2015), to draw attention to exploring protective factors among intersectional populations, such as SMPWDs.

References

American Psychological Association (APA). (2012a). Guidelines for assessment of and intervention with persons with disabilities. *American Psychologist*, 67, 43–62. https://dx.doi.org/10.1037/a0025892

American Psychological Association (APA). (2012b). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist*, 67, 10–42. https://dx.doi.org/10.1037/a0024659

Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

Amtmann, D., Bocell, F. D., Bamer, A., Heinemann, A. W., Hoffman, J. M., Juengst, S. B., ... & McMullen, K. (2019). Psychometric properties of the Satisfaction with Life Scale in people with traumatic brain, spinal cord, or burn injury: A National Institute on Disability, Independent Living, and Rehabilitation Research Model System Study. *Assessment*, *26*(4), 695-705. https://doi.org/10.1177/1073191117693921

Asakura, K. (2017). Paving pathways through the pain: A grounded theory of resilience among lesbian, gay, bisexual, trans, and queer youth. *Journal of Research on Adolescence*, 27(3), 521–536. https://doi.org/10.1111/jora.12291

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultural Diversity and Ethnic Minority Psychology*, *17*(2), 163-174. https://doi.org/10.1037/a0023244

Bariola, E., Lyons, A., Leonard, W., Pitts, M., Badcock, P., & Couch, M. (2015). Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals. *American journal of public health*, *105*(10), 2108-2116. https://doi.org/10.2105/AJPH.2015.302763

Bernert, D. J., Ding, K., & Hoban, M. T. (2012). Sexual and substance use behaviors of college students with disabilities. *American journal of health behavior*, *36*(4), 459-471. https://doi.org/10.5993/AJHB.36.4.3

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. *American journal of community psychology*, *14*(4), 413-445. https://doi.org/10.1007/BF00922627

Barth, J., Schneider, S., & Von Känel, R. (2010). Lack of social support in the etiology and the prognosis of coronary heart disease: a systematic review and meta-analysis. *Psychosomatic medicine*, *72*(3), 229-238. https://doi: 10.1097/PSY.0b013e3181d01611

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American journal of public health*, *103*(5), 943-951. https://doi.org/10.2105/AJPH.2013.301241

Burns, M. N., Kamen, C., Lehman, K. A., & Beach, S. R. (2012). Attributions for discriminatory events and satisfaction with social support in gay men. *Archives of sexual behavior*, *41*(3), 659–671. https://doi.org/10.1007/s10508-011-9822-5

Chaudoir, S. R., Wang, K., & Pachankis, J. E. (2017). What reduces sexual minority stress? A review of the intervention “toolkit.” *Journal of Social Issues*, *73*(3), 586-617. https://doi.org/10.1111/josi.12233

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic medicine*. https://doi.org/10.1097/00006842-197609000-00003

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*(2), 310-357. https://doi.org/10.1037/0033-2909.98.2.310

Conover, K. J., & Israel, T. (2019). Microaggressions and social support among sexual minorities with physical disabilities. *Rehabilitation Psychology*, *64*(2), 167-178. https://doi.org/10.1037/rep0000250

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017). Development and validation of the ableist microaggressions scale. *The Counseling Psychologist*, *45*(4), 570-599. https://doi.org/10.1177/0011000017715317

Corbett, J. (1994). A proud label: Exploring the relationship between disability politics and gay pride. *Disability & Society*, 9(3), 343-357. https://doi.org/10.1080/09687599466780381

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of personality assessment*, *49*(1), 71-75. https://doi.org/10.1207/s15327752jpa4901_13

Dispenza, F., & Watson, L. B. (2015). Comparing sexual risk behaviors between sexual minority men living with and without a chronic illness/disability (CID). *Sexuality and Disability*, 33(3), 399-403. https://doi.org/10.1007/s11195-014-9376-2

Douglass, R. P., Conlin, S. E., Duffy, R. D., & Allan, B. A. (2017). Examining moderators of discrimination and subjective well-being among LGB individuals. *Journal of Counseling Psychology*, *64*(1), 1. https://doi.org/10.1037/cou0000187

Eliason, M. J., Martinson, M., & Carabez, R. M. (2015). Disability among sexual minority women: Descriptive data from an invisible population. *LGBT health*, 2(2), 113-120. https://doi.org/10.1089/lgbt.2014.0091

Emerson, E. (2010). Self-reported exposure to disablism is associated with poorer self-reported health and well-being among adults with intellectual disabilities in England: A cross-sectional survey. *Public Health*, *124*(12), 682-689. https://doi.org/10.1016/j.puhe.2010.08.020

Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annu. Rev. Public Health*, *26*, 399-419. https://doi.org/10.1146/annurev.publhealth.26.021304.144357

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Sage.

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European Psychologist*, *18*(1), 12-23. https://doi.org/10.1027/1016-9040/a000124

Fredriksen-Goldsen, K. I., Kim, H. J., & Barkan, S. E. (2012). Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk. *American Journal of Public Health*, *102*(1), e16-e21. https://dx.doi.org/10.2105/AJPH.2011.300379

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2014). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American journal of public health*, *103*(10), 1802-1809. https://doi.org/10.2105/AJPH.2012.301110

Froland, C., Brodsky, G., Olson, M., & Stewart, L. (1979). Social support and social adjustment: Implications for mental health professionals. *Community Mental Health Journal*, *15*(2), 82-93. https://dx.doi.org/10.1023/A:1001804727462

Froland, C., Brodsky, G., Olson, M., & Stewart, L. (2000). Social support and social adjustment: Implications for mental health professionals. *Community Mental Health Journal*, *36*(1), 61-75. https://doi.org/10.1023/A:1001804727462

Frost, D. M., Lehavot, K., & Meyer, I. H. (2015). Minority stress and physical health among sexual minority individuals. *Journal of behavioral medicine*, *38*(1), 1-8. https://doi.org/10.1007/s10865-013-9523-8

Gates, G. J. (2017). Sexual Minorities in the 2008 General Social Survey: Coming Out and Demographic Characteristics-*eScholarship*. 2010. http://papers.ccpr.ucla.edu/index.php/pwp/article/view/PWP-CCPR-2010-015

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. *Washington, DC: Institute of Medicine*, *10*, 13128.

Grossman, A. H., D'augelli, A. R., & Frank, J. A. (2011). Aspects of psychological resilience among transgender youth. *Journal of LGBT youth*, *8*(2), 103-115. https://doi.org/10.1080/19361653.2011.541347

Haber, M. G., Cohen, J. L., Lucas, T., & Baltes, B. B. (2007). The relationship between self-reported received and perceived social support: A meta-analytic review. *American journal of community psychology*, *39*(1-2), 133-144. https://doi.org/10.1007/s10464-007-9100-9

Hampton, N. Z. (2004). Social support and quality of life among elderly Chinese Americans/immigrants with disabilities: an exploratory study. *Journal of Applied Rehabilitation Counseling*, *35*(2), 17-24. https://dx.doi.org/10.1891/0047-2220.35.2.17

Hampton, N. Z. (2004). Subjective well-being among people with spinal cord injuries: The role of self-efficacy, perceived social support, and perceived health. *Rehabilitation Counseling Bulletin*, *48*(1), 31-37. https://doi.org/10.1177/00343552040480010401

Hariharan, M., Karimi, M., & Kishore, M. T. (2014). Resilience in persons with physical disabilities: Role of perceived environment and emotional intelligence. *Journal of the Indian Academy of Applied Psychology*, *40*(1), 96. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2014-22567-012&site=ehost-live&scope=site

Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological bulletin*, *135*(5), 707-730. https://doi.org/10.1037/a0016441

Hilliard, M. E., McQuaid, E. L., Nabors, L., & Hood, K. K. (2015). Resilience in youth and families living with pediatric health and developmental conditions: Introduction to the special issue on resilience. *Journal on Pediatric Psychology*. 40 (9), 835–839. https://doi.org/10.1093/jpepsy/jsv072

Horne, S. G., Levitt, H. M., Sweeney, K. K., Puckett, J. A., & Hampton, M. L. (2015). African American gay family networks: An entry point for HIV prevention. *Journal of Sex Research, 52*(7), 807–820. https://doi.org/10.1080/00224499.2014.901285

Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development*, *84*(2), 163-173. https://doi.org/10.1002/j.1556-6678.2006.tb00392.x

Hunter, T., Dispenza, F., Huffstead, M., Suttles, M., & Bradley, Z. (2020). Queering Disability: Exploring the Resilience of Sexual and Gender Minority Persons Living With Disabilities. *Rehabilitation Counseling Bulletin*. https://doi.org/10.1177/0034355219895813

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington: The National Academies Press.

Kann, L. (2011). *Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12: Youth risk behavior surveillance, selected sites, United States, 2001-2009* (Vol. 60, No. 7). DIANE Publishing.

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. *Microaggressions and marginality: Manifestation, dynamics, and impact*. John Wiley & Sons, Inc.

Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *American Journal of Orthopsychiatry, 79*(4), 500–510. https://doi.org/10.1037/a0016848

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*, 70-71. https://dx.doi.org/10.1186/1471-244X-8-70

Kool, M. B., van Middendorp, H., Lumley, M. A., Bijlsma, J. W., & Geenen, R. (2013). Social support and invalidation by others contribute uniquely to the understanding of physical and mental health of patients with rheumatic diseases. *Journal of Health Psychology, 18*, 86–95. https://dx.doi.org/10.1177/1359105312436438

Kraus, L., Stoddard, S., & Gilmartin, D. (1996). *Chartbook on disability in the United States: An Info Use report*. Washington, DC: U.S. National Institute on Disability and Rehabilitation Research.

Krokavcova, Martina, Jitse P. van Dijk, Iveta Nagyova, Jaroslav Rosenberger, Miriam Gavelova, Berrie Middel, Zuzana Gdovinova, and Johan W. Groothoff. (2008). Social support as a predictor of perceived health status in patients with multiple sclerosis. *Patient Education and Counseling, 73*, 159–165. https://dx.doi.org/10.1016/j.pec.2008.03.019

Kwon, P. (2013). Resilience in lesbian, gay, and bisexual individuals. *Personality and Social Psychology Review, 17*, 371-383. http://dx.doi.org/10.1177/1088868313490248

Lee, I. C. (2013). Perceptions of success and life satisfaction: a gender examination in Taiwan. *Journal of Applied Social Psychology, 43*(2), 446-455. https://doi.org/10.1111/j.1559-1816.2013.01028.x

Levitt, H. M., Horne, S. G., Herbitter, C., Ippolito, M., Reeves, T., Baggett, L. R., ... & Geiss, M. (2016). Resilience in the face of sexual minority stress: “Choices” between authenticity and self-determination. *Journal of Gay & Lesbian Social Services, 28*(1), 67-91. https://doi.org/10.1080/10538720.2016.1126212

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8*(5), 521-548. https://doi.org/10.1177/1745691613497965

Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71,* 543-562. http://dx.doi.org/10.1111/1467-8624.00164

Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., … Morse, J. Q. (2008). Sexual orientation and adolescent substance use: A meta-analysis and methodological review. *Addiction, 103*(4), 546–556. https://dx.doi.org/10.1111/j.1360-0443.2008.02149.x

Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. *Development and Psychopathology, 19,* 921-930. http://dx.doi.org/10.1017/S0954579407000442

Matsuno, E., & Israel, T. (2018). Psychological interventions promoting resilience among transgender individuals: Transgender resilience intervention model (TRIM). *The Counseling Psychologist*, *46*(5), 632-655. https://doi.org/10.1177/0011000018787261

McCabe, P. C., Dragowski, E. A., & Rubinson, F. (2013). What is homophobic bias anyway? Defining and recognizing microaggressions and harassment of LGBTQ youth. *Journal of School Violence*, 12(1), 7-26. https://doi.org/10.1080/15388220.2012.731664

McConnell, E. A., Janulis, P., Phillips, G., II, Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 1–12. https://dx.doi.org/10.1037/sgd0000265

