THE IMPACT OF VERBAL VICTIMIZATION ON PSYCHOPATHOLOGY IN LGB YOUTHS WHO HAVE EXPERIENCED TRAUMA: THE ROLES OF SELF-CRITICISM AND INTERNALIZED HOMOPHOBIA

A dissertation submitted to Kent State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

by

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CHAPTER 1

INTRODUCTION

Research has indicated that lesbian, gay, and bisexual (LGB) individuals are significantly more likely than heterosexual individuals to be at risk for mental health and behavioral difficulties (see Meyer, 2003 for a meta-analytic review). There is evidence that this mental health disparity may be larger in LGB youth than in LGB adults. LGB youth report experiencing psychological symptoms, such as depression and anxiety, significantly more often than their heterosexual peers (D’Augelli, 2002; Faulkner & Cranston, 1998; Feurgusson, Horwood, & Beautrais, 1999; Lock & Steiner, 1998, Remafedi, French, Story, Resnick, & Blum, 1998; Saewyc, Bearinger, Heinz, Blum, & Resnick, 1998; Safren, & Heimberg, 1999; Safren, & Pantalone, 2006; Ueno, 2005). They are also more likely than heterosexual youths to engage in health risk behaviors including alcohol and substance use (Bontempo, & D’Augelli, 2002; Faulkner & Cranston, 1998; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Remafedi, 1994; Robin et al., 2002; Rosario, Meyer-Bahlburg, Hunter, & Gwadz, 1999; Rotheram-Boris, Marelich, & Srinivasan, 1999; Rotheram-Boris, Rosario, Meyer-Bahlburg; 1994; Rotheram-Borus, Rosario, Van Rossem, Reid, & Gillis, 1995; Russell, Driscoll, & Truong, 2002), high-risk sexual behavior that could lead to HIV and/or other sexually transmitted infections (Bontempo & D’Augelli, 2002, Garofalo et al., 1998; Remafedi,
1994, Rosario et al, 1999; Rotheram-Boris, Hunter, & Rosario, 1994), and unhealthy weight control practices (Robin et al., 2002). Additionally, high rates of suicide attempts have been consistently found among LGB youths (D’Augelli & Hershberger, 1993; D’Augelli, Hershberger, & Pilkington, 2001; Garofalo et al., 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, Farrow, & Deisher, 1991; Rotheram-Boris et al., 1994; Schneider, Farberow, & Kurks, 1989).

The high levels of psychological and behavioral problems found in LGB youth have been proposed to stem from social stress that LGB individuals experience due to being members of a highly stigmatized minority group. The social stressors experienced by LGB individuals occur quite frequently, and include both objective (e.g., discrimination, victimization, trauma) and subjective events (perceptions of stigma, internalized homophobia: Meyer, 1995, 2003). Most of the work examining social stress among LGB individuals has focused on the experiences of LGB adults, and most of what is known about LGB youths has been gleaned from LGB adults’ retrospective reports. More recently, however, LGB individuals have been disclosing their sexual orientation or “coming out” much earlier than previous cohorts (Savin-Williams, 1990, 1995), and given the prevalence of mental health issues in this group, LGB youth have been the subject of growing research attention.

Most of the studies conducted with LGB youth to date have focused on identifying prevalence rates of social stressors for this population. These studies have indicated that LGB youth may be at higher risk than LGB adults for experiencing certain objective social stressors, most notably physical, sexual, and verbal victimization (e.g.,
Bontempo & D’Augelli, 2002; D’Augelli, 2002; D’Augelli, Grossman, & Starks, 2006;
Faulkner & Cranston, 1998; Hershberger, & D’Augelli, 1995; Pilkington & D’Augelli,
1995; Saewyc et al., 2006). Given that LGB youth are at high risk for experiencing
victimization, more research is needed to guide prevention and intervention efforts.

Prevalence of Victimization among LGB Youths

Adolescents and young adults are more likely than individuals in any other age
group to experience victimization (US Department of Justice, 2006). In comparison to
youths in the general population, rates of victimization among LGB youths are
disproportionately high (e.g., Pilkington & D’Augelli, 1995). LGB youth experience
victimization in many different settings, including the home, school, and the community.
In general, children and adolescents are limited in their ability to alter their social
environment. Therefore, these youths are often “stuck” with their families, schools, and
communities even if they are sources of victimization, and are usually unable to leave
these environments in the way that adults are able to (e.g., move away from a
stigmatizing community). Given the high rates of victimization found among LGB
youths and their likely inability to change their environment, they may be vulnerable to
repeated victimization.

Physical Victimization

LGB youth are at high risk for experiencing physical violence, and they are more
likely than their heterosexual peers to report being physically attacked in their home, in
school, and in the community (Pilkington & D’Augelli, 1995; Saewyc et al., 2006).
Studies involving LGB youth attending lesbian, gay, bisexual, and transgender (LGBT) community centers indicate that 15-40% of these youths have experienced physical victimization, with up to 12% having suffered physical attacks with a weapon (D’Augelli, 2002; Hunter, 1990; Pilkington & D’Augelli, 1995; D’Augelli, Grossman, & Sparks, 2006).

Many of the physical attacks experienced by LGB youth occur at home. Retrospective research with adults indicates that LGB individuals are more likely than heterosexual adults to report being physically maltreated by parents as a child (Corliss, Cochran, & Mays, 2002). Research with LGBT community center attendees has found that approximately 18% of lesbian and bisexual females and 8% of gay and bisexual males reported being physically attacked by a family member (Pilkington & D’Augelli, 1995). Saewyc and colleagues (2006) examined prevalence of physical abuse in a sample of both LGB and heterosexual youths from population based high school surveys taken from 7 schools in the United States and Canada. They found that LGB youth were more likely to report physical abuse in their family than were heterosexual youth, with lesbian and bisexual females reporting abuse most often. In contrast to studies involving LGBT community center samples, much higher rates were found in this study: as many as 20-33% of gay and bisexual boys reported being physically victimized by a family member. Girls in general reported a higher prevalence of physical victimization at home than boys with any type of sexual orientation, but lesbian and bisexual girls were twice as likely as their peers to report this experience.
LGB youth also report being physically victimized in the school environment as well. LGBT community center based studies have found that 22% of gay and bisexual males and 19% of lesbian and bisexual female reported being physically harmed at school due to others knowing or assuming their sexual orientation. School-based surveys have indicated that LGB youth experience significantly more victimization at school than do heterosexual youth (Bontempo & D’Augelli, 2002). Faulkner and Cranston (1999) found that LGB youth report significantly greater exposure to physical violence, and also that they were three times more likely than heterosexual youth to report not going to school because they felt unsafe. LGB youth have been twice as likely to report being threatened with a weapon while at school (Faulkner and Cranston, 1999), and approximately 6 percent of LGB youth have actually been assaulted with a weapon (D’Augelli, 2002). Additionally, LGB youth were more likely than their heterosexual peers to be in 10 or more physical fights within the past year (Faulkner, & Cranston, 1999).

Sexual Victimization

As with physical victimization, rates of sexual victimization have also been found to be elevated among LGB youth. Nationally representative studies have estimated that between 3-16% of men (regardless of sexual orientation) report childhood sexual abuse (Finkelhor, Hotaling, Lewis, and Smith, 1990; Molnar, Buka, & Kessler, 2001; Rind, & Tromovitch, 1997). In comparison, rates of sexual victimization are much higher in samples of gay and bisexual men both from convenience and representative samples (20 – 39%; Doll et al., 1992, Lenderking et al, 1997; Paul, Catania, Pollack, & Stall, 2001).
Results from several studies directly involving LGB youth have confirmed the retrospective data provided by LGB adults regarding risk for sexual abuse. In youth recruited from LGBT community centers, rates of sexual victimization have been found to range from 16-54% (D’Augelli, 2002; D’Augelli, 2006; Hershberger, & D’Augelli, 1995; Pilkington & D’Augelli, 1995; Rosario, Schrimshaw, & Hunter, 2006). In one such study, D’Augelli, Grossman, and Starks (2006) asked LGB youths to report sexual abuse that they felt occurred because of their sexual orientation. Fourteen percent of gay and bisexual male youth and 7% of lesbian and bisexual female youth reported that they had been sexually victimized for this reason. The vast majority of the youth in this study (97%) reported feeling very distressed by the sexual abuse that they had experienced. In addition, Pilkington and D’Augelli (1995) found that 22% of LGB youth reported a sexual assault occurring because someone knew or assumed that they were lesbian, gay, or bisexual.