McGee, M. G. (2015). Peer victimization as a mediator of the relationship between disability status and psychosocial distress. *Disability and Health Journal*, *8*(2), 250-257. https://doi.org/10.1016/j.dhjo.2014.09.006

Meltzer, H., Brugha, T., Dennis, M.S., Hassiotis, R.J., McManus, S., Rai, D., & Bebbington, P. (2012). The influence of disability on suicidal behavior. *European Journal of Disability Research*, *6,* 1-12, http://dx.doi.org/10.1016/j.alter.2011.11.004

Merton, R. K., & Merton, R. C. (1968). *Social theory and social structure*. Simon and Schuster.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56. https://www.jstor.org/stable/2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697. http://dx.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. https://dx.doi.org/10.1037/sgd0000132

Meyer, I. H., & Frost, D. M. (2013). Minority stress and the health of sexual minorities. In C. J. Patterson & A. R. D'Augelli (Eds.), Handbook of psychology and sexual orientation. (pp. 252–266). New York, NY: Oxford University Press. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2012-32754-018&site=ehost-live&scope=site

Meyer, I. H., Ouellette, S. C., Haile, R., & McFarlane, T. A. (2011). 'We'd be free': Narratives of life without homophobia, racism, or sexism. *Sexuality Research & Social Policy: A Journal of the NSRC, 8(*3), 204–214. https://dx.doi.org/10.1007/s13178-011-0063-0

Moradi, B., & Funderburk, J. R. (2006). Roles of perceived sexist events and perceived social support in the mental health of women seeking counseling. *Journal of Counseling Psychology*, *53*(4), 464-473. https://doi.org/10.1037/0022-0167.53.4.464

Nadal, K. L., Wong, Y., Issa, M.-A., Meterko, V., Leon, J., & Wideman, M. (2011). Sexual orientation microaggressions: Processes and coping mechanisms for lesbian, gay, and bisexual individuals. Journal of LGBT Issues in Counseling, 5, 21–46. http://dx.doi.org/10.1080/15538605 .2011.554606

Nadal, K. L. (2019). Measuring LGBTQ Microaggressions: The Sexual Orientation Microaggressions Scale (SOMS) and the Gender Identity Microaggressions Scale (GIMS). *Journal of homosexuality*, *66*(10), 1404-1414. https://doi.org/10.1080/00918369.2018.1542206

Okoro, C. A., Hollis, N. D., Cyrus, A. C., & Griffin-Blake, S. (2018). Prevalence of disabilities and health care access by disability status and type among adults—United States, 2016. *Morbidity and Mortality Weekly Report*, *67*(32), 882. http://dx.doi.org/10.15585/mmwr.mm6732a3external icon

O'Toole, C.J., & Brown, A.A. (2003). No reflection in the mirror. *Journal of Lesbian Studies, 7*, 35-49. http://dx.doi.org/10.1300/J155v07n01_03

Prati, G., & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of loss and trauma, 14*(5), 364-388. https://doi.org/10.1080/15325020902724271

Proujansky, R. A., & Pachankis, J. E. (2014). Toward formulating evidence-based principles of LGB-affirmative psychotherapy. *Pragmatic Case Studies in Psychotherapy*, *10*(2), 117-131. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2014-43315-003&site=ehost-live&scope=site

Puckett, J. A., Matsuno, E., Dyar, C., Mustanski, B., & Newcomb, M. E. (2019). Mental health and resilience in transgender individuals: What type of support makes a difference? *Journal of Family Psychology*. https://doi.org/10.1037/fam0000561

Pyra, M., Weber, K., Wilson, T. E., Cohen, J., Murchison, L., Goparaju, L., & Cohen, M. H. (2014). Sexual minority status and violence among HIV infected and at-risk women. *Journal of general internal medicine*, *29*(8), 1131-1138. http://dx.doi.org/10.1007/s11606-014-2857-2.

Ramirez, J. L., & Paz Galupo, M. (2019). Multiple minority stress: The role of proximal and distal stress on mental health outcomes among lesbian, gay, and bisexual people of color. *Journal of Gay & Lesbian Mental Health*, *23*(2), 145-167. https://doi.org/10.1080/19359705.2019.1568946

Remedios, J. D., & Snyder, S. H. (2015). Where do we go from here? Toward an inclusive and intersectional literature of multiple stigmatization. *Sex Roles: A Journal of Research*, *73*(9–10), 408–413. https://dx.doi.org/10.1007/s11199-015-0543-4

Riggle, E. D., Whitman, J. S., Olson, A., Rostosky, S. S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional psychology: Research and practice*, *39*(2), 210. https://doi.org/10.1037/0735-7028.39.2.210

Sarason, I. G., & Sarason, B. R. (2009). Social support: Mapping the construct. *Journal of Social and Personal Relationships*, *26*(1), 113-120. https://doi.org/10.1177/0265407509105526

Scott, K. M., Von Korff, M., Alonso, J., Angermeyer, M. C., Bromet, E., Fayyad, J., . . .Williams, D. (2009). Mental-physical co-morbidity and its relationship with disability: Results from the World Mental Health Surveys. *Psychological Medicine*, *39*, 33–43. http://dx.doi.org/10.1017/S0033291708003188

Sheets, R. L., Jr., & Mohr, J. J. (2009). Perceived social support from friends and family and psychosocial functioning in bisexual young adult college students. *Journal of Counseling Psychology, 56*(1), 152–163. https://doi.org/10.1037/0022-0167.56.1.152

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology*, *58*(2), 210. https://doi.org/10.1037/2329-0382.1.S.59

Smedema, S. M., & Ebener, D. (2010). Substance abuse and psychosocial adaptation to physical disability: analysis of the literature and future directions. *Disability and Rehabilitation*, *32*(16), 1311-1319. https://doi.org/10.3109/09638280903514721

Strutz, K. L., Herring, A. H., & Halpern, C. T. (2015). Health disparities among young adult sexual minorities in the US. *American Journal of Preventive Medicine*, *48*(1), 76-88. https://doi.org/10.1016/j.amepre.2014.07.038

Stuntzner, S. (2014). Compassion & self-compassion: Exploration of utility as potential components of the rehabilitation counseling profession. *Journal of Applied Rehabilitation Counseling*, 45(1), 37–44. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2014-12546-005&site=ehost-live&scope=site

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American psychologist*, *62*(4), 271-286. Retrieved from https://psycnet.apa.org/buy/2007-07130-001

Szymanski, D. M. (2009). Examining potential moderators of the link between heterosexist events and gay and bisexual men's psychological distress. *Journal of Counseling Psychology, 56*(1), 142–151. https://doi.org/10.1037/0022-0167.56.1.142

Tatum, A. K. (2016). Proximal minority stress processes and subjective well-being of leathermen. *Psychology of Sexual Orientation and Gender Diversity*, *3*(3), 374–379. https://dx.doi.org/10.1037/sgd0000189

Turner, J. B., & Turner, R. J. (2004). Physical disability, unemployment, and mental health. *Rehabilitation Psychology*, *49*, 241–249. http://dx.doi.org/10.1037/0090-5550.49.3.241

Turner, R. J., Frankel, B., & Levin, D. (1983). Social support: Conceptualization, measurement, and implications for mental health. In J. R. Greenley (Ed.), *Research in community and mental health* (Vol. 3, pp. 67–111). Greenwich, CT: JAI Press.

Turner, R. J., Lloyd, D. A., & Taylor, J. (2006). Physical disability and mental health: An epidemiology of psychiatric and substance disorders. *Rehabilitation Psychology, 51,* 214–223. http://dx.doi.org/10.1037/0090-5550.51.3.214

Turner, R. J., & McLean, P. D. (1989). Physical disability and psychological distress. *Rehabilitation Psychology, 34*(4), 225. https://doi.org/10.1037/h0091727

Uchino, B. N. (2006). Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *Journal of Behavioral Medicine, 29*(4), 377-387. https://doi.org/10.1007/s10865-006-9056-5

Wheaton, B. (1985). Models for the stress-buffering functions of coping resources. *Journal of Health and Social Behavior,* 26, 352–364.

Wethington, E., & Kessler, R. (1986). Perceived Support, Received Support, and Adjustment to Stressful Life Events. *Journal of Health and Social Behavior, 27*(1), 78-89. Retrieved June 21, 2020, from www.jstor.org/stable/2136504

Woodford, M. R., Kulick, A., Sinco, B. R., & Hong, J. S. (2014). Contemporary heterosexism on campus and psychological distress among LGBQ students: The mediating role of self-acceptance. *American Journal of Orthopsychiatry*, *84*(5), 519–529. https://dx.doi.org/10.1037/ort0000015

Wright, A. J., & Wegner, R. T. (2012). Homonegative microaggressions and their impact on LGB individuals: A measure validity study. *Journal of LGBT Issues in Counseling*, *6*(1), 34-54. https://doi.org/10.1080/15538605.2012.648578

CHAPTER 2

CORRELATES AND PREDICTORS OF LIFE SATISFACTION AND RESILIENCE AMONG SEXUAL MINORITY PERSONS LIVING WITH DISABILITIES

Lazarus and Folkman (1984) asserted that the incongruence between a person and negative societal experiences is the root of all social stress. Minority stress theory asserts that minority groups, such as sexual minority persons (SMPs; for example, lesbian, gay, pansexual, queer) and persons living with disabilities (PWDs), experience chronic identity-related stressors due to stigma, marginalization, objectification, and discrimination (Conover et al., 2017; Meyer, 1995; 2003). Minority stress leads to mental and physical health disparities (Hatzenbuehler, 2009). Similar to minority stress theory, the psychological framework avers that sexual minority persons are at increased risk for mental health concerns as compared to heterosexual persons (Hatzenbuehler, 2009). Hatzenbuehler (2009) asserts the need to consider unique marginalized identity-based stigma and stressors (i.e., minority stress) in concert with general psychological processes, such as emotional regulation, that SMPs share with non-sexual minority persons. The aim of integrating Meyer’s (2003) minority stress theory and Hatzenbuehler’s (2009) psychological framework is increased opportunities to develop timely interventions to assist clients.

Prejudice, discrimination, and stigma based on marginalized identity contribute to minority stress. Persons living with disabilities and sexual minority persons experience minority stress which is associated with greater mental and physical health disparities (Fredriksen-Goldsen, 2012, 2014; Lick et al, 2013; Conover & Israel, 2019). However, there is limited research regarding the influence of minority stress on the lives of SMPWDs. Fredriksen-

Goldsen, Kim, and Barkan (2012) broadly examined disability rates among SMPs and determined that disability rates were significantly higher among sexual minority adults as compared to heterosexual persons. In addition, SMPs experience disability at significantly younger ages, when compared with heterosexual persons (Fredriksen-Goldsen et al., 2014). An estimated 3 to 5 million sexual minority persons may be living with chronic illnesses and disabilities in the United States (Fredriksen-Goldsen et al., 2012). Multiple marginalized persons, such as SMPWDs, are particularly susceptible to the cumulative and detrimental impact of minority stress (Balsam et al., 2011; Conover & Israel, 2019), calling into question how minority stressors impact life satisfaction and resilience of SMPWDs.

Life satisfaction is a global, subjective indicator of well-being that is a particularly useful measure of quality of life among persons living with disabilities (Amtmann, 2019; Smedema, 2017). Resilience is described as “triumph over adversity” (Hunter et al., 2020). Researchers hypothesized that resilience is associated with life satisfaction and happiness among persons with disabilities (Kim et al., 2016). Life satisfaction is an individual’s judgment about the overall quality of their lives, and it is the cumulative effect of satisfaction with various domains, including work, family, and health (Diener, 1993; Smedema, 2017). In a sample of individuals living with spinal cord injuries, social support was significantly associated with life satisfaction (Smedema & Tansey, 2015). Sexual minority persons who are exposed to minority stress have an increased risk for negative mental health outcomes and decreased life satisfaction (Douglass et al., 2017). As an example, discrimination was significantly and positively linked with negative affect and reduced life satisfaction (Douglass et al., 2017). Scholars have called for a shift from pathogenic (i.e., disease-causing) focus in research among sexual minority persons to a salutogenic (i.e., health-promoting, positive functioning) focus (Conlin et al, 2019; Kwon, 2013;

Meyer, 2015). As a part of this shift, there is a need to uncover the mechanisms through which marginalization impacts positive functioning including life satisfaction and resilience for SMPWDs.