High rates of sexual victimization among LGB youth have also been found in studies employing representative school-based surveys. Saewyc and colleagues (2006) compared rates of sexual victimization in LGB and heterosexual youth. Females were more likely than males to report sexual victimization, with lesbian and bisexual females being more likely than heterosexual or mostly heterosexual females to report being sexually victimized (25-50% for lesbian and bisexual females versus 10-25% for heterosexual and mostly heterosexual females). While male youth in this study were found to experience significantly less sexual abuse than females as a whole, examined separately, gay and bisexual males’ rates of sexual abuse were close to those of lesbian
and bisexual females. Less than 10% of heterosexual or mostly heterosexual male youth reported sexual abuse versus 20% of gay and 25% of bisexual male youth.

**Verbal Victimization**

By far, the most prevalent form of victimization for LGB youth occurs verbally. Studies indicate that as many as 78% of LGB youth have been verbally victimized due to their sexual orientation, with over one-half (54%) suffering from verbal victimization on three or more occasions. As with other forms of victimization, verbal victimization occurs frequently in and out of the home. At home, reports of verbal victimization have ranged from being called “sissies” or “tomboys” for perceived gender atypical behavior (D’Augelli et al., 2006) to being threatened with physical harm (Berrill, 1990). Pilkington and D’Augelli (1995) found that over one third of their sample of LGB youth had been verbally victimized by a family member. Additionally, Berrill (1990) found that approximately 19-41% of LGB individuals report experiencing verbal victimization at home.

As with physical and sexual victimization, the school environment often provides another source of verbal victimization for LGB youths. Recent research by the Gay, Lesbian, and Straight Education Network (GLSEN, 2006) indicated that in 2005 up to 64% of the 1732 polled LGB high school students reported being verbally victimized at school because of their sexual orientation. Other studies from LGBT community centers indicate that between 30 and 35% of LGB youth reported experiencing verbal victimization at school (Pilkington & D’Augelli, 1995).
In sum, LGB youth are likely to experience high levels of physical, sexual, and verbal victimization in many different environments. Therefore, it is important to examine what is known about the impact of these experiences on the mental health of LGB youth.

Consequences of Victimization among LGB Youths

Consequences of Physical and Sexual Victimization

The high rates of victimization directed towards LGB youth because of their sexual orientation are alarming given that victimization during childhood and adolescence can contribute to or lead to the onset of numerous psychological and behavioral problems. In particular, interpersonal trauma, such as physical or sexual victimization, often confers risk for developing posttraumatic stress disorder (PTSD, American Psychiatric Association, 1994; Rodriguez, Ryan, Rowan, & Foy, 1996; Schaaf & McCanne, 1998). In order for individuals to meet diagnostic criteria for PTSD, they must experience an event that involves actual or threatened death or serious physical injury to the self or others, and must respond with intense fear, helplessness, or horror (APA, 1994). To receive a PTSD diagnosis, individuals must report three categories of symptoms: re-experiencing symptoms (e.g., intrusive thoughts, flashbacks), avoidance and numbing symptoms (e.g., avoidance of thoughts and feelings, emotional numbness), and hyperarousal symptoms (e.g., trouble sleeping, irritability). Individuals who experience an interpersonal trauma, such as physical or sexual victimization, are more likely to develop PTSD symptoms than are individuals who suffer another form or
trauma (e.g., natural disaster), particularly if the victim has a history of prior interpersonal trauma (Breslau et al., 1999, Kessler et al., 1995; Resnick et al., 1993). Since LGB youth are at high risk for experiencing interpersonal traumas, it is likely that PTSD diagnoses and symptoms will be more prevalent among this population.

Depression is another common reaction following interpersonal trauma in childhood (e.g., Boudewyn & Leim, 1995; Gibb et al., 2001; Silverman, Reinherz, & Giaconia, 1996). The National Comorbidity Survey (NCS) identified PTSD and depression as being highly comorbid, with approximately 48% of participants with a PTSD diagnosis also meeting criteria for major depressive disorder (Kessler et al., 1995). Additionally, research with women who have been sexually (Beichtman et al., 1992; Weiss, Longhurst, & Mazure, 1999) or physically victimized (Duncan, Saunders, Kilpatrick, Hanson, & Resnick, 1996) during childhood has shown that they are at greater risk for developing depression than women who did not experience physical or sexual victimization. Research with adolescents and young adults who have a history of childhood victimization indicates that they are 3 times more likely than individuals without a history of victimization to become depressed and to be suicidal (Brown, Cohen, Johnson, & Smailes, 1999).

While not much is known empirically about the impact of anti-gay motivated victimization on psychopathology, studies have found patterns of consequences that are similar to interpersonal trauma in general. In LGB adults, experiences of physical and sexual victimization have been significantly associated with depressive symptoms, anxiety symptoms, and PTSD symptoms (Herek, Gillis, & Cogan, 1999; Herek, Gillis,
Cogan, & Glunt, 1997). Similar patterns have been found within samples of LGB youth. D’Augelli (2002) found that anti-gay victimization was significantly related to general psychological distress, including depression symptoms. In addition, in the only published study to examine the relationship between PTSD and anti-gay victimization among LGB youth, D’Augelli and colleagues (2006) found that this form of victimization was related to higher rates of PTSD symptoms and diagnoses. Diagnostic interviewing with the youth in this study indicated that nine percent met full criteria for a PTSD diagnosis, while self-report measures indicated high levels of sub-clinical PTSD symptoms. A nine percent prevalence of PTSD in this sample is quite high compared to the estimated prevalence of PTSD diagnoses in children and adolescents in the general population (e.g., < 1%; Copeland, Keeler, Angold, & Costello, 2007), indicating that LGB youths may be at higher risk than their peers for developing PTSD.

Consequences of Verbal Victimization

Compared to physical and sexual victimization, verbal victimization has not received as much attention in the empirical literature. Kaplan and colleagues (Kaplan, Pelcovitz, & Labruna, 1999) have suggested that fewer research studies have investigated verbal victimization because it is likely to be viewed as less severe and/or less traumatic than physical or sexual victimization. Data suggest that this is not always the case, as some studies have found that verbal victimization may have an even more significant relationship with long-term negative psychological outcomes than other forms of victimization (Kaplan et al., 1999). For example, verbal victimization was found to have a stronger relationship with internalizing and externalizing behaviors, social impairment,
low self-esteem, suicidal behavior, and psychiatric disorders than physical victimization (e.g., Gore-Felton, Koopman, McGarvey, Hernandez, & Canterbury, 2001; McGee, Wolfe, & Wilson, 1999; Mullen, Martin, Anderson, Romans, & Herbison, 1996, Vissing, Straus, Gelles, & Harrop, 1991). Additionally, parental verbal victimization during childhood has been found to increase risk for experiencing a wide range of affective and anxiety disorders (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006), and has been significantly related to personality disorders (Gibb, Wheeler, Alloy, & Abramson, 2001; Johnson et al., 2001).

While verbal victimization is the most common form of victimization experienced by LGB youth, only a small amount of research has examined its consequences. The available studies with LGB youth suggest that being verbally victimized because of one’s sexual orientation is linked with general mental health symptoms including depression (D’Augelli, 2002), and increased risk of suicide attempts in LGB youth (D’Augelli, 2005; Hershberger et al., 1997). Additionally, being verbally victimized regarding one’s sexual orientation has been associated with increased rates of PTSD symptoms in LGB youth who have experienced a traumatic event (D’Augelli et al., 2006).

It should be noted that although verbal victimization has been found to occur independently of other forms of victimization, it is also likely to co-occur with other forms (Claussen & Crittenden, 1991). Research suggests that individuals who experience more than one form of victimization suffer more negative psychological consequences than individuals who have experienced one form of victimization. For example, a study investigating the additive impact of physical, sexual, and emotional abuse found that
individuals who experienced all three types were more likely than those that experienced one or two forms of abuse to attempt suicide (82% vs. 52% and 57% respectively: Anderson, Tiro, Price, Bender, & Kaslow, 2002).