Resilience is an essential part of understanding minority stress theory (Meyer, 2015). Resilience can only be assessed as a response to stress. Resilience is described as "bouncing back from adversity" or a positive adaption to adverse conditions such that health is protected (Levitt et al., 2016; McConnell et al., 2018). Resilience is related to, but distinct from, coping. Coping represents the *effort* made to adapt to stress but does not indicate positive adaptation to stress, as does resilience.

Resilience has some legitimate critiques. Limited consensus on the definitions and operationalization of resilience poses a challenge (Luthar et al.2000). Researchers describe resilience as a personal trait, which implies that resilience is solely an innate quality, rather than one impacted by systemic inequities (Fletcher & Sarkar, 2013; Hunter, et al., 2020; Meyer, 2015). Despite these resilience criticisms, scholars recommend additional resilience studies, particularly those involving groups with multiple marginalized identities, given its potential to ameliorate the harmful impact of minority stress on health (Conover & Israel, 2019; Kwon, 2013).

Minority Stress and Microaggressions

Minority stress theory avers that minority groups endure chronic stress due to societal stigma, marginalization, and discrimination and that this stress leads to adverse health outcomes (Brooks, 1981; Lick et al., 2013; Meyer, 1995, 2003). Meyer (2015) described the minority stress process as one that is along a continuum of proximal and distal stressors. Proximal stressors are based on the internalization of negative societal messages regarding one's minority identity

(Meyer, 2015). Self-stigma is a proximal stressor defined as a marginalized person's acceptance of societal stigma and prejudice as a part of their value system (Herek et al., 2015). For example, an African American woman who begins to believe that her romantic interest in women is a 'perversion' or is cause for punishment. Another example is someone who has a physical disability that begins to view themselves as a "burden" as a result of societal messages.

Microaggressions are insidious, distal (i.e. external) minority stressors that have been described as "death by thousand cuts." Microaggressions are brief, commonplace verbal, behavioral, or environmental indignities that intentionally or unintentionally communicate negative slights or insults toward marginalized social groups (Pierce et al., 1978; Sue et al., 2007). Microaggressions contribute to minority stress and are a significant source of distal stress for marginalized groups, such as people of color (Sue et al., 2007), sexual minority persons of color (Cyrus, 2017), Latino and Asian adolescents (Huynh, 2012), and sexual minority persons (Nadal et al., 2011). As an example, Nadal and colleagues (2011) found that sexual orientation microaggressions negatively impacted mental health by increasing depression, anxiety, suicidal ideation, self-destructive behaviors, and substance abuse. Researchers also examined the deleterious impact of microaggressions among trans and gender non-binary persons (Matsuno et al., 2019; Pitcher, 2017), Asian American college students (Kulick et al., 2017; Woodford et al., 2014; Wang et al., 2011), as well as persons living with disabilities.

Persons living with intellectual disabilities who were exposed to disability-related microaggressions (i.e., ableist microaggressions) reported poorer physical and mental health (Emerson, 2010). Ableist microaggressions are unique minority stressors based on disability status and ableism (Conover et al., 2017). Conover and colleagues categorized one type of ableist microaggressions as *minimization.* Minimization occurs when an individual has a chronic illness or disability that is not readily apparent. Study participants described being told they were "just being lazy" on days when they were not well enough to engage in typical daily activities due to relapsing and remitting chronic health conditions. Similarly, Nadal and colleagues (2019) describe unique the unique minority stressors experienced by sexual minority persons as sexual orientation microaggressions. An example is having people use the phrase "that's so gay" to describe something undesirable or negative.

The harmful impact of minority stress on SMPs is well-documented (Brooks, 1981; Fredriksen-Goldsen 2012, 2014; Lick et al., 2013; Meyer 1995, 2003), and while scholarship on PWDs and minority stress is growing (Emerson, 2010), research on the impact of minority stress, in the form of microaggressions, on sexual SMPWDs is in its infancy. SMPWDs are in a unique position to experience marginalization based on disability and sexual minority identities. Sixty-one percent of sexual minority youth with disabilities reported experiencing microaggressions in the past 30 days, compared with 30.6% of the general high school student population (McGee, 2014). Further, sexual minority males with disabilities reported the highest rates of peer victimization when compared to other intersectional populations, with 75% reporting experiencing microaggression and peer victimization (McGee, 2014). Despite the fact that multiple minority stress may make SMPWDs particularly vulnerable to adverse mental and physical health outcomes (Balsam et al., 2011; Hilliard et al., 2015; McConnell et al., 2018), SMPWDs are capable of living a resilient and satisfying life. This prompts the question: what are possible factors that buffer against the damaging impact of minority stress?

Social Support

Social support is defined as information leading people to believe they are: (a) cared for and loved, (b) esteemed and valued, and/or (c) belonging to a network of communication and mutual obligation (Conover & Israel, 2019). Researchers have provided extensive evidence of the positive impact of social support has on physical and mental health (see Kool et al., 2013 for a review), as well as the negative effects of low social support (Barth et al., 2010). The role of social support and buffering against the detrimental effects of stress on health is well-documented (Hatzenbuehler 2009; McConnell et al., 2018 Meyer 1995, 2003). Relatedly, when SMPs experience discrimination, prejudice, and stigma, they may self-isolate or increase attempts to conceal their sexual minority identity, which lessens the connection to community and social support. SMPWDs may need a significant amount of support, depending on the nature of their disabilities, but may also be limited in their ability to access it if the community does not affirm or support sexual minority identity. Social support may also function as a moderator since it has the potential to increase or decrease the likelihood that stressors (in this case, minority stressors) contribute to some psychosocial or health outcome (Hatzenbuehler, 2009).

Hunter and colleagues (2020) conducted a qualitative study of 13 SGMPWDs, to explore what contributed to their resiliency. Social support emerged as a significant resilience maximizer. Social support from family and friends was noted as bolstering participant's resilience when their sexual and gender minority identities were accepted and supported. However, when SGMPWDs did not have support from family and friends, participants faced some unique challenges, most apparent in the discussion of the theme, "Punishment," when accessing social support. SGMPWDs experienced the deliberate removal of financial, familial, and other forms of social support (i.e., 'punishment'), as result of sexual and/or gender identity disclosure, with the understanding that doing so would likely harm the participants' mental and physical health (Hunter et al., 2020). The results of this study suggest that social support is essential to building resilience and that limited social support is detrimental to SGMPWDs. In addition to promoting life satisfaction and resilience, some studies show higher levels of perceived social support may protect against psychological distress caused by minority stress among sexual minority persons (Meyer, 2003; Sheets, 2009), and may bolster life satisfaction and resilience among people with disabilities (Hunter et al., 2020; Ganguly & Perera, 2019).

Additionally, social support may moderate the relationships between minority stress and psychosocial outcomes. However, empirical scholarship is inconclusive about its role. Conover and Israel (2019) found that social support did not moderate the relationship between microaggressions and psychological distress among sexual minority persons living with physical disabilities. Social support did not strengthen or weaken the relationship between psychological distress and microaggressions. Specific to microaggressions, at least one study suggests social support may buffer the negative impact of minority stress in the form of microaggressions (McCabe, 2009), while others have not found evidence of the stress-buffering hypothesis (Kaufman et al., 2017). Yet another study, Itzick and colleagues (2018), found that social support moderated the relationship between perceived discrimination (i.e., minority stress) and life satisfaction.

Inconsistent findings suggest there is a need to better understand the role of resilience, social support, and life satisfaction for intersectional populations, such as SMPWDs. In addition, more information is needed about how to bolster life satisfaction and resilience (Conover & Israel, 2019; Hilliard et al., 2014; Meyer, 2015). Moreover, scholars have called on researchers to move away from solely discussing deleterious risks faced by intersectional populations to examining protective factors, such as life satisfaction and resilience to more comprehensively address minority physical and mental health concerns (Asakura, 2016; Kwon, 2013; Meyer et al., 2011; Remedios & Snyder, 2015). Thus, the current study extends the work of Conover and

Israel (2019) and answers the call for more studies with strength-based outcomes, such as life satisfaction and resilience. The well-documented physical and mental health risks facing persons with disabilities and sexual minority persons may signal greater health risks to SMPWDs and makes social support, resilience, and life satisfaction compelling to study.

The Current Study

Persons living disabilities and sexual minority persons face greater physical and mental health disparities due to minority stress as compared to their nondisabled and heterosexual counterparts. Thus, the overarching research question guiding this study was: “What are the correlates and predictors of life satisfaction and resilience among sexual minority persons living with disabilities?” The study was designed to advance understanding of which constructs may predict life satisfaction and resilience among SMPWDs.

Conover and Israel (2019) published the first known study to quantitatively examine the relationship between microaggressions and social support for sexual minority persons living with physical disabilities. Social support is thought to attenuate the negative impact of minority stress (Meyer 1995, 2003; Hatzenbeuhler, 2009). Conover and Israel (2019) sought to understand the relationship between microaggressions and perceived social support for sexual minority persons. A sample of 192 sexual minority persons living with physical disabilities participated in their study. Participants responded to an online survey that included measures related to social support, microaggressions, and mental health outcomes. Social support was not found to moderate (i.e., strengthen or weaken) the relationship between microaggressions and mental health outcomes.

The current study expands Conover and Israel’s important work while having distinct differences. First, in addition to participants living with physical disabilities, the present study includes participants living with a broader range of chronic health conditions and disabilities, including learning, attention-related, and psychiatric disabilities. Second, Conover and Israel narrowed their study's focus to within-community support by instructing participants to only consider ableist microaggressions enacted by other sexual minority persons living with disabilities. In addition, when social support was provided by other SMPWDs, participants were asked to consider the support as coming from both the disability and the sexual minority communities. This approach was a challenge for participants, so the support received from this group remains unclear. As an example, Conover and Israel uncovered an unexpected finding, SMPWDs' satisfaction with social support was not influenced by homonegative experiences within the disability community (Conover & Israel, 2019). Interestingly, SMPWDs still perceived the disability community as a source of social support, despite enduring homonegative microaggressions (Conover & Israel, 2018). This illuminates the need to better understand the specific types of social support, whether from significant others, family, or friends most influence life satisfaction and resilience among SMPWDs. Additionally, inconsistent reports regarding social support's stress-buffering properties, as well as the potential for resiliency to be health-promoting make it important to study.

Third, the current study is salutogenic (i.e., focused on factors that contribute to the promotion and maintenance of health and wellbeing, such as life satisfaction and resilience for SMPWDs. More specifically, while many studies center on adverse mental and physical health outcomes related to minority stress, the current study is strengths-based. The researchers are interested in factors that bolster resilience and promote life satisfaction. At its core, this study is an acknowledgment of the strength of multiple marginalized communities, like SMPWDs, despite the vulnerabilities.

The contributors to life satisfaction and resilience among SMPWDs go largely unexamined (Hunter, 2020). The researchers sought to fill this gap by examining multiple minority stressors in the form of ableist and homophobic microaggressions, as well as self-stigma, which negatively impact mental and physical health. The researchers also explored whether social support bolsters life satisfaction and resilience, therefore, promoting better health among SMPWDs. This study allowed a better understanding of greater within-group differences. In this diverse, intersectional sample, we examined: (a) the factors that influence life satisfaction and resilience in a sample of SGMPWDs (b) the associations between social support, resilience, and life satisfaction.

More specifically, my research questions and hypotheses are as follows: (1) What are the relationships between ableist microaggressions, sexual orientation microaggressions, self-stigma, perceived social support, resilience, and life satisfaction? (2) To what degree do ableist microaggressions, sexual orientation microaggressions, self-stigma, and perceived social support uniquely predict life satisfaction and resilience? (3) To what degree does perceived social support moderate the relationship between minority stress and resilience? (4) To what degree does perceived social support moderate the relationship between minority stress and life satisfaction?