Although intuitively the additive impact of different forms of victimization makes sense, there has been very little empirical work examining how multiple forms of victimization interact with one another to increase risk for psychopathology. It is possible that each form of victimization contributes to or increases risk for psychopathology in different ways. For example, research has found that verbal victimization is more likely than physical or sexual victimization to contribute to a negative cognitive style, which in turn increases risk for many different emotional problems, such as depression (Gibb, 2002). Therefore, development of a negative cognitive style may be a psychological mechanism specific to verbal victimization. It is possible that experiencing verbal victimization in addition to other forms of trauma (e.g., physical and sexual abuse) can lead to increased risk for subsequent psychopathology, for example depression and PTSD, through its contribution to a negative cognitive style. Since a high percentage of LGB youths report verbal victimization, it is important to examine whether verbal victimization can contribute to increased symptoms of PTSD and depression in LGB youths who have experienced trauma.
Psychological Mechanisms Related to Verbal Victimization

Cognitive Theory and Negative Cognitive Style

Although to date there have been no studies examining mechanisms by which verbal victimization leads to psychological distress in LGB youth, there have been studies conducted with non-LGB identified participants that can provide valuable information as to possible psychological mechanisms. The majority of the studies examining mechanisms related to verbal victimization have utilized cognitive theories of psychopathology. Cognitive theory (Beck, 1964, 1987) has provided much insight into processes that contribute to the development of psychological and behavioral problems. According to this theory, the way individuals interpret events, not the events themselves, determine how individuals will respond and adjust. For example, if an individual perceives an event as being stressful or traumatic, he or she will be more likely to experience distress than an individual who perceives an event to be less stressful or traumatic. Based on Cognitive theory (Beck, 1964, 1987), individuals develop patterns of how they view events, and additionally how they view themselves, based on earlier life experiences. Early negative experiences, such as verbal victimization, may therefore lead to the development of a stable, maladaptive style of cognitions, known as a negative cognitive style. This type of cognitive style has been associated with predicting future outcomes as negative and attributing failure to one’s lack of self-worth or lack of ability, which, in turn, increases risk for the development of psychopathology (Abramson et al., 1987).
Verbal victimization has been linked to the development of a negative cognitive style in several studies. Rose and Abramson (1992) hypothesized that, compared to physical and sexual victimization, verbal victimization is more likely to be related to the development of a negative cognitive style because it provides victims with words that they can incorporate into cognitions about the self. According to this hypothesis, the more individuals are verbally victimized, and the more they hear abusive and criticizing things, the more likely they are to internalize these experiences. Several research studies have supported this hypothesis. In a review of the literature examining the relationship between verbal, physical and sexual victimization, and negative cognitive styles, Gibb (2002) found that verbal abuse and sexual abuse (only in samples of older female adults), but not physical abuse, were significantly related to the presence of a negative cognitive style. Additionally verbal victimization was found to predict negative changes in children’s cognitive style (Gibb et al., 2006).

Research has indicated that negative cognitive styles can also mediate the relationship between verbal victimization and negative psychological outcomes. For example, negative cognitive styles have been found to explain a significant amount of variance in the relationship between childhood verbal victimization and major depression episodes in adulthood (Gibb et al., 2001b). Additionally, negative cognitive styles have been found to mediate the relationship between verbal victimization and suicidality in a college student sample (Gibb et al., 2001a). In these studies, cognitive style only mediated the relationship between verbal victimization and suicidality; it did not mediate relationships involving physical or sexual victimization.
Most of the studies linking verbal victimization and negative cognitive style examined verbal victimization stemming from parents or other relatives, but research has also demonstrated that verbal abuse from outside of the family is likely to contribute to the development of a negative cognitive style as well. In Gibb’s (2002) review, he indicated that the relationship between verbal victimization and negative cognitive styles is stronger for individuals who experience verbal victimization by both family and non-family member perpetrators. Research has also demonstrated that verbal victimization from peers predicts a significant amount of variance in negative cognitive styles when entered into the same regression equation with parental emotional maltreatment (Gibb, Abramson, & Alloy, 2004). The combination of verbal abuse by relatives and non-relatives (such as peers) may be particularly relevant for LGB youths since they often report experiencing verbal abuse in many different settings (e.g., home, school, community; e.g., Pilkington & D’Augelli, 1995).

**Self-Criticism**

While negative cognitive styles have been found to be a potent risk factor for depression (Alloy et al., 1999), one aspect of a negative cognitive style, self-criticism, has been found to be related to a wide range of psychopathology. The self-critical aspect of cognitive styles is seen as an enduring personality trait that can be characterized by self-scrutiny and negative self-evaluation (Blatt, Quinlan, Chevron, Mcdonald, & Zuroff, 1982; Blatt & Zuroff, 1992). Self-criticism has been positively associated with numerous mental health and behavioral difficulties including depression (Shahar, Gallagher, Blatt, Kupermine, & Leadbeater, 2004), social phobia (Cox, Fleet, & Stein,
posttraumatic stress disorder (PTSD: Cox, MacPherson, Enns, & McWilliams 2004), interpersonal problems (Mongrain, Vettese, Schuster, & Kendal, 1998), and high negative/low positive affect and distress (e.g., Zuroff, Moskowitz, & Cote, 1999). Although most of the research examining cognitive styles as a whole has focused on depression, self-criticism appears to confer risk for many different internalizing disorders (including anxiety disorders); therefore the relationship between verbal victimization and self-criticism warrants further study with LGB youths due to disproportionate rates of psychopathology in many domains.

As with negative cognitive styles in general, verbal victimization has demonstrated a significant relationship to the more specific construct of self-criticism as well. A recent study with a nationally representative sample indicated that self-criticism fully mediated the relationship between verbal abuse and internalizing disorders (i.e., both mood and anxiety disorders) (Sachs-Ericsson et al, 2006). Sexual victimization only partially mediated this relationship in this study and physical victimization did not mediate the relationship between self-criticism and negative psychological outcomes.

*Internalized Homophobia*

Although verbal victimization is significant for LGB individuals, no studies have examined psychological mechanisms associated with verbal victimization in this population. It is possible that victimization leads to negative outcomes in ways that are similar to individuals in the general population (e.g., self-criticism), but since many LGB youth also experience victimization specifically related to their sexual orientation, there might be mechanisms that are specific to verbal victimization in LGB youth. Research
suggests that many LGB individuals struggle with internalized homophobia. Internalized homophobia has been described as an internalization of society’s negative view of LGB orientations, so that LGB individuals develop negative attitudes and distress related to their own sexual orientation (Malyon, 1981-1982). It is likely that LGB individuals who experience verbal victimization related to their sexual orientation will experience higher levels of internalized homophobia than those who do not, although there has not yet been an empirical investigation of this relationship.

The development of internalized homophobia is important to consider when investigating the mental health of LGB youth because it has been significantly related to several negative mental and behavioral outcomes. For example, significant associations have been found between internalized homophobia, and depression, anxiety, substance use, eating disorders, and HIV risk behaviors (DiPlacidio, 1998; Meyer & Dean, 1998; Williamson, 2000). Additionally, there is evidence that internalized homophobia is related to higher rates of PTSD and depression symptoms in gay men who had experienced sexual assault (Gold, Marx, & Lexington, 2006).