My first hypothesis was that a relationship exists between minority stressors in the form of ableist microaggressions, sexual orientation microaggressions, and self-stigma; perceived social support, resilience, and life satisfaction. My second hypothesis was that perceived social support would uniquely predict life satisfaction and resilience. My third and fourth hypotheses are that perceived social support will moderate the relationship between ableist microaggressions, sexual orientation microaggressions, self-stigma, and perceived social support, resilience, and life satisfaction.

Method

Participants

G*Power 3.1 (Faulet et al., 2009) was used to determine the minimum sample size required for this research study. For the analysis, the effect size was set at a moderate .15, an alpha of .05, power was set at .80, with six predictors (i.e., ableist microaggressions, sexual orientation microaggressions, self-stigma, and three different types of social support from one's significant other, family, and friends). The recommended sample size was 120 participants (Cohen, 1988; Faulet al., 2009; Hayes, 2013). Based on this input, I recruited a sufficient sample of 286, with 257 valid cases. Participants were 257 sexual minority persons with disabilities, living in the United States.

Participants ranged from 18 to 64 years of age (*M* = 23.70, *SD* = 9.42). The majority of participants (*n* = 155) self-identified as cisgender females. Participants also included cisgender males (*n* = 31), transgender persons (*n* = 39), gender non-binary persons (*n* = 35), and genderqueer persons (*n* = 16). In terms of racial and ethnic identity, the sample self-identified as Indigenous/Alaska Natives (*n* = 7), Asian/Asian American (*n* = 7), African American or Black (*n* = 21), Latino/Latina, or Hispanic (*n* = 16), as Middle Eastern (*n* = 3), Native Hawaiian or Pacific Islander (n = 1), White or European American (*n* = 255), and Biracial or Multiracial (*n* = 12). For sexual orientation, participants identified as lesbian (*n* = 56), gay (*n* = 32), bisexual (*n* = 68), queer (*n* = 91), pansexual (*n* = 30), and asexual (*n* = 11). In terms chronic illness or disability, one participant self-identified as living with an acquired brain injury, attention deficit (*n* = 24) disorder, and with chronic illnesses\medical conditions (*n* = 53). In addition, participants self-identified as Deaf/Hard of Hearing (*n* = 7) as living with a learning disability (*n* =9), a having motor/mobility disability (*n* = 19), the majority self-identified as living with a psychological disability (*n* = 94), and as blind\low vision (*n* = 2) .

Procedure

Formal IRB approval was attained before the start of the study. Participants were recruited through social media platforms, such as Facebook and Instagram, using electronic flyers asking for participation. Participants were not provided compensation for their participation. Participants were required to affirm that they were 18 years old or older, living in the United States; to self-identify as lesbian, gay, bisexual, transgender (if same-sex/gender attracted), pansexual, or queer; and to self-identify as living with a disability. Disability was defined broadly to include brain injury, chronic illness, mobility, vision, hearing impairments, and psychiatric disabilities. The authors acknowledge that gender identity is distinct from sexual identity, and that gender identity likely makes a unique contribution to the minority stress model. Thus, only those transgender persons who also identify as sexual minority persons were included in the study. Participants who were interested in participating were directed to an online survey posted on Qualtrics that they could complete anonymously from any device that was connected to the Internet.

When accessing the link to the survey, participants were given basic information about the survey, its purpose, and the benefits and risks of participation. Participants were asked to provide informed consent by selecting “agree,” signifying that they agree to participate in the study. Upon selecting “agree” participants were directed to the survey. Participants who did not provide informed consent were unable to access the survey. Ethical considerations were followed as students were informed of various risks and benefits and notified of the participation was optional. Participants were also informed of how data was managed and how confidentiality was maintained. Once participants agreed to continue, they were asked to complete the online survey. Participants were provided a brief description of the purpose of the study, inclusion criteria, informed consent, and a URL link to the secure, confidential survey hosted on Qualtrics. The study was Section 508 compliant and accessible to participants with disabilities. Search terms listed for this study "survey," "disability," "counseling," "stress," "LGB," "health," "research," "illness," "impairment," "demographics," and "sexual orientation." Participants did not receive an incentive for their participation.

Measures

Demographic Questionnaire. Participants completed a 10-item demographic survey that included items related to age, gender identity, sexual orientation, relationship status, race/ethnicity, educational level, and ability status.

Ableist Microaggressions Scale (AMS; Conover et al., 2017). The AMS was designed to measure people with disabilities' experiences with microaggressions; it is the only known measure of disability microaggressions (Conover et al., 2017). The AMS was developed over three studies, resulting in a 20-item measure (Conover et al., 2017). Participants are asked about their life experiences with microaggressions on a 6-point Likert-type scale, ranging from 0 (*never*) to 5 (*very frequently*). Scores are averaged across the 20 items, with scores ranging from 0 to 5. Examples of items include "*People minimize my disability or suggest that it could be worse"* and "*People don't see me as a whole person because I have a disability."* Positively worded items are reversed scored (Conover et al., 2017). Cronbach's alpha for the AMS was .94 in this sample of sexual minority adults with physical disabilities (Conover & Israel, 2019). The Cronbach's alpha for the current study was .91.

Brief Resilience Scale (BRS; Smith et al., 2008) assesses participants' abilities to recover easily from stressful experiences (Smith et al., 2008). This scale includes 6-item items and responses were measured on a 5-point scale from *strongly disagree (1)* to *strongly agree (5),* and appropriate items were reverse scored before calculating a mean score (Smith et al., 2008). Sample items include: "*I tend to bounce back quickly after hard times.*" Higher scores on this measure represent higher levels of resilience (Smith et al., 2008). The BRS was developed over four samples, including two student samples and samples with cardiac and chronic pain patients (Smith et al., 2008). The BRS was inversely related to depression, negative affect, physical health disparities, and the presence of social support (Smith et al., 2008). The BRS has been validated on a variety of marginalized populations (e.g., Spanish population (Rodriguez-Rey et al., 2016), a sample of Mexican and Chilean university students (Hidalgo-Rasmussen, 2019), and LGBTQ+ health care professionals (Eliason, 2018). The Cronbach's alpha for the current study was .90.

Self-Stigma Scale-Short Form (SSS-S; Mak & Cheung, 2010). The SSS-S is used as a measure of proximal stress and is a 9-item, self-report instrument that systematically assesses the extent of stigma that concealable minorities may have internalized. This measure utilizes a 4-point Likert-type scale *from (1) "strongly disagree"* to (*4) "strongly agree.".* Participants are given the option not to answer. Example items include, *"My identity is a burden to me"* and "*I feel uncomfortable because I am a SMPWD .*" For this study, the acronym, SMPWD (i.e. sexual minority persons living with a disability) was placed in the blank. Lower scores on the SSS-S indicate a higher amount of self-stigma (Mak & Cheung, 2010).

The final nine-item SSS–S was highly correlated with the 39-item SSS–Long form (Mak & Cheung, 2010. A sample of mental health consumers and another of Hong Kong immigrant women were compared (Mak & Cheung, 2010). In two initial samples, one of mental health service clients in another sample of immigrant women, reliability was listed as .95 and .93, respectively (Mak & Cheung, 2010). The internal consistency of the SSS–S for mental health consumer was great at a Cronbach's alphas of .91 and .84 in immigrant women, which was comparable to the SSS–Long from (Mak & Cheung, 2010). Cronbach's alpha was .97 for mental health consumers and .93 in immigrant women (Mak & Cheung, 2010). The SSS–S was negatively correlated with self-esteem, collective self-esteem, and self-efficacy (Mak & Cheung, 2010). These correlations provided evidence for convergent validity in both mental health consumers and recent immigrants (Mak & Cheung, 2010). Cronbach's alpha of the present study was .88.

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988)**.** The MSPSS is used to assess support from family, friends, and significant other (MSPSS; Zimet et al., 1988)**.** Response options were on a 7-point scale from *very strongly disagree* (1) *to very strongly agree* (7). Averages were calculated for each subscale (MSPSS; Zimet et al., 1988)**.** This measure has been supported with factor analyses and was reliable (Cronbach's alphas of .90 and .94 for family and friend's subscales, respectively (MSPSS; Zimet et al., 1988)**.** A sample item is *I receive invitations to be with other people* (MSPSS; Zimet et al., 1988). Social support was negatively related to anxiety and depression symptoms as significantly inversely related to both depression, *r* = -.24, and anxiety, *r* = -.18. Perceived support from friends was related to depression symptoms, *r* = - .24, but not to anxiety. It was significantly inversely related to both depression, *r* = -.24, , and anxiety, *r* = -.18.

The MPSS has been well-researched (e.g., it has been used with as a sample of sexual minority persons of color (Wise et al., 2019; LGBTQ college students (Moran et al., 2018; a study on resiliency and social support for African Americans (Brown, 2008). For the current study, the Cronbach's alpha was .90 for the full-scale measure, .95 for the significant other, .94 for the friend, and .94 family subscales.

The Satisfaction with Life Scale (SWLS; Diener et al., 1985). The SWLS is being used as a measure of life satisfaction in this study. The SWLS is s 5-item scale designed to measure global cognitive evaluations of life satisfaction, rather than a measure of positive or negative reactions or affect. Participants indicate how much they agree or disagree with each of the 5 items using a 7-point scale that ranges from *7 strongly agree* to *1 strongly disagree.* Sample items include, *If I could live my life over, I would change almost nothing,* and *the conditions of my life are excellent*. Further, life satisfaction, assessed using the SWLS has been validated as a measure of wellbeing among disability populations (e.g., the National Institute on Disability, a sample of over 17,000 people with disabilities (Amtmann, 2019) a sample of veterans living with spinal cord injuries (Ames et al., 2017); a sample of gender, racial, and sexual minority persons (Prempas, 2015); and a group of Black sexual minority persons (Thomas, 2017). For the current study, the Cronbach's alpha was .91.

Sexual Orientation Microaggressions Scale (SOMS; Nadal, 2019). The SOMS was created based on qualitative studies on the experiences of LGBTQ with microaggressions (e.g., Nadal et al., 2011). The SOMS was developed over three studies, resulting in a 24-item measure. The 24-item SOMS yielded five components: (1) Microinvalidations, (2) Assumption of Pathology, (3) Heterosexist Language, (4) Enforcement of Binary Gender Roles, and (5) Environmental Microaggressions. A sample item includes, "*Someone has tried to keep their children from coming into physical contact with me because of my sexual orientation."* Participants were instructed to indicate whether they experienced a microaggression event at least once in the last six months (i.e*., 1 indicates yes, and scores of 0 indicates no*). The overall SOMS yielded a Cronbach's alpha of .91, with strong alphas for each component: .94 for Subscale 1, .85 for Subscale 2, .88 for Subscale 3, .88 for Subscale 4, and .8 for Subscale 5 (Nadal, 2019). The Cronbach's alpha for this sample was .79.

Data Diagnostics and Analytic Strategy

A total of 276 participants were recruited and completed the survey. Outliers and missing data were first evaluated. Two participants who identified as heterosexual were removed from the data set since the focus of the study was sexual minority persons. Additionally, 2 cases were deleted for having significant amounts of missing data. Casewise diagnostics were utilized to check residuals for bias. Two cases exceeded a Cook's distance greater than 1 and were removed. Mahalonobis distance was used to access for multivariate outliers (Tabachnick & Fidell, 2012; Field, 2013). Three cases were identified as outliers using Mahalonobis' criterion of 27.62 (χ^2 critical value for 6 degrees of freedom, $p = .001$), and removed from the data set. Once the outliers were removed, all diagnostics indicated that the data were reliable and none of the separate models were influenced by any individual case or outlier. The survey contained accuracy checks, where participants were instructed to select a specific answer in response to an item. Seven participants failed to answer the questions correctly and were dropped from the data set, leaving a total of 257 participants.

IBM SPSS Version 25 was used to analyze all data. All study variables were found to be in the satisfactory range for skewness and kurtosis (i.e., skewness ≤ 3, kurtosis ≤ 10; Weston & Gore, 2006). Afterward, descriptive statistics (e.g., means, standard deviations, and bivariate correlations) were used to address the first research question. Afterward, I used two separate hierarchical regression analyses to approach the second research question. Predictors were entered into the two separate regression models in two blocks based on theoretically supported literature (Field, 2013). More specifically, under minority stress theory (1995, 2003) and the psychological framework (Hatzenbuehler, 2009), distal and proximal stressors, ableist microaggressions, sexual orientation microaggressions, and self-stigma were entered into the regression model at step 1, and social support was entered in step 2, for each of the two outcomes, life satisfaction and resilience.

Before interpreting the models, violations of assumptions of independence, homogeneity of variance, multicollinearity, linearity, normality, homoscedasticity, and bias were assessed for each regression outcome (i.e., life satisfaction and resilience). Homoscedasticity was present as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values for life satisfaction and resilience. Multicollinearity was evaluated using the variance inflation factor (VIF), with VIFs well under 10 for both hierarchical regressions, and therefore acceptable (Myers, 1990). Linearity and homogeneity of variance were analyzed using scatterplots. The Durbin-Watson statistic with resilience as the outcome variable was 1.67 while Durbin-Watson statistic with life satisfaction as the outcome variable was 1.88, indicating that the assumption for independent errors were met. Before conducting moderation analysis, violations of assumptions of independence, homogeneity of variance, multicollinearity, linearity, normality, homoscedasticity, and bias were assessed for each regression outcome (i.e., life satisfaction and resilience). All assumptions were satisfied.

Results

For the first research question, bivariate correlations indicated statistically significant relationships between study variables (see Table 2 for full details). Consistent with minority stress theory, ableist microaggressions and self-stigma were significantly correlated with life satisfaction. Surprisingly, sexual orientation microaggressions had a small, positive correlation with life satisfaction. Life satisfaction yielded a significant, moderate negative correlation with self-stigma(r = -.39, p <.001). Perceived social support from a significant other (r = .29, p <.001), as well as from friends (r = .29, p <.001) both yielded a small, but statistically significant positive correlation with life satisfaction. Perceived social support from family members was moderately positively correlated (r = .34, p < .001) with life satisfaction. Life satisfaction also moderately and positively correlated with resilience (r = .48, p < .001). Resilience was moderately negatively correlated (r = -.29, p < .001) with ableist microaggressions and self-stigma (r = -.32, p < .001) , and is positively correlated with (r = .18, p < .001).

Two separate blockwise hierarchical multiple regression analyses were then employed for each of the outcome variables: life satisfaction and resilience. Predictor valuables were entered in two steps for each of the two separate regression outcomes, life satisfaction and resilience. Minority stressors, ableist microaggressions, sexual orientation microaggressions, and self-stigma were entered into the first block for each regression outcome. This was done to control for distal and proximal minority stressors, according to minority stress theory (Meyer, 2015). The three sources of perceived social support (i.e., support from a significant other, family member, or friend) were entered into the second block for each regression outcome.

For life satisfaction as the outcome variable, each step yielded a significant model (see Table 3). Ableist and sexual orientation microaggressions, and self-stigma were all significant predictors in step 1, accounting for approximately 22.1% of the variance. Adding the three dimensions of social support (i.e., social support from a significant other, family member, and friend) significantly changed the model in step 2, $\Delta F(3, 255) = 9.49$, p = .001, $\Delta R^{2 =}$ .078.

Ableist microaggressions and self-stigma remained statistically significant predictors in step 2. Together, these six predictors accounted for 29.9% of the variance.

For the second research question related to resilience (Table 4), ableist and sexual orientation microaggressions, and self-stigma, were all significant predictors in step 1, accounting for approximately 14.5% of the variance. The model in step 2 was nonsignificant after adding the three dimensions of social support (i.e., social support from a significant other, family member, and friend). Social support did not significantly change the model, Δ F(3 , 250) = .717, p = .543, $\Delta R^{2\,=}$ .007. Thus, social support did not uniquely predict resilience. Together, these six predictors accounted for 15.2.% of the variance.

For the third research question, I conducted a moderation analyses using the Hayes' PROCESS Macro on SPSS (Hayes, 2013) to determine whether perceived social support moderated the relationship between minority stressors: ableist microaggressions, sexual orientation microaggressions, self-stigma, and life satisfaction. The interaction term between ableist microaggressions and social support was not significant, b = -.0014, 95% CI [-.0049, .0022], t = -.7658, p = .44, indicating that the relationship between ableist microaggressions is not moderated by social support. Relatedly, the interaction term between sexual orientation microaggressions and social support was nonsignificant, b =.0013, 95% CI [-.0059, .0285], t = 1.2911, p = .1978. Thus, the relationship between distal stressors: ableist and sexual orientation microaggressions is not moderated by social support. The relationship between proximal stressor, self-stigma, was also nonsignificant, b = .0113, 95% CI [-.0059, .0285], t = 1.2911, p = .6353.

For the fourth research question, I conducted a moderation analyses using the Hayes' PROCESS Macro on SPSS (Hayes, 2013) to determine whether perceived social support moderated the relationship between minority stressors: ableist microaggressions, sexual orientation microaggressions, self- stigma and resilience. The interaction term between ableist microaggressions and social support was nonsignificant, b = .0004, 95% CI [.- 0023, .0031], t = .3084, p = .7580. The interaction term between sexual orientation microaggressions and social support was nonsignificant, b = . 0088, 95% CI [-.0043, .0219] t = 1.328, p = .1852. Finally, the relationship between proximal stressor, self-stigma, was also nonsignificant, b = .-0016, 95% CI [-.0103, .0285], t = 1.2911, p = .071.

Discussion

Minority stress theory (Meyer, 2003) and the psychological framework (Hatzenbuehler, 2009) were employed in the present study to illuminate how stress and stigma impact life satisfaction and resilience among SMPWDs. Research centering intersectional populations, such as SMPWDs, is sorely needed to advance our understanding of minority stress and multiple minority stress (Bowleg et al., 2003; Remedios & Snyder, 2015). As is recommended, this study is intentionally focused on a specific intersection of identities (i.e., sexual minority persons living with disabilities) in relation to specific constructs, rather than demographic comparisons (Parent et al., 2013). SMPWDs may face increased mental and physical health risks (Fredriksen-Goldsen et al., 2012, 2014) as compared to nondisabled heterosexual persons. Life satisfaction and resilience are strength-based constructs that are important to study to understand factors that promote positive functioning among SMPWDs.

As minority stress theory (Meyer 1995, 2003) and the psychological framework (Hatzenbuehler, 2009) suggest, proximal and distal minority stressors, ableist microaggressions and self-stigma, had a significant, negative relationship with life satisfaction. Life satisfaction also had a positive relationship with the three dimensions of social support (i.e., social support from a significant other, family member, or friend). This finding indicates that as social support increases, so does life satisfaction. An unexpected finding was the positive relationship between sexual orientation microaggressions and life satisfaction. While correlations are not causal, this surprising finding appears to be consistent with Conover and Israel (2019). Conover and Israel (2019) found that SMPWDs continue to be satisfied with the disability community, despite experiencing sexual orientation microaggressions. These results are consistent with Conover and Israel's (2019) findings that SMPMDs remain content with the disability community despite experiencing sexual orientation microaggressions. SMPWDs likely do not expect to have their sexual minority identity affirmed within the disability community. An alternate consideration is that SMPWDs may find disability communities difficult to locate and to access. Therefore, for SMPWDs, maintaining relationships within the disability community may be a priority over one that also affirms sexual minority identity. Further, friendships with other persons living with disabilities have been shown to positively affect mood and life satisfaction (Silverman et al., 2017).

Current study results indicate that despite experiences with minority stressors, ableist and sexual orientation microaggressions, and self-stigma, SMPWDs reported being satisfied with their lives and being resilient. However, perceived social support did not appear to promote or predict resilience among SMPWDs. This finding suggests that while social support has long been associated with bolstering resilience and wellbeing (Hatzenbuehler, 2009; Kwon, 2013; Meyer, 2015), social support may only be able to bolster resilience when there is low to moderate amounts of adversity and stress (Robbins et al., 2018). Further, Robbins and colleagues noted that a longitudinal study of adults who experienced higher lifelong levels of adversity were not resilient, despite having social support. In contrast, individuals who experienced lifelong stress and adversity at low to moderate levels were noted as resilient. Sexual orientation microaggressions had a small, but significant positive relationship with resilience, which may support Meyer’s (2015) assertion that sexual minority persons mount responses to survive and thrive, despite experiencing stress.

Perceived social support from significant others and family members produced greater life satisfaction among SMPWDs, while perceived social support from friends did not life satisfaction. This is aligned with literature, indicating that social support, particularly from families, has been identified as an important promotive factor among (McConnell et al., 2016). However, when facing rejection from family members, friendships become essential sources of social support as SMPs often develop “chosen families,” consisting of sexual and gender minority persons (Hunter et al., 2020; Levitt et al., 2016; McConnell et al., 2016).

Relatedly, three separate moderation analyses were conducted for each of the two outcome variables, life satisfaction and resilience. None of the moderation analyses yielded significant results. Social support did not moderate the relationship between minority stress, stigma, and life satisfaction and resilience (i.e., the interaction between minority stress and social support social does not strengthen or weaken the relationship between these constructs). This finding is consistent with Conover and Israel (2019) and suggests that intersectional populations, such as SMPWDs may face greater complexity when accessing social support or may need higher amounts of social support. For instance, Hunter and colleagues (2020) found that SGMPWDs that needed assistance with activities of daily living (e.g., grooming, toileting, transportation) faced the possibility of social support being withdrawn as punishment once they disclosed their sexual or gender minority identities. Alternatively, social support may not buffer against the harmful effects of multiple minority stress among SMPWDs. This result suggests there may be a stress threshold above which social support ceases to be effective against the deleterious effect of multiple minority stress.

Implications for Counseling and Counselor Education

Strength-based approaches to counseling PWDs emphasize an individual’s positive characteristics, rather focusing on perceived deficits has long been a core value of rehabilitation counselors and counselor educators (Smedema and Tansey, 2015). Findings from the current study indicate perceived social support from significant others and family members increases life satisfaction among SMPWDs, while social support from friends does not, so counselors should assess SMPWDs’ support system early in the counseling relationship. These results comport studies that indicate clinicians can help SMPWDs bolster life satisfaction and social support through interventions such as family and couples/ partner counseling (Smedema, 2017). Family and partner counseling can be used to help clients navigate issues around acceptance of disability and sexual identities and to improve life satisfaction.

Though the results of this study suggest that social support from friends does not increase life satisfaction, it may be that intersectional populations, such as SMPWDs contend with added challenges related to inaccessibility and attitudinal barriers when attempting to access social support from potential friends. Thus, counselor educators should be aware that while SMPWDs do benefit from friendships with other PWDs, those friendships are only beneficial when disability is viewed positively (Silverman et al., 2017; Smedema, 2017). More specifically, research shows that persons living with disabilities benefit from social support from friendships with others who share the same disability type (Silverman et al., 2017). It is important to note that friendships with persons who share the same diagnosis are only beneficial when the friend has a positive disability identity. Thus, clinicians should assess where clients are located on sexual and disability identity development models, to help them identify affirming networks. In addition to assisting clients identify affirmative social support networks, counselors should employ stress-reducing activities with clients. Present study results could mean that higher levels of stress appear to lower resiliency among SMPWDs. Therefore, mental health professionals should employ appropriate mindfulness and relaxation techniques to assist clients in reducing stress.

Persons living with disabilities represent the largest minority group in the United States, at 56.7 million (US Census Bureau, 2016). Despite being the largest minority group and broader conceptualizations of identity in the counseling field, multicultural courses rarely include discussions about disability (Rivas, 2020). When disability is discussed, it is seldom framed appropriately as an element of diversity (Pieterse et al., 2009). Therefore, counselor educators should advocate for disability training across the counselor education curriculum (Chapin et al., 2018) for a more robust, contextualized understanding of the experiences of PWDs across the lifespan. A nuanced understanding of the psychosocial and identity development needs is particularly important when working with intersectional populations, such as SMPWDs. Counselor educators should also examine their own biases regarding disability and sexual minority identities, as well as the dynamics of power and privilege, impacting counselor education and practice (Chapin et al., 2018). Drawing attention to protective factors, such as life satisfaction and resilience, when working with SMPWDs, allows us to move beyond understanding the factors that decrease well-being to those that increase it. This approach supports positive adaptation among multiple minority clients.