Verbal victimization in LGB youth may contribute to both self-criticism and internalized homophobia. It is possible that these two constructs will mediate the relationship between verbal victimization and psychopathology among these youth. Additionally, if verbal victimization occurs in addition to other forms of trauma (e.g., physical and/or sexual victimization), subsequent self-criticism and internalized homophobia may contribute to higher rates of depression and PTSD symptoms.
**Present Study**

The present study examined the relationships between verbal victimization, self-criticism, internalized homophobia, and PTSD and depression in LGB youths who have experienced trauma. Based on prior research, it was hypothesized that verbal victimization would lead to higher levels of depression and PTSD, and would do so by contributing to the development of self-criticism and internalized homophobia. This would be the first study to examine psychological mechanisms related to verbal victimization among LGB youth. It is hoped that this study will help to clarify the nature of co-occurring forms of victimization and trauma in LGB youth, specifically whether verbal victimization could contribute to increased post-traumatic distress via psychological mechanisms thought to be specific to verbal forms of victimization. More specifically, several hypotheses were tested in the present study: 1) Verbal victimization would be positively associated with PTSD and depression symptoms; 2) Verbal victimization would be positively associated with self-criticism and internalized homophobia; 3) Self-criticism and internalized homophobia would be positively associated with PTSD and depression symptoms; and 4) Self-criticism and internalized homophobia would serve as mediators of the relationship between verbal victimization, and PTSD and depression symptoms. Additionally, exploratory analyses were conducted to investigate whether relative and non-relative verbal victimization would add incrementally above the other in their prediction of self-criticism, internalized homophobia, depressive symptoms, and PTSD symptoms. Further, the incremental
impact of self-criticism and internalized homophobia on depressive and PTSD symptoms was also examined.
CHAPTER 2

METHODS

Participants

One hundred and two youth were recruited from a lesbian, gay, bisexual, transgender (LGBT) community center in a large Midwestern city as part of a larger project examining trauma, depression, and risk behaviors among LGBT youths. All youth attending the community center who could speak and read English were eligible to participate in the project. In order to test the study’s hypotheses, only participants who endorsed being LGB, and who reported experiencing a traumatic event, were included in the analyses. Of the 102 youth who participated in the larger project, 72 identified as being LGB and reported prior experience of a traumatic event. Of those 72 participants, 7 did not complete questionnaires that were central to the study’s hypotheses, and were excluded from the analyses. The final sample included 65 participants. See Table 1 for a description and comparison of sociodemographic characteristics for both the excluded and retained samples. The only significant difference found was in level of employment: individuals who were excluded from the study were more likely to have a lower level of employment than participants who were retained in the study.
Table 1. Sociodemographic Characteristics of the Excluded and Retained Samples

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Retained (n=65)</th>
<th>Excluded (n=37)</th>
<th>F or $\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, Mean (SD)</td>
<td>19.71 (2.11)</td>
<td>19.22 (2.42)</td>
<td>$F(1,101) = 1.149$</td>
<td>.29</td>
</tr>
<tr>
<td>Gender, n (%)</td>
<td></td>
<td></td>
<td>$\chi^2(1) = 1.357$</td>
<td>.24</td>
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<tr>
<td>Male</td>
<td>46 (70.8)</td>
<td>22 (59.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19 (29.2)</td>
<td>15 (40.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity, n (%)</td>
<td></td>
<td></td>
<td>$\chi^2(1) = .229$</td>
<td>.63</td>
</tr>
<tr>
<td>Black/African American</td>
<td>62 (95.4)</td>
<td>36 (97.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino/Chicano</td>
<td>7 (10.8)</td>
<td>2 (5.4)</td>
<td>$\chi^2(1) = 2.370$</td>
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<tr>
<td>White/Caucasian</td>
<td>4 (6.2)</td>
<td>0</td>
<td>$\chi^2(1) = .843$</td>
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</tr>
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<td>Asian/Asian American</td>
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<td>$\chi^2(1) = 1.161$</td>
<td>.28</td>
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<td>Native American/American Indian</td>
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<td>1 (2.7)</td>
<td>$\chi^2(1) = 1.572$</td>
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<td>Education Level, n (%)</td>
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<td>.34</td>
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<tr>
<td>6th – 11th grade</td>
<td>15 (23.1)</td>
<td>8 (21.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12th or GED</td>
<td>29 (44.6)</td>
<td>23 (62.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>19 (29.2)</td>
<td>5 (13.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College graduate</td>
<td>2 (3.1)</td>
<td>1 (2.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Status, n (%)</td>
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<td></td>
<td>$F(1,101) = 5.950$</td>
<td>.02</td>
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<td>Working full-time</td>
<td>25 (38.5)</td>
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<tr>
<td>Working part-time</td>
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<td>6 (16.2)</td>
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<tr>
<td>Student</td>
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<td></td>
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<tr>
<td>Unemployed</td>
<td>18 (27.7)</td>
<td>14 (37.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e.g., Disability)</td>
<td>2 (3.1)</td>
<td>4 (10.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Procedure

The following procedure was approved by the Kent State University Institutional Review Board. Potential participants attending the LGBT community center were informed about the study by one of the community center staff members. A staff member directed interested individuals to a study representative from Kent State University who discussed the study in more detail. Given that many of the community center attendees have parents who do not know their sexual orientation or who do not know that they attend an LGBT community center, it is possible that parental knowledge of the youths’ participation in the study would increase risk of harm and victimization. Therefore, parental consent for participation in the study was waived. Interested individuals were read a script and were given a study summary form providing general information about the study, information regarding risks and benefits of participation, and contact information for the research study as well as the Kent State University Institutional Review Board. If still interested after hearing the script and reading the summary, participants provided verbal consent to the study representative. No information was collected that would identify the individuals who participated in this study (e.g., name, birth date). Additionally, a Certificate of Confidentiality was obtained from the National Institutes of Health to further protect the participants’ identities. Following verbal consent, participants completed a battery of questionnaires assessing the study’s variables of interest. In order to maintain confidentiality, participants were instructed not to write any indentifying information on the questionnaires. Additionally, upon completion of the questionnaires, participants sealed the questionnaires in an envelope before giving them
to a study representative. All youths who participated in the study were provided 10 dollars for their time.

**Measures**

Participants were administered the following questionnaires for the present study.

**Sociodemographic Information**

A standard sociodemographic questionnaire was administered to participants. In addition to other sociodemographic information, this questionnaire assessed age, gender, race/ethnicity, sexual orientation, education level, and employment status. Sexual orientation was measured using a scale ranging from 1 to 9. Participants were asked to circle a number on the scale that represents how they view their sexual orientation with three anchors: 1 representing “completely homosexual or gay,” 5 representing “bisexual,” and 9 representing “completely heterosexual or straight.” Participants endorsing any number between 1 and 8 were included in the present study. Additionally, participants were asked if they had told others of their sexual orientation and if so, how accepting the individuals they told are of their sexual orientation.

**Verbal Victimization**

Verbal victimization was assessed using 4 questions based on questions from the National Comorbidity Survey (NCS: Sachs-Ericsson et al., 2006). The questions included: 1) How often have you been verbally insulted? 2) How often have you been sworn or cursed at? 3) How often has someone tried to make you upset on purpose? and 4) How often have you been threatened with harm? For each question, participants were
asked to indicate how often they were verbally victimized, in general, and also specifically by relatives and non-relatives, using a 4-point Likert scale: 0) Never, 1) Rarely, 2) Sometimes, 4) Often. Given that prior research has suggested that relative and non-relative verbal victimization may have a differential impact on negative cognitive styles (Gibb, Abramson, & Alloy, 2004), and potentially on psychopathology, relative and non-relative verbal victimization were calculated and examined independently in all analyses. A total score was calculated for relative and non-relative verbal victimization by summing the participants’ responses. Internal consistency was found to be good for relative verbal victimization ($\alpha = .844$) and adequate for non-relative verbal victimization ($\alpha = .686$).

**Self-criticism**

Self-criticism was measured using a 6-item index developed through exploratory and confirmatory factor analysis of psychological dimensions assessed in the NCS (Cox, McWilliams, Enns, & Clara, 2004). The index includes items from both the Depressive Experiences Questionnaire (Blatt, D’Afflitti, & Quinlan, 1976) and Rosenberg’s (1965) measure of self-esteem. This self-criticism index has been shown to have strong predictive validity in a number of studies with the NCS (Cox, Enns, & Clara, 2004; Cox, Fleet, et al., 2004; Cox, MacPherson, et al., 2004; Cox, Williams, et al., 2004). Participant were asked to rate each item on a Likert scale with 1 representing “Very true” and 4 representing “Not true at all.” Items were reverse coded so that a higher score indicated higher levels of self-criticism. A total self-criticism index score was calculated
by summing participants’ responses to each item. Internal consistency of the index was found to be adequate ($\alpha = .645$).

*Internalized Homophobia*

The Sexual Identity Distress scale (SID; Wright & Perry, 2006) was used to assess internalized homophobia. The SID consists of 7 items asking participants to indicate how much they agree or disagree on a 5-point Likert scale with both positive and negative statements regarding their feelings about their sexual orientation: For example, “I have a positive attitude about being gay/lesbian/bisexual,” “I often feel ashamed that I am gay/lesbian/bisexual.” Several items were reverse coded so that a higher score on an item indicates greater distress about being LGB. A SID total score was created by summing each item. The SID was found to have good internal consistency reliability ($\alpha = .810$) in the current sample.

*PTSD Symptomatology*

The Posttraumatic Diagnostic Scale (PDS, Foa, Cashman, Jaycox, & Perry, 1997) was used to assess for posttraumatic stress disorder symptoms. The PDS is a self-report measure that consists of three different parts. Part 1 of the PDS asks respondents to list prior traumatic events. For part two, participants are to select the most distressing traumatic event from the list that they had completed and respond to questions about their reaction to that traumatic event. Part 3 of the PDS provides a list of PTSD symptoms for participants to rate. Each of the questions in part 3 corresponds to a DSM-IV symptom of PTSD. The PDS provides an estimate of diagnostic level of PTSD and also allows for
the calculation of a continuous measure of PTSD symptom severity. For the present study, a total continuous score of PTSD symptom severity was used in the analyses. The total symptom severity score was found to have very good internal consistency in the present study ($\alpha = .949$). Additionally, data from prior research indicates that the PDS has adequate concurrent and convergent validity (Foa et al., 1997).

**Depressive Symptomatology**

Participants completed the Center for Epidemiological Studies Depression Scale for Children (CES-DC; Weissman, Orvaschel, & Padian, 1980) to assess depression symptoms occurring within the past week. The CES-DC is a 20-item measure based on the Center for Epidemiological Studies Depression scale, but adapted for use with children and adolescents. The CES-DC showed very good internal consistency reliability in the present study ($\alpha = .916$), and prior research has found it to be a valid measure of depressive symptoms, particularly among children and adolescents between the ages of 12 and 18 (Fendrich, Weissman, & Warner, 1990). A total symptom score was computed by summing the ratings of all 20 items, with a higher score indicating more depressive symptoms.

**Hypotheses and Statistical Analyses**

Hypotheses were tested using the statistical analyses described below. The Statistical Package for the Social Sciences (SPSS), Version 16.0 was used for all analyses.
Preliminary Analyses

Initial bivariate correlations and analyses of variance (ANOVAs) were conducted in order to examine the relationships among variables of interest (i.e., relative verbal victimization, non-relative verbal victimization, self-criticism, internalized homophobia, depression symptoms, and PTSD symptoms), and to determine possible covariates (i.e., demographic variables.)

Hypothesis 1: Verbal victimization would be positively associated with depressive and PTSD symptoms.

Hierarchical multiple regression analyses were conducted to examine the relationships between verbal victimization, and depression and PTSD symptoms. In all analyses, depression and PTSD were examined separately since, given the high comorbidity, controlling for one while examining the other may be removing an important part of the outcome being measured. Three regressions were conducted with PTSD symptoms as the dependent variable and three with depression symptoms as the dependent variable. For each dependent variable, a hierarchical linear regression was conducted with covariates identified in the preliminary analyses entered into the first step, and relative verbal victimization entered into the second step. Next, a regression was conducted with covariates in the first step and non-relative verbal victimization entered into the second step. Finally, in order to examine whether relative or non-relative verbal victimization would add incrementally above the other in predicting depression or PTSD symptoms, a regression was conducted with covariates entered into the first step and both relative and non-relative verbal victimization entered into the second step.
Hypothesis 2: Verbal victimization would be positively associated with self-criticism and internalized homophobia.

Similar hierarchical linear regression analyses were conducted in order to further assess the relationship between verbal victimization, and self-criticism and internalized homophobia. A total of six regressions were conducted: 3 with self-criticism serving as the dependent variable and 3 with internalized homophobia as the dependent variable. For each dependent variable, a regression was conducted with possible covariates entered into the first step of the model, then relative verbal victimization entered into the second step. Next, a regression was conducted with covariates entered into the first step and with non-relative verbal victimization entered into the second step. Finally, a regression was conducted with possible covariates entered into the first step, and relative and non-relative verbal victimization entered into the second step regression equation simultaneously in order to examine if one form of verbal victimization added incrementally to the prediction of self-criticism or internalized homophobia, above the other form of verbal victimization.

Hypothesis 3: Self-criticism and internalized homophobia would be positively associated with depressive and PTSD symptoms.

Hierarchical linear regression analyses were also conducted to further assess the impact of self-criticism and internalized homophobia on depressive and PTSD symptoms. Again, a total of six regressions were conducted: 3 with depressive symptoms serving as the dependent variable and 3 with PTSD symptoms as the dependent variable. For each dependent variable, a regression was conducted with possible covariates entered into the first step of the model, then self-criticism entered into the second step. Next, a regression
was conducted with covariates entered into the first step and with internalized homophobia entered into the second step. Finally, regressions were conducted with possible covariates entered into the first step, and both self-criticism and internalized homophobia entered into the second step to test if self-criticism or internalized homophobia added incrementally in the prediction of depressive or PTSD symptoms.

Hypothesis 4: Self-criticism and internalized homophobia would mediate the relationship between verbal victimization, and depression and PTSD symptoms.

Mediation was tested using the causal steps approach (Baron & Kenny, 1986). According this approach, in order for mediation to occur, 4 conditions must be met: 1) the independent variable must be significantly related to the outcome variable, 2) the independent variable must be significantly related to the mediator, 3) the mediator must be significantly related to the dependent variable, and finally, 4) the standardized regression coefficient representing the relationship between the independent and dependent variables must be reduced when the mediator is entered into the same regression equation. Additionally, Sobel (1982) tests were conducted in order to formally test for mediation by determining if there was a significant reduction in the strength of the relationship between the independent and dependent variables with the addition of the mediator. This approach directly assesses for the significance of indirect effects, and confirms the presence of mediation.

Based on the present study’s hypotheses, there was the potential for 8 mediation analyses (See Figures 1– 8). Mediation analyses were conducted when results from the
testing of hypotheses 1–3 revealed that conditions 1–3 of the causal steps method have been met.

Figure 1. Model of self-criticism mediating the relationship between relative verbal victimization and depressive symptoms.

Figure 2. Model of self-criticism mediating the relationship between non-relative verbal victimization and depressive symptoms.
**Figure 3.** Model of internalized homophobia mediating the relationship between relative verbal victimization and depressive symptoms.

**Figure 4.** Model of internalized homophobia mediating the relationship between non-relative verbal victimization and depressive symptoms.
Figure 5. Model of self-criticism mediating the relationship between relative verbal victimization and PTSD symptoms.

Figure 6. Model of self-criticism mediating the relationship between non-relative verbal victimization and PTSD symptoms.
Internalized Homophobia

Relative Verbal Victimization

PTSD Symptoms

*Figure 7.* Model of internalized homophobia mediating the relationship between relative verbal victimization and PTSD symptoms.

Internalized Homophobia

Relative Verbal Victimization

PTSD Symptoms

*Figure 8.* Model of internalized homophobia mediating the relationship between non-relative verbal victimization and PTSD symptoms.
CHAPTER 3

RESULTS

Descriptive Analyses

Verbal Victimization

A total of 56 (86.2%) participants reported experiencing relative verbal victimization and, 61 (93.8%) participants reported non-relative verbal victimization. On average, participants rated a score of 4.52 (SD = 3.35; range = 0-12) for relative verbal victimization and 6.17 (SD = 2.88; range = 0-12) for non-relative verbal victimization.

Self-Criticism and Internalized Homophobia

Participants’ mean score on the self-criticism index was 20.23 (SD = 5.49; range = 7.00-28.0), indicating high levels of self-criticism in the current sample. Regarding internalized homophobia, on average, participants reported a total score of 7.82 (SD = 5.67; range = 0-24) on the Sexual Identity Distress scale, suggesting relatively low levels of internalized homophobia.
Depression and PTSD

Participants reported high levels of depressive symptoms (mean = 24.35; SD = 12.93) on the CES-DC. In the current sample, 78.5% (n = 51) scored 15 or higher, which is suggestive of clinically significant depression symptoms (Weissman et al., 1980).