Limitations

The current study must be considered in light of some limitations. First, study participants were recruited through online, social media platforms so only those individuals who had access to a computer, the Internet, and a social media platform, were included. Second, the data used in this study were correlation and cross-sectional; therefore, it only assessed the participant's experiences at a given time. Third, though current measures provide meaningful information, the development of specific measures, normed on SMPWDs may be able to capture additional nuances related to intersectional experiences otherwise missed by employing single-identity measures.

Future Research Implications

This study supports the continued examination of positives psychological constructs within the minority stress (Meyer, 2003) and the psychological framework (Hatzenbuehler, 2009). Additional studies focused on intersectional population, for example, sexual minority persons of color are needed to deepen our understanding of study variables among diverse populations. Relatedly, this study was limited to sexual minority persons, so studies centering the unique perspective of trans and gender diverse persons in relation to minority stress would deepen our understanding of within-group differences. The researchers acknowledge that gender identity makes a unique contribution to stress-related research, thus, future research should include studies focused on transpersons and other gender-expansive communities. Study results suggest there may be a limit to the amount of stress endured by SMPWDs before social support becomes ineffective, so future research studies should examine how levels of stress impact the effectiveness of social support among SMPWDs. Future research utilizing longitudinal designs would allow for the identification of causal relationships among study variables.

Conclusion

Previous studies have suggested the minority stress contributes to negative psychological outcomes among marginalized and multiple marginalized communities (Hatzenbuehler, 2009; Meyer 2003), but research-based on positive psychology constructs is less prevalent. This study illuminated the need for additional attention to protective functions that may buffer against threats to well-being and resilience, among multiple marginalized populations, such as SMPWDs. This study sought to respond to the research call to shift the focus from psychopathology to better understanding contributors to positive functioning among multiple minority populations, such as SMPWDs, by examining strength-based constructs, life satisfaction resilience (Kwon, 2013; Riggle et al., 2008).

References

American Psychological Association (APA). (2012a). Guidelines for assessment of and intervention with persons with disabilities. *American Psychologist, 67,* 43–62. http://dx.doi.org/10.1037/a0025892

American Psychological Association (APA). (2012b). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67,* 10–42. http://dx.doi.org/10.1037/a0024659

Ames, H., Wilson, C., Barnett, S. D., Njoh, E., & Ottomanelli, L. (2017). Does functional motor incomplete (AIS D) spinal cord injury confer unanticipated challenges? *Rehabilitation Psychology*, *62*(3), 401-406. https://doi.org/10.1037/rep0000146

Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

Amtmann, D., Bocell, F. D., Bamer, A., Heinemann, A. W., Hoffman, J. M., Juengst, S. B., ... & McMullen, K. (2019). Psychometric properties of the Satisfaction with Life Scale in people with traumatic brain, spinal cord, or burn injury: a National Institute on Disability, Independent Living, and Rehabilitation Research Model System Study. *Assessment*, *26*(4), 695-705. https://doi.org/10.1177/1073191117693921

Asakura, K. (2017). Paving pathways through the pain: A grounded theory of resilience among lesbian, gay, bisexual, trans, and queer youth. *Journal of Research on Adolescence, 27*(3), 521–536. https://doi.org/10.1111/jora.12291

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultural Diversity and Ethnic Minority Psychology*, *17*(2), 163-174. https://doi.org/10.1037/a0023244

Barth, J., Schneider, S., & Von Känel, R. (2010). Lack of social support in the etiology and the prognosis of coronary heart disease: a systematic review and meta-analysis. *Psychosomatic medicine*, *72*(3), 229-238. https://doi: 10.1097/PSY.0b013e3181d01611

Brooks, V. R. (1981). *Minority stress and lesbian women*. Free Press. Meyer

Brown, D. L. (2008). African American resiliency: Examining racial socialization and social support as protective factors. *Journal of Black Psychology*, *34*(1), 32-48. https://doi.org/10.1177/0095798407310538

Conover, K. J., & Israel, T. (2019). Microaggressions and social support among sexual minorities with physical disabilities. *Rehabilitation Psychology*, 64(2), 167-178. https://doi.org/10.1037/rep0000250

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017). Development and validation of the ableist microaggressions scale. *The Counseling Psychologist*, *45*(4), 570-599. https://doi.org/10.1177/0011000017715317

Cyrus, K. (2017). Multiple minorities as multiply marginalized: Applying the minority stress theory to LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, 21(3), 194-202. https://doi.org/10.1080/19359705.2017.1320739

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75. https://doi.org/10.1207/s15327752jpa4901_13

Douglass, R. P., Conlin, S. E., Duffy, R. D., & Allan, B. A. (2017). Examining moderators of discrimination and subjective well-being among LGB individuals. *Journal of Counseling Psychology*, *64*(1), 1-11. https://doi.org/10.1037/cou0000187

Duke, T. S. (2011). Lesbian, gay, bisexual, and transgender youth with disabilities: A meta-synthesis. *Journal of LGBT Youth*, *8*(1), 1-52. https://doi.org/10.1080/19361653.2011.519181

Eliason, M. J., Martinson, M., & Carabez, R. M. (2015). Disability among sexual minority women: Descriptive data from an invisible population. *LGBT Health*, *2*(2), 113-120. https://doi.org/10.1089/lgbt.2014.0091

Emerson, E. (2010). Self-reported exposure to disablism is associated with poorer self-reported health and well-being among adults with intellectual disabilities in England: A cross-sectional survey. *Public Health*, 124(12), 682-689. https://doi.org/10.1016/j.puhe.2010.08.020

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Sage.

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European psychologist*, *18*(1), 12-23. https://doi.org/10.1027/1016-9040/a000124

Fredriksen-Goldsen, K. I., Kim, H. J., & Barkan, S. E. (2012). Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk. *American Journal of Public Health*, *102*(1), e16-e21. https://dx.doi.org/10.2105/AJPH.2011.300379

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2014). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American journal of public health*, *103*(10), 1802-1809. https://doi.org/10.2105/AJPH.2012.301110

Ganguly, R., & Perera, H. N. (2019). Profiles of psychological resilience in college students with disabilities. *Journal of Psychoeducational Assessment, 37*(5), 635-651. https://doi.org/10.1177/0734282918783604

Harley, D. A., Alston, R. J., & Turner-Whittaker, T. (2008). Social Justice and Cultural Diversity Issues. *Rehabilitation Education, 22*, 237-248. https://doi.org/10.1891/088970108805059264

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, *135*(5), 707-730. https://doi.org/10.1037/a0016441

Hayes, A. F., Montoya, A. K., & Rockwood, N. J. (2017). The analysis of mechanisms and their contingencies: PROCESS versus structural equation modeling. *Australasian Marketing Journal (AMJ)*, *25*(1), 76-81. https://doi.org/10.1016/j.ausmj.2017.02.001

Hidalgo-Rasmussen, C., Molina, T., Molina, R., Sepúlveda, R., Martínez, V., Montaño, R., ... & George, M. (2015). Influence of bullying on the quality of life perception of Chilean students. *Revista medica de Chile, 143*(6), 716-723. https://doi.org/10.4067/s0034-98872015000600004

Hilliard, M. E., McQuaid, E. L., Nabors, L., & Hood, K. K. (2015). Resilience in youth and families living with pediatric health and developmental conditions: Introduction to the special issue on resilience. *Journal of Pediatric Psychology*. 40(9):835-9. https://doi.org/10.1093/jpepsy/jsv072

Herek, G. M. (2015). Beyond "homophobia": Thinking more clearly about stigma, prejudice, and sexual orientation. *American Journal of Orthopsychiatry, 85*(5S), S29-37. https://doi.org/10.1037/ort0000092

Hunter, T., Dispenza, F., Huffstead, M., Suttles, M., & Bradley, Z. (2020). Queering Disability: Exploring the Resilience of Sexual and Gender Minority Persons Living With Disabilities. *Rehabilitation Counseling Bulletin*, 0034355219895813. https://doi.org/10.1177/0034355219895813

Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *Journal of Youth and Adolescence*, *41*(7), 831-846. https://doi.org/10.1007/s10964-012-9756-9

Itzick, M., Kagan, M., & Tal-Katz, P. (2018). Perceived social support as a moderator between perceived discrimination and subjective well-being among people with physical disabilities in Israel. *Disability and Rehabilitation*, *40*(18), 2208-2216. https://doi.org/10.1080/09638288.2017.1331380

Kaufman, T. M., Baams, L., & Dubas, J. S. (2017). Microaggressions and depressive symptoms in sexual minority youth: The roles of rumination and social support. *Psychology of Sexual Orientation and Gender Diversity*, *4*(2), 184–192. https://doi.org/10.1037/sgd0000219

Keller, R. M., & Galgay, C. E. (2010). Keller, R. M., & Galgay, C. E. (2010). *Microaggressive experiences of people with disabilities.* In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (241–267). John Wiley & Sons Inc.

Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *American Journal of Orthopsychiatry, 79*(4), 500–510. https://doi.org/10.1037/a0016848

Kool, M. B., van Middendorp, H., Lumley, M. A., Bijlsma, J. W., & Geenen, R. (2013). Social support and invalidation by others contribute uniquely to the understanding of physical and mental health of patients with rheumatic diseases. *Journal of Health Psychology, 18,* 86–95. https://dx.doi.org/10.1177/1359105312436438

Kulick, A., Wernick, L. J., Woodford, M. R., & Renn, K. (2017). Heterosexism, depression, and campus engagement among LGBTQ college students: Intersectional differences and opportunities for healing. *Journal of Homosexuality, 64*(8), 1125-1141. https://doi.org/10.1080/00918369.2016.1242333

Kwon, P. (2013). Resilience in lesbian, gay, and bisexual individuals. *Personality and Social Psychology Review, 17,* 371-383. http://dx.doi.org/10.1177/1088868313490248

Folkman, S., Lazarus, R. S. (1984). Stress, Appraisal, and Coping. Ukraine: Springer Publishing Company.

Levitt, H. M., Horne, S. G., Herbitter, C., Ippolito, M., Reeves, T., Baggett, L. R., ... & Geiss, M. (2016). Resilience in the face of sexual minority stress: “Choices” between authenticity and self-determination. *Journal of Gay & Lesbian Social Services, 28*(1), 67-91. https://doi.org/10.1080/10538720.2016.1126212

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8*(5), 521-548. https://doi.org/10.1177/1745691613497965

Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71,* 543-562. http://dx.doi.org/10.1111/1467-8624.00164

Mak, W. W., & Cheung, R. Y. (2010). Self-stigma among concealable minorities in Hong Kong: conceptualization and unified measurement. *American Journal of Orthopsychiatry, 80*(2), 267-81. https://doi.org/10.1111/j.1939-0025.2010.01030.x

Matsuno, E., & Israel, T. (2018). Psychological interventions promoting resilience among transgender individuals: Transgender resilience intervention model (TRIM). *The Counseling Psychologist, 46*(5), 632-655. https://doi.org/10.1177/0011000018787261

McCabe, P. C., Dragowski, E. A., & Rubinson, F. (2013). What is homophobic bias anyway? Defining and recognizing microaggressions and harassment of LGBTQ youth. *Journal of School Violence, 12*(1), 7-26. https://doi.org/10.1080/15388220.2012.731664

McConnell, E. A., Janulis, P., Phillips, G., II, Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 1–12. https://dx.doi.org/10.1037/sgd0000265

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 36(1) 38-56. https://doi.org/10.1080/09638288.2017.1331380

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697. http://dx.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. https://dx.doi.org/10.1037/sgd0000132

Meyer, I. H., Ouellette, S. C., Haile, R., & McFarlane, T. A. (2011). "We'd Be Free": Narratives of Life Without Homophobia, Racism, or Sexism. *Sexuality research & social policy: journal of NSRC*, *8*(3), 204–214. https://doi.org/10.1007/s13178-011-0063-0

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

Myers, R. H. (1990). *Classical and Modern Regression with Applications*. United States: Duxbury/Thompson Learning.