Participants reported experiencing 3 traumatic events on average (SD = 1.62; range = 1-7). Interpersonal traumatic events were among the most frequently reported with sexual contact when under the age of 18 with someone 5 or more years older reported as the most common event (55.4%) followed by non-sexual assault by a stranger (53.8%), and sexual assault by a family member or someone known (44.6%). See table 2 for a summary of traumatic events, by type, reported by participants. Participants were asked to rate the traumatic event they felt contributed to the most distress. The most frequently reported event was sexual assault by a family member or someone known (43.1) followed by the experience of a serious accident (15.4), and non-sexual assault by a stranger (13.3). The remaining responses were scattered across various other traumatic events such as disaster, imprisonment, torture, and diagnosis with a life threatening illness (see table 3). Participants reported a mean total PTSD symptom severity score of 22.11 (SD = 15.04; range = 0-51), indicating that, on average, participants were experiencing moderate to severe PTSD symptoms (Foa, 1995). Additionally, based on symptom severity and constellation, 41 participants (63.1%) were estimated to meet full criteria for PTSD.
Table 2. *Frequency by Type of Traumatic Event Reported*

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Frequency n,(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault by family/someone known</td>
<td>29 (44.6)</td>
</tr>
<tr>
<td>Sexual assault by stranger</td>
<td>15 (23.1)</td>
</tr>
<tr>
<td>Sexual contact under age of 18 with someone 5+ years older</td>
<td>36 (55.4)</td>
</tr>
<tr>
<td>Non-sexual assault by family/someone known</td>
<td>27 (41.5)</td>
</tr>
<tr>
<td>Non-sexual assault by stranger</td>
<td>35 (53.8)</td>
</tr>
<tr>
<td>Accident</td>
<td>27 (41.5)</td>
</tr>
<tr>
<td>Life-threatening illness</td>
<td>6 (9.2)</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>16 (24.6)</td>
</tr>
<tr>
<td>Torture</td>
<td>7 (10.8)</td>
</tr>
<tr>
<td>Disaster</td>
<td>12 (18.5)</td>
</tr>
<tr>
<td>Military/Combat</td>
<td>1 (1.5)</td>
</tr>
<tr>
<td>Other</td>
<td>10 (15.4)</td>
</tr>
</tbody>
</table>

Table 3. *Frequency of Trauma Type Reported as Most Distressing* *

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Frequency n,(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault by family/someone known</td>
<td>28 (43.1)</td>
</tr>
<tr>
<td>Sexual assault by stranger</td>
<td>3 (4.6)</td>
</tr>
<tr>
<td>Sexual contact under age of 18 with someone 5+ years older</td>
<td>5 (7.7)</td>
</tr>
<tr>
<td>Non-sexual assault by family/someone known</td>
<td>8 (12.3)</td>
</tr>
<tr>
<td>Non-sexual assault by stranger</td>
<td>9 (13.8)</td>
</tr>
<tr>
<td>Accident</td>
<td>10 (15.4)</td>
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<tr>
<td>Life-threatening illness</td>
<td>6 (9.2)</td>
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<tr>
<td>Imprisonment</td>
<td>6 (9.2)</td>
</tr>
<tr>
<td>Torture</td>
<td>4 (6.2)</td>
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<tr>
<td>Disaster</td>
<td>3 (4.6)</td>
</tr>
<tr>
<td>Military/Combat</td>
<td>1 (1.5)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (6.2)</td>
</tr>
</tbody>
</table>

* The percentages do not add up to 100 as it was unclear as to which trauma was selected as the most distressing for 12 participants (i.e., participants identified more than one event as the most distressing)
Preliminary Analyses

Preliminary bivariate correlations and ANOVAs were conducted in order to assess the relationships between sociodemographic variables, independent variables (i.e., relative and non-relative verbal victimization), potential mediators (i.e., self-criticism and internalized homophobia), and dependent variables (i.e., depressive symptoms and PTSD symptoms). See table 4. None of the sociodemographic variables were significantly related to the independent variables, potential mediators, or dependent variables; therefore, no covariates were identified. Relative verbal victimization and non-relative verbal victimization were significantly correlated with one another. A significant and positive relationship was observed between relative verbal victimization, and self-criticism, internalized homophobia, and depressive symptoms. Non-relative verbal victimization was significantly correlated with both depressive and PTSD symptoms, but not with either self-criticism or internalized homophobia. A significant relationship was found between the potential mediators, self-criticism and internalized homophobia. Self-criticism was significantly related to depressive symptoms and PTSD symptoms. Internalized homophobia was significantly correlated with PTSD symptoms only. As observed in prior research (Kessler et al., 1995), depressive symptoms and PTSD symptoms were highly correlated with one another.
Table 4. Correlations Between Verbal Victimization, Potential Mediators, and Psychopathology.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
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<tbody>
<tr>
<td>Relative Verbal</td>
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<td>Victimization</td>
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<tr>
<td>Non-Relative</td>
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<td></td>
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<tr>
<td>Verbal Victimization</td>
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<tr>
<td></td>
<td>p =</td>
<td>.001</td>
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<tr>
<td>Self-Criticism</td>
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<td>.213</td>
<td>.003</td>
<td>.09</td>
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<td>Internalized Homophobia</td>
<td>.223</td>
<td>-.060</td>
<td>.490</td>
<td>.07</td>
<td>.63</td>
<td>&lt;.001</td>
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<td>Depressive Symptoms</td>
<td>.455</td>
<td>.239</td>
<td>.608</td>
<td>.274</td>
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</tr>
<tr>
<td></td>
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<td>.05</td>
<td>&lt;.001</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Symptoms</td>
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<td>.249</td>
<td>.524</td>
<td>.118</td>
<td>.705</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.05</td>
<td>.05</td>
<td>&lt;.001</td>
<td>.35</td>
<td>&lt;.001</td>
<td></td>
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</tbody>
</table>

Hypothesis 1: Verbal victimization will be positively associated with depressive and PTSD symptoms.

When relative and non-relative verbal victimization were entered into regression equations separately, both accounted for a significant amount of variance (approximately 21% and 6% respectively) in depressive symptoms. Further, when relative and non-relative verbal victimization were entered into a regression equation together, the overall model was found to account for a significant amount of variance (approximately 21%) in depressive symptoms, but only relative verbal victimization contributed significantly to the model. See Table 5.
Table 5. *Summary of Hierarchical Linear Regression Analysis for Verbal Victimization Predicting Depressive Symptoms*

<table>
<thead>
<tr>
<th>Variable</th>
<th>( \Delta R^2 )</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
<tr>
<td>Relative Verbal Victimization</td>
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<td>.455</td>
<td>4.060</td>
<td>&gt;.001</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>.057</td>
<td>.239</td>
<td>1.952</td>
<td>.05</td>
</tr>
<tr>
<td>Step 1</td>
<td>.210</td>
<td></td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>1.658</td>
<td>3.472</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>.275</td>
<td>.494</td>
<td>.62</td>
<td></td>
</tr>
</tbody>
</table>

The regression analyses were repeated with PTSD symptoms serving as the dependent variable. Again, both relative and non-relative verbal victimization accounted for a small, but significant amount of variance (approximately 6% for both) in PTSD symptoms. When relative and non-relative verbal victimization were entered into the regression equation simultaneously, the overall model did not account for a significant amount of variance in PTSD symptoms, and neither relative nor non-relative verbal victimization contributed significantly to the prediction of PTSD symptoms. See Table 6.
Table 6. Summary of Hierarchical Linear Regression Analysis for Verbal Victimization Predicting PTSD Symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.057</td>
<td>.239</td>
<td>1.955</td>
<td>.05</td>
</tr>
<tr>
<td>Non-Restricted Verbal Victimization</td>
<td>.062</td>
<td>.249</td>
<td>2.038</td>
<td>.05</td>
</tr>
<tr>
<td>Step 1</td>
<td>.084</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.165</td>
<td></td>
<td>1.233</td>
<td>.22</td>
</tr>
<tr>
<td>Non-Restricted Verbal Victimization</td>
<td>.181</td>
<td></td>
<td>1.355</td>
<td>.18</td>
</tr>
</tbody>
</table>

Hypothesis 2: Verbal victimization will be positively associated with self-criticism and internalized homophobia.