Nadal, K. L. (2019). Measuring LGBTQ Microaggressions: The Sexual Orientation Microaggressions Scale (SOMS) and the Gender Identity Microaggressions Scale (GIMS). *Journal of Homosexuality*, *66*(10), 1404-1414. https://doi.org/10.1080/00918369.2018.1542206

Nguyen, T. Q., Bandeen-Roche, K., German, D., Nguyen, N. T., Bass, J. K., & Knowlton, A. R. (2016). Negative treatment by family as a predictor of depressive symptoms, life satisfaction, suicidality, and tobacco/alcohol use in Vietnamese sexual minority women. *LGBT Health*, *3*(5), 357-365. https://doi.org/10.1089/lgbt.2015.0017

Pierce, C., & Carew, J. Pierce-Gonzalez, D., & Willis, D.(1978). An experiment in racism: TV commercials. *Television and education,* 10(1), 62-88. https://doi.org/10.1177/001312457701000105

Pitcher, E. N. (2017). 'There's stuff that comes with being an unexpected guest': Experiences of trans* academics with microaggressions. *International Journal of Qualitative Studies in Education, 30*(7), 688-703. https://doi.org/10.1080/09518398.2017.1309588

Prempas, J. D. (2014). *Role of Mindfulness and Acceptance on the Life Satisfaction of Gender, Racial, and Sexual Minorities*. (Identifier FSU_migr_etd-9233) [Doctoral dissertation, Florida State University]. Retrieved from: http://purl.flvc.org/fsu/fd/FSU_migr_etd-9233

Remedios, J. D., & Snyder, S. H. (2015). Where do we go from here? Toward an inclusive and intersectional literature of multiple stigmatization. *Sex Roles: A Journal of Research*, 73(9–10), 408–413. https://dx.doi.org/10.1007/s11199-015-0543-4

Rodríguez-Rey, R., Alonso-Tapia, J., & Hernansaiz-Garrido, H. (2016). Reliability and validity of the Brief Resilience Scale (BRS) Spanish Version. *Psychological Assessment*, *28*(5), e101–e110. https://doi.org/10.1037/pas0000191

Sheets, R. L., Jr., & Mohr, J. J. (2009). Perceived social support from friends and family and psychosocial functioning in bisexual young adult college students. *Journal of Counseling Psychology*, *56*(1), 152–163. https://doi.org/10.1037/0022-0167.56.1.152

Silverman, A. M., Molton, I. R., Smith, A. E., Jensen, M. P., & Cohen, G. L. (2017). Solace in solidarity: Disability friendship networks buffer well-being. *Rehabilitation Psychology, 62*(4), 525–533. https://doi.org/10.1037/rep0000128

Smedema, S. M., & Tansey, T. N. (2015). Mediators of the relationship between core self-evaluations and life satisfaction in individuals with spinal cord injuries. *Rehabilitation Counseling Bulletin*, *58*(4), 217-226. https://doi.org/10.1177/0034355214554608

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine*, *15*(3), 194-200. https://doi.org/10.1080/10705500802222972

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American psychologist, 62*(4), 271-286. Retrieved from https://psycnet.apa.org/buy/2007-07130-001

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Upper Saddle River, NJ: Pearson.

Tatum, A. K. (2016). Proximal minority stress processes and subjective well-being of leathermen. *Psychology of Sexual Orientation and Gender Diversity*, *3*(3), 374–379. https://dx.doi.org/10.1037/sgd0000189

Wang, J., Leu, J., & Shoda, Y. (2011). When the seemingly innocuous "stings" racial microaggressions and their emotional consequences. *Personality and Social Psychology Bulletin, 37*(12), 1666-1678. https://doi.org/10.1177/0146167211416130

Wise, A. E., Smith, B. C., Armelie, A. P., Boarts, J. M., & Delahanty, D. L. (2019). Age moderates the relationship between source of social support and mental health in racial minority lesbian, gay, and bisexual youth. *Journal of Health Psychology, 24*(7), 888-897. https://doi.org/10.1177/1359105316686667

Woodford, M. R., Kulick, A., Sinco, B. R., & Hong, J. S. (2014). Contemporary heterosexism on campus and psychological distress among LGBQ students: The mediating role of self-acceptance. *American Journal of Orthopsychiatry, 84*(5), 519–529. https://dx.doi.org/10.1037/ort0000015

Yaghmaian, R., & Miller Smedema, S. (2019). A feminist, biopsychosocial subjective well-being framework for women with fibromyalgia. *Rehabilitation Psychology, 64*(2), 154. https://doi.org/10.1037/rep0000226

Zimet, G. D., Powell, S. S., Farley, G. K., Werkman, S., & Berkoff, K. A. (1990). Psychometric characteristics of the multidimensional scale of perceived social support. *Journal of*

Personality Assessment, *55*(3-4), 610-617.

https://doi.org/10.1080/00223891.1990.9674095

Table 1

Demographic Data for Participants

Variable	n	%
Gender Identity		
Cisgender Female	155	56%
Cisgender Male	31	11%
Transgender	39	14%
Gender Non-Binary	35	13%
Gender Queer	16	6%
Race/Ethnicity*		
American Indian/Alaska Native	7	2%
Asian/Asian American	7	2%
African American/Black	21	7%
Latino/Latina/Hispanic	16	6%
Middle Eastern	3	1%
Native Hawaiian/Pacific Islander	1	.3%
White or European American	256	88%
Biracial/Multiracial	12	4%
Sexual Orientation		
Lesbian	56	20%
Gay	32	11%
Bisexual	68	24%
Queer	91	32%
Pansexual	30	11%
Asexual	9	3%
Chronic Illness/Disability		
Acquired Brain Injury / TBI	1	.3%
Attention Deficit Disorder	24	8%
Chronic/Other Medical Health	53	19%
Deaf/Hard of Hearing	7	2%
Learning Disability	9	3.1%
Motor/Mobility Disability	19	7%
Psychological Disability	94	33%
Blind/Low Vision	2	.7%

**Note*. Participants could select more than one Race/Ethnicity and Chronic Illness/Disability categories, so added percentages may exceed 100%.

Table 2.

Means, Standard Deviations, and Correlations for Study Constructs

	M	*SD*	AMS	SOMS	SSS	MSPSS SO	MSPSS FAM	MSPSS FRI	BRS	SWLS
1. AMS	58.13	17.24	---							
2. SOMS	31.07	3.71	-.399**	---						
3. SSS	17.49	5.58	.269**	-.210**	---					
4. MSPSSSO	18.87	5.07	-.088	-.005	-.196**	----				
5. MSPSSFAM	13.43	5.87	-.338**	.257**	-.288**	.264**	---			
6. MSPSSFRI	17.93	4.32	-.095	.104	-.340**	.575**	.284**	---		
7. BRS	16.42	5.54	-.297**	.177**	-.313**	.070	.180**	.180**	---	
8. SWLS	19.71	7.96	-.355**	.201**	-.387**	.292**	.338**	.251**	.477**	---

Note. p <.05 = * p <.01 = ** in the table, n = 257

AMS = Ableist Microaggressions Scale, SOMS = Sexual Orientation Microaggressions Scale, SSS = Self-Stigma Scale, MSPSS = Multidimensional Survey for Perceived Social Support; SO = Significant Other, FAM = Family, FRI = Friend, BRS = Brief Resilience Scale, SWLS = Satisfaction With Life Scale.

Table 3

Hierarchical Linear Regression Analyses for Life Satisfaction

Step	Construct	*b*	*SE*	β	*p*	$R^2\Delta$	*F*	*p*
Step 1	Constant	33.771	5.148		<.001	.221	24.436	<.000
	AMS	-.130	.029	-.282	<.001			
	SOMS	.026	.130	.012	.840			
	SSS	-.421	.082	-.296	<.001			
Step 2	Constant	22.278	5.508		<.001	.078	18.171	<.000
	AMS	-.108	.028	-.234	<.001			
	SOMS	.020	.126	.010	.872			
	SSS	-.327	.084	-.230	<.001			
	MSPSSSO	.380	.103	.243	<.001			
	MSPSSFAM	.197	.080	.146	.015			
	MSPSSFRI	-.062	.126	-.034	.625			

AMS = Ableist Microaggressions Scale, SOMS = Sexual Orientation Microaggressions Scale, SSS = Self-Stigma Scale, MSPSS = Multidimensional Survey for Perceived Social Support; SO = Significant Other, FAM = Family, FRI = Friend, BRS = Brief Resilience Scale, SWLS = Satisfaction With Life Scale.

Step	Construct	*b*	*SE*	β	*p*	$R^2\Delta$	*F*	*p*
Step 1	Constant	23.451	3.818		<.001	.145	14.251	<.000
	AMS	-.067	.021	-.208	.002			
	SOMS	.039	.097	.026	.689			
	SSS	-.248	.061	-.251	<.001			
Step 2	Constant	21.246	4.296		<.001	.007	7.460	<.000
	AMS	-.066	.022	-.206	.003			
	SOMS	.026	.098	.018	.788			
	SSS	-.216	.065	-.218	<.001			
	MSPSSSO	-.029	.079	-.027	.714			
	MSPSSFAM	.023	.062	.024	.711			
	MSPSSFRI	.124	.097	.097	.205			

Table 4

Hierarchical Linear Regression Analyses for Resilience

AMS = Ableist Microaggressions Scale, SOMS = Sexual Orientation Microaggressions Scale, SSS = Self-Stigma Scale, MSPSS = Multidimensional Survey for Perceived Social Support; SO = Significant Other, FAM = Family, FRI = Friend, BRS = Brief Resilience Scale, SWLS = Satisfaction With Life Scale.

APPENDICES

APPENDIX A

Recruitment Email
Dear (insert name of listserv):

My name is Tameeka Hunter, and I am a doctoral student at Georgia State University. I am interested in hearing from Lesbian, Gay, Bisexual, Transgender (if same sex/gender attracted) persons for a research study. The purpose of the study is to look at how being lesbian, gay, bisexual, transgender and/or queer (LGBTQ) with condition or chronic illness, resulting in a physical disability, affects your life.

You are asked to be in this study because you are 18 years or older and living in the United States; self-identify as lesbian, gay, bisexual, transgender (if same-sex/gender attracted), pansexual, or queer; and self-identify as a person who has a condition or chronic illness, resulting in a physical disability; and feel you have been able to get through tough things in life.

If you decide to participate, you asked to complete a questionnaire that will take approximately 20-40 minutes to complete. The survey completed with an online through the Qualtrics website. All information you provide kept confidentially. The survey includes questions about disability, sexual orientation, etc., so please take the online survey in a private place. Please make sure to close your computer when you finish the survey. We hope to get approximately 500 people to be in this this study.

If interested in participating, please contact Tameeka Hunter at thunter8@gsu.edu.

Sincerely

Tameeka Hunter
Doctoral Student
Department of Counseling and Psychological Services
College of Education
Georgia State University

APPENDIX B

DEMOGRAPHIC SURVEY

DEMOGRAPHICS

1. Age: (You must be 18 years or older to participate in this survey): ________________

2. Identified Gender: _____Male ____Female ___Transgender ___Gender Non-Binary ___ Genderqueer ____[ ] My preferred choice is not listed (please specify): ____

3. What term best describes your sexual orientation?
   [ ] Lesbian
   [ ] Gay
   [ ] Bisexual
   [ ] Queer
   [ ] Pansexual
   [ ] My preferred choice is not listed (please specify):
   ____

4. Are you single or partnered?
   Single
   [ ] Partnered
   [ ] My preferred choice is not listed (please specify):
   ____

5. Race and/or Ethnicity: Categories reflective of the most recent US Federal Census. Please check ALL that apply.
   [ ] American Indian and Alaska Native
   [ ] Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, My preferred choice is not listed Asian)
   [ ] Black (African American, African, Atlantic Islander, Indian Islander)
   [ ] Hispanic or Latino (Mexican, Puerto Rican, Cuban, My preferred choice is not listed Hispanic or Latin descent)
   [ ] Middle-Eastern
   [ ] Native Hawaiian and My preferred choice is not listed Pacific Islander
   [ ] South-central Asian
   [ ] White (Anglo, European descent)
   [ ] Biracial/Multi-racial
   [ ] In terms of race and/or ethnicity, I think of myself differently from those offered above. I refer to myself as:____

EDUCATION

6. What is the highest (most advanced) degree you have COMPLETED at this time? Do not include degrees that are in progress.