For self-criticism, analyses revealed that when entered into a regression equation independently, relative verbal victimization accounted for a significant amount of variance in self-criticism (approximately 13%), but non-relative verbal victimization did not. When relative and non-relative verbal victimization were entered into a regression equation simultaneously, the overall model accounted for a significant amount of variance (approximately 13%) in self-criticism, however, only relative verbal victimization contributed significantly to the model. See Table 7.

When internalized homophobia served as the dependent variable, neither relative verbal victimization nor non-relative verbal victimization accounted for a significant amount of variance in internalized homophobia. When relative and non-relative verbal victimization were entered into a regression equation together, the overall model did not account for a significant amount of variance in internalized homophobia, although
relative verbal victimization contributed significantly to the prediction of internalized homophobia. See Table 8.

Table 7. Summary of Hierarchical Linear Regression Analyses for Verbal Victimization Predicting Self-Criticism

<table>
<thead>
<tr>
<th>Variable</th>
<th>Δ R²</th>
<th>β</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.128</td>
<td>.358</td>
<td>3.042</td>
<td>.003</td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>.045</td>
<td>.213</td>
<td>1.728</td>
<td>.09</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.133</td>
<td>.326</td>
<td>2.508</td>
<td>.02</td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>.078</td>
<td>.604</td>
<td>.55</td>
<td></td>
</tr>
</tbody>
</table>

Table 8. Summary of Hierarchical Linear Regression Analysis for Verbal Victimization Predicting Internalized Homophobia

<table>
<thead>
<tr>
<th>Variable</th>
<th>Δ R²</th>
<th>β</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.050</td>
<td>.223</td>
<td>1.814</td>
<td>.07</td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>.004</td>
<td>-.060</td>
<td>-.479</td>
<td>.63</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.078</td>
<td>.299</td>
<td>2.229</td>
<td>.03</td>
</tr>
<tr>
<td>Non-Relative Verbal Victimization</td>
<td>-.183</td>
<td>-1.370</td>
<td>.18</td>
<td></td>
</tr>
</tbody>
</table>
Hypothesis 3: Self-criticism and internalized homophobia would be positively associated with depressive and PTSD symptoms.

When depressive symptoms served as the dependent variable, both self-criticism and internalized homophobia accounted for a significant amount of the variance (approximately 37% and 8% respectively). When self-criticism and internalized homophobia were entered into a regression equation together, the overall model significantly predicted depressive symptoms (accounting for approximately 37% of the variance), but only self-criticism contributed significantly to the model. See Table 9.

Table 9. Summary of Hierarchical Linear Regression Analysis for Potential Mediators Predicting Depressive Symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>( \Delta R^2 )</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-criticism</td>
<td>.369</td>
<td>.608</td>
<td>6.075</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Internalized homophobia</td>
<td>.075</td>
<td>.274</td>
<td>2.261</td>
<td>.03</td>
</tr>
<tr>
<td>Step 1</td>
<td>.370</td>
<td></td>
<td></td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Self-criticism</td>
<td>.623</td>
<td>5.390</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Internalized homophobia</td>
<td>-.031</td>
<td>-.271</td>
<td>.79</td>
<td></td>
</tr>
</tbody>
</table>

The same set of regression analyses were conducted with PTSD symptoms serving as the dependent variable. When self-criticism and internalized homophobia were entered into a regression equation separately, only self-criticism was found to account for a significant amount of variance (approximately 27%) in PTSD symptoms. Further, when self-criticism and internalized homophobia were entered into the regression equation together, the overall model accounted for a significant amount of
variance (approximately 30%) in PTSD symptoms, but again only self-criticism contributed significantly to the overall model. See Table 10.

Table 10. Summary of Hierarchical Linear Regression Analysis for Potential Mediators Predicting PTSD Symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>ΔR²</th>
<th>β</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self–criticism</td>
<td>.274</td>
<td>.524</td>
<td>4.880</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Internalized homophobia</td>
<td>.014</td>
<td>.118</td>
<td>.946</td>
<td>.35</td>
</tr>
</tbody>
</table>

Hypothesis 4: Self-criticism and internalized homophobia would mediate the relationship between verbal victimization, and depressive and PTSD symptoms.

Based on the results of the prior regression analyses, two potential mediation relationships were identified that met the first 3 conditions required by the causal steps approach to meditational analyses (Baron & Kenny, 1986): Relative verbal victimization (predictor) was significantly related to self-criticism (potential mediator), and both relative verbal victimization and self-criticism were significantly related to depressive and PTSD symptoms (both outcome variables). Therefore, the role of self-criticism was examined as a mediator in both the relationship between relative verbal victimization and
depressive symptoms, and the relationship between relative verbal victimization and PTSD symptoms.

Additional regressions were conducted in order to see if the 4th condition of the causal steps method was satisfied. That is, whether the relationship between the independent variable and dependent variable lost significance when the mediator was entered into the same regression equation. Following the regression analyses, Sobel tests were conducted to test if the decrease in strength of the relationship between the independent and dependent was significant.

First, self-criticism and relative verbal victimization were entered simultaneously into a regression model predicting depressive symptoms. The addition of self-criticism decreased the strength of the relationship between relative verbal victimization and depressive symptoms, however both remained significantly related to depressive symptoms. A Sobel test was conducted and indicated that the decrease in strength between relative verbal victimization and depressive symptoms with the addition of self-criticism to the model was significant (Sobel $z = 2.59; p = .01$). These data suggest that self-criticism partially mediated the relationship between relative verbal victimization and depressive symptoms. See Table 11 and Figure 9.

Table 11. *Summary of Hierarchical Regression Analysis with Self-Criticism and Relative Verbal Victimization Predicting Depressive Symptoms*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\Delta R^2$</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.434</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Criticism</td>
<td>.510</td>
<td>2.667</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.237</td>
<td>4.987</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>
Figure 9. Standardized regression coefficients for a mediation model in which self-criticism is tested as a mediator of the relationship between relative verbal victimization and depressive symptoms. The standard regression coefficients for the original simple regression models are presented in parentheses.

Next, relative self-criticism and verbal victimization were entered simultaneously into a model predicting PTSD symptoms. The addition of self-criticism decreased the strength of the relationship between relative verbal victimization and PTSD symptoms, and although the relationship between self-criticism and PTSD symptoms remained significant, relative verbal victimization was no longer significantly related to PTSD symptoms. A subsequent Sobel test (Sobel z = 2.49, p = .01) indicated that the decrease in relationship strength between relative verbal victimization and PTSD symptoms was significant. Taken together, data suggest that self-criticism mediated the relationship between relative verbal victimization and PTSD symptoms. See Table 12 and Figure 10.
Table 12. Summary of Hierarchical Regression Analysis with Self-Criticism and Relative Verbal Victimization Predicting PTSD Symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>Δ $R^2$</th>
<th>β</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>.277</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Criticism</td>
<td>.503</td>
<td>4.317</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Relative Verbal Victimization</td>
<td>.059</td>
<td>.512</td>
<td>.61</td>
<td></td>
</tr>
</tbody>
</table>

Self-Criticism

$\beta = .358; \ p = .003$

Relative Verbal Victimization

$\beta = .059; \ p = .61$

(β = .237; p = .05)

PTSD Symptoms

$\beta = .524; \ p < .001$

(β = .669; p <.001)

Figure 10. Standardized regression coefficients for a mediation model in which self-criticism is tested as a mediator of the relationship between relative verbal victimization and PTSD symptoms. The standard regression coefficients for the original simple regression models are presented in parentheses.
CHAPTER 4

DISCUSSION

The present study investigated psychological mechanisms related to verbal victimization and their impact on psychopathology in LGB youths who have experienced trauma. This is an important addition to the literature given that LGB youths are at high risk for multiple forms of victimization and trauma, and that few studies have investigated psychological mechanisms related to these victimization experiences among LGB populations. The finding that participants in the present study experienced high rates of verbal, physical, and sexual victimization is consistent with prior findings with LGB youths, (e.g., Pilkington & D’Augelli, 1995; Saewyc et al, 2006). The vast majority of participants reported verbal victimization from family members as well as from non-relatives. Further, interpersonal trauma (e.g., physical assault, sexual assault) was the most frequently reported type of traumatic event experienced by participants, with over one-half of participants reporting physical assault by a stranger, and with slightly fewer than one-half of participants reporting sexual assault by a relative or someone else that they know. Participants also reported significant psychological distress, echoing prior research with LGB youths (D’Augelli, 2002) as well as victims of interpersonal trauma (e.g., Schaaf & McCane, 1998). In the present sample, three-fourths of participants
reported clinically significant depressive symptoms, and over one-half reported symptoms suggesting that they would meet full diagnostic criteria for PTSD.