( ) I do not have any degrees at this time
( ) High School Diploma, G.E.D. or My preferred choice is not listed certificate for completion of secondary level education
( ) A Certificate, Describe:
____
( ) A.A., A.A.S. or My preferred choice is not listed Associate's degree. Describe:
____
( ) B.S., B.A., B.I. or My preferred choice is not listed Bachelor's degree. Describe:
____
( ) M.A., M.S., M.S.W, M.Ed. or My preferred choice is not listed Master's degree.
Describe:_____________________________________
( ) Ph.D., Ed.D., J.D., MD, or My preferred choice is not listed Doctorate degree.
Describe: ______________________________________
( ) Other? Please specify degree:
____

7. Do you identify as person who experiences disability and/or who is D/deaf?
   ( ) Yes, I personally experience disability
   ( ) At times, I personally experience disability
   ( ) No, I do not consider myself experience disability
   ( ) Other? Explain:
   ____

8. If you identify as a person who experiences disability and/or who is D/deaf, please indicate which of the following best describes your disability/diagnos(es). Please check all that apply:
   [ ] Acquired Brain Impairment
   [ ] Attention-Deficit/Hyperactivity Disorder (ADHD) Chronic Illness/Medical
   [ ] Deaf-blind
   [ ] Deaf /Hard of Hearing
   [ ] Intellectual Disability
   [ ] Learning Disabilities
   (e.g. a specific learning disability in reading, math, written expression)
   [ ] Motor/Mobility Impairment (e.g. Cerebral Palsy, Muscular Dystrophy, Essential Tremor Syndrome, etc.)
   [ ] Psychological/Psychiatric
   [ ] Blind/Low Vision
   [ ] Other:
   ____

9. rehabilitation services, but would like to, what are the top three of the barriers to your participation?

10. What do you want people to understand about being a member of the LGBTQ community, while living with chronic illness/disability?

APPENDIX C

Ableist Microaggression Scale

(Conover et al., 2017)

1. People feel they need to do something to help me because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

2. People express admiration for me or describe me as inspirational simply because I live with a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

3. People express pity for me because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

4. People do not expect me to have a job or volunteer activities because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

5. People offer me unsolicited, unwanted, or unneeded help because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

6. People are unwilling to accept that I have a disability because I appear able-bodied.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

7. People minimize my disability or suggest that it could be worse.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

8. People act as if accommodations for my disability are unnecessary.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

9. People don't see me as a whole person because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

10. People act as if I am nothing more than my disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

11. People speak to me as if I am a child or do not take me seriously because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

12. People assume I have low intelligence because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

13. Because I have a disability, people attempt to make decisions for me that I could make myself.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

14. People think I should not date or pursue sexual relationships because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

15. People indicate that they would not date a person with a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

16. People suggest that I cannot or should not have children because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

17. People stare at me because I have a disability.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

18. Because I have a disability, people seem surprised to see me outside my home.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

19. Because I have a disability, people assume I have an extraordinary gift or talent.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

20. People suggest that living with a disability would not be a worthwhile existence.

Never	**Very Rarely**	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
0	1	2	3	4	5

APPENDIX D

Sexual Orientation Microaggressions Scale

(Nadal, 2019)

Participants are instructed to indicate whether they have experienced each event at least once in the last six months (i.e., 1 indicates yes, and scores of 0 indicates no).

1. I was told I was overreacting when I confronted someone about their heterosexist behaviors / slights.

YES	**NO**
1	0

2. I have been told that I should stop complaining about heterosexism.

YES	**NO**
1	0

3. When I thought something was heterosexist or homophobic, a heterosexual person provided alternative rationales.

YES	**NO**
1	0

4. When I thought something was heterosexist or homophobic, a heterosexual person disagreed with me.

YES	**NO**
1	0

5. Someone told me that I was oversensitive when it came to LGBTQ issues.

YES	**NO**
1	0

6. Someone has responded defensively when I pointed out their homophobic language.

YES	**NO**
1	0

7. I have been told I was being paranoid when I thought someone was being heterosexist.

YES	**NO**
1	0

8. Someone has tried to keep their children form coming into physical contact with me because of my sexual orientation.

YES	**NO**
1	0

9. Someone has assumed I have HIV or AIDS because of my sexual orientation.

YES	**NO**
1	0

10. Someone assumed that I would be a child molester or sexual predator because of my sexual orientation.

YES	**NO**
1	0

11. Someone has avoided sitting next to me because of my sexuality.

YES	**NO**
1	0

12. A friend has stopped talking to me after finding out about my sexuality.

YES	**NO**
1	0

13. People have made negative comments or jokes about LGBTQ people in my presence without realizing my sexual orientation.

YES	**NO**
1	0

14. I have heard the term “That’s so gay” when someone was talking about something negative.

YES	**NO**
1	0

15. People have used terms like “fag/dyke/queer/homo” in front of me.

YES	**NO**
1	0

16. I have heard a person call someone else “gay” because she/he was “weird” or “different.”

YES	**NO**
1	0

17. People have made insensitive gay or lesbian jokes in front of me.

YES	**NO**
1	0

18. I have been criticized about not wearing clothes that are typical for my gender.

YES	**NO**
1	0

19. I have been criticized about the way I dress because I choose clothes that are different than people of my gender.

YES	**NO**
1	0

20. I have been told to act more “masculine” or “feminine.”

YES	**NO**
1	0

21. I have seen LGBTQ people portrayed positively in magazines.

YES	**NO**
1	0

22. I have seen LGBTQ people portrayed positively in movies.

YES	**NO**
1	0

23. I have seen LGBTQ people portrayed positively on television.

YES	**NO**
1	0

24. I have seen advertisements/commercials that include same-sex couples.

YES	**NO**
1	0

APPENDIX E

Self-Stigma Scale
Scale (Mak, & Cheung, 2010)

Note: Sexual Minority Person Living with a Disability (SMPWD)

1. My identity as a person with a SMPWD is a burden to me

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

2. My identity as a SMPWD causes struggles in my daily life.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

3. The identity of being a SMPWD taints my life.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

4. I feel uncomfortable because I am a SMPWD.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

5. I fear that others would know that I am a SMPWD.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

6. I feel like I cannot do anything about being a SMPWD, and that bothers me..

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

Behavioral

7. I estrange myself from others because I am a SMPWD.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

8. I avoid interacting with others because I am a SMPWD.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

9. I dare not to make new friends lest they find out that I am a SMPWD.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1	2	3	4

APPENDIX F

Multidimensional Scale of Perceived Social Support

(Zimet et al. 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

> Circle the “1” if you Very Strongly Disagree; Circle the “2” if you Strongly Disagree; Circle the “3” if you Mildly Disagree; Circle the “4” if you are Neutral; Circle the “5” if you Mildly Agree; Circle the “6” if you Strongly Agree; Circle the “7” if you Very Strongly Agree

1. There is a special person who is around when I am in need.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

2. There is a special person with whom I can share joys and sorrows.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

3. My family really tries to help me.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

4. I get the emotional help & support I need from my family.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

5. I have a special person who is a real source of comfort to me.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

6. My friends really try to help me.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

7. I can count on my friends when things can go wrong.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

8. I can talk about my problems with my family.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

9. I have friends with whom I can share my joys and sorrows.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

10. There is a special person in my life who cares about my feelings.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

11. My family is willing to help me make decisions.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

12. I can talk about my problems with my friends.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6	7

APPENDIX G

Satisfaction with Life Scale

(Smith et al., 2008)

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

1. In most ways my life is close to my ideal.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

2. The conditions of my life are excellent.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

3. I am satisfied with my life.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

4. So far, I have gotten the important things I want in life.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

5. If I could live my life over, I would change almost nothing.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

APPENDIX H

The Brief Resilience Scale

(Diener et al., 1985)

1. I tend to bounce back quickly after hard times.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

2. I have a hard time making it through stressful events.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

3. It does not take me long to recover from a stressful event.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

4. It is hard for me to snap back when something bad happens.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

5. I usually come through difficult times with little trouble.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

6. I tend to take a long time to get over set-backs in my life.

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1	2	3	4	5

APPENDIX I

Georgia State University
Department of Counseling and Psychological Services
College of Education

INFORMED CONSENT FORM – ONLINE SURVEY (SML)

Title: Predictors of Well-being and Resilience for Sexual Minority Persons with Physical Disabilities (SMPWDs)

Principal Investigator:	Franco Dispenza, PhD, CRC
Principal Student Investigator:	Tameeka Hunter, MS, LPC, NCC,CRC

I. Purpose:

You are being asked to be in a research study. The purpose of the study is to look at how being lesbian, gay, bisexual, transgender and/or queer (LGBTQ) with condition or chronic illness, resulting in a physical disability, affects your life. You are asked to be in this study because you are 18 years or older and living in the United States; self-identify as lesbian, gay, bisexual, transgender (if same-sex/gender attracted), pansexual, or queer; and self-identify as a person who has a condition or chronic illness, resulting in a physical disability; and feel you have been able to get through tough things in life.

II. Procedures:

If you decide to participate, you will be asked to complete a questionnaire that will take approximately 20-40 minutes to complete. The survey will be completed with an online through the Survey Monkey website. All information you provide will be kept confidentially. The survey includes questions about disability, sexual orientation, etc., so please take the online survey in a private place. Please make sure to close your computer when you finish the survey. We hope to get approximately 500 people to be in this this study.

III. Risks:

We do not think there will be any big risks with this study. Some people may feel uncomfortable when answering the questions. You can stop being in this study at any time. If you feel uncomfortable, here is the contact information for: Substance Abuse & Mental Health Services Administration's (SAMHSA) National Helpline

1-800-662-HELP (4357)
TTY: 1-800-487-4889
Website: www.samhsa.gov/treatment/natHelpFAQs.aspx

Also known as the Treatment Referral Routing Service, this Helpline provides 24-hour free and confidential treatment referral and information about mental and/or substance use disorders, prevention, and recovery in English and Spanish.

IV. Benefits:

Participation in this study may not benefit you. But, we hope to learn more about how being lesbian, gay, bisexual, transgender and/or queer (LGBTQ) with a disability/chronic illness affects your life.

V. Voluntary Participation and Withdrawal:

You do not have to be in this study. If you decide to be in the study and then change your mind, you have the right to stop at any time. You may skip questions or stop being a part of the study at any time. No matter what you decide, you will not lose any benefits you would normally get.

VI. Confidentiality:

We will keep your records private as the law requires. Dr. Franco Dispenza and Tameeka Hunter will have access to the information you provide. Information may also be shared with people who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP)). We will use a study number, not your name, on study records. The information you provide will be stored in a locked office on password- and firewall-protected computers. Your name and other facts that could identify you will not appear when we present this study or publish its results.

VII. Contact Persons:

Contact Dr. Franco Dispenza at 404-413-8174 or FDispenza1@gsu.edu if you have questions, concerns, or complaints about this study. You can also call if think you have been harmed by the study. Call Susan Vogtner in the Georgia State University Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu if you want to talk to someone who is not part of the study team. You can talk about questions, concerns, or suggestions about the study. You can also call Susan Vogtner if you have questions or concerns about your rights in this study.

VIII. Copy of Consent Form to Subject:

If you agree to participate in this research, please continue with the survey. You may print a copy of this form for your records.