Verbal Victimization and Psychopathology

Consistent with multiple research studies describing the negative psychological consequences of verbal victimization (e.g., Gore-Felton et al., 2001; McGee et al., 1999; Mullen et al., 1996; Vissing et al., 1991), significant associations were found between verbal victimization and psychopathology in the present study. Both relative and non-relative verbal victimization were related to higher levels of depressive and PTSD symptoms. Relative verbal victimization, however, was a stronger predictor of depressive symptoms compared to non-relative verbal victimization. When both relative and non-relative verbal victimization were added to the same regression equation to predict depressive symptoms, only relative verbal victimization continued to predict a significant amount of variance. This suggests that verbal abuse by family members confers particularly strong risk for the experience of depressive symptoms. These findings were different from those of Gibb and Abela (2008), who demonstrated that both parental emotional abuse and verbal victimization from peers contribute uniquely to variance in depressive symptoms. It is possible that this finding reflects social support received from non-relatives, given that the youth in this study were recruited from an LGBT community center, where they were likely to be surrounded by supportive peers and staff members. While the vast majority of participants in this study experienced verbal victimization by non-relatives, they may also have received positive messages from other non-relatives that buffered the effects of this form of verbal victimization.
This finding also supports the importance of the family environment in the psychological adjustment of LGB youths. For example, research has demonstrated that psychological (D’Augelli et al., 2005) and verbal abuse (Hershberger et al., 1997) from family members is related to higher rates of suicide attempts among LGB youths. Further research is needed to help clarify the possibly differential impact of relative versus non-relative verbal victimization on LGB youth.

Higher levels of PTSD symptoms were also related to relative and non-relative verbal victimization; however, the relationship did not appear to be as strong as it was with depressive symptoms, particularly with regard to relative verbal victimization. It was suggested by Gibb, Chelminski, and Zimmerman (2007) that emotional abuse (i.e., verbal victimization) may confer more specific risk for depression than for PTSD, which they suggested is more broadly related to multiple forms of abuse (i.e., emotional, physical, and sexual abuse). Therefore, the small amount of variance in PTSD symptoms predicted by verbal victimization could be due to other variables (such as physical and sexual abuse) accounting for a significant proportion of the variance as well.

Verbal Victimization, Self-criticism, and Internalized Homophobia

The hypothesis regarding the impact of verbal victimization on the psychological mechanism of self-criticism was partially supported. Relative verbal victimization predicted higher levels of self-criticism, replicating the findings of Sachs-Ericsson and colleagues (2006), and extending it to an LGB sample. Non-relative verbal victimization, however, was unrelated to self-criticism. This is in contrast to prior research, which demonstrated that verbal victimization from peers incrementally predicted negative
cognitive styles when entered into the same regression equation with relative emotional abuse (Gibb, Abramson, & Alloy, 2004). Again, since participants were recruited from an LGBT community center with a group of potentially supportive peers, it is possible that positive interactions with peers from the community center protected these youths from the negative consequences related to verbal interactions with victimizing peers. Additionally, given that almost all of the youths in the present study endorsed non-relative verbal victimization, it is possible that there was a ceiling effect, which limited the variability of this measure. Future research should examine the role of social support as a moderator between verbal victimization and self-criticism.

In contrast to hypotheses, both relative and non-relative verbal victimization were unrelated to internalized homophobia. This may have been due to the measure of verbal victimization used, as it did not assess for verbal victimization that was perceived to stem from reactions to sexual orientation. A significant association may have been found if a measure was used that was more specific to sexual orientation-motivated verbal victimization. Additionally, the recruitment site for the study may have contributed to our inability to support this hypothesis. Since participants were recruited from an LGBT community center that supported acceptance of diversity in sexual orientation, then they were likely to receive positive messages about their sexuality. These supportive messages may have served as a buffer against the impact of verbal victimization on internalized homophobia for these youth.
**Self-criticism, Internalized Homophobia, and Psychopathology**

Consistent with prior research (e.g., Cox et al., 2004, Shahar et al., 2004), self-criticism was related to higher levels of both depressive and PTSD symptoms. Internalized homophobia, however, only predicted a small amount of variance in PTSD symptoms, and was unrelated to depressive symptoms. Further, self-criticism was found to predict PTSD symptoms above and beyond internalized homophobia. The non-significant relationship between internalized homophobia and depressive symptoms was surprising given that a number of studies have found that internalized homophobia is related to several negative mental and physical health consequences, including depression (DiPlacido, 1998; Meyer & Dean, 1998; Williamson, 2000). In contrast to internalized homophobia, self-criticism may be related to depression because it is likely to represent more global, negative feelings about the self. Individuals who experience internalized homophobia may have very negative feelings about their sexual orientation, but may also view other aspects of the self in a positive manner. Self-criticism and internalized homophobia were significantly correlated with one another in the present study. Future research should help to clarify the nature of the relationship between more global aspects of low self-esteem (e.g., self-criticism), and internalized homophobia.

**Self-criticism as a Mediator between Relative Verbal Victimization and Psychopathology**

This study provides support for Rose and Abramson’s theory (1992) that verbal victimization is likely to lead to the development of a negative cognitive style, such as self-criticism, which will then confer risk for the development of psychopathology. Self-
criticism was found to partially mediate the relationship between relative verbal victimization and depressive symptoms and to partially mediate the relationship between relative verbal victimization and PTSD symptoms. These data are consistent with Sachs-Ericsson and colleagues’ (2006) findings that self-criticism mediates the relationship between parental verbal abuse and affective disorders. While the mediating relationship of self-criticism has been found in prior research with depression, this is the first study to the author’s knowledge that examined self-criticism as a mediator between verbal victimization and PTSD. These findings help to clarify the interaction between multiple types of trauma and victimization, by suggesting how verbal victimization may predispose individuals to psychopathology.

Given that internalized homophobia was unrelated to verbal victimization, it is not likely to serve as a mediator between verbal victimization and psychopathology in this sample. Further research is needed to help clarify the relationship between verbal victimization and internalized homophobia.

**Clinical Implications**

Findings from the present study have important implications for working with LGB youth, and more specifically LGB youth who have been victims of trauma and victimization. First, this study adds to a growing body of literature indicating that LGB youth are at risk for trauma, and in particular, physical, sexual, and verbal victimization. Participants also reported high levels of trauma related psychopathology (i.e., depressive and PTSD symptoms). While the experience of traumatic events occur frequently in the general population by the time they reach adulthood (e.g., 60%: Kessler, Sonnega,
Bromet, Hughes, & Nelson, 1995), only 8 - 18% are estimated to meet criteria for PTSD (Breslau, 1998; Breslau, Davis, Andreski, & Peterson, 1991; Kessler et al., 1995). In contrast, data from this study indicate that approximately 63% (41) of the 65 participants are likely to meet criteria for PTSD. These data underscore the importance of assessing for trauma and victimization in clinical work with these youths. It is important to note that many victims of trauma disclose this experience if it is not directly assessed (Briere & Zaidi, 1989; Read & Fraser, 1998).

Next, the vast majority of participants reported verbal victimization from family members, and almost all reported verbal victimization from non-relatives. These highly prevalent experiences were associated with more depressive and PTSD symptoms. Efforts should be made to decrease verbal victimization in order to prevent the psychological consequences they have for these youth. When victimization is stemming from family members, youths are likely to benefit from family therapy interventions that seek to improve communication between child and parent/family members with the hopes that acquired communication skills will replace verbal victimization. If the victimization is due to family members’ reactions to a youth’s sexual orientation, the family may benefit from a referral to a support group consisting of family members of other LGB youth, for example, organizations such as Parents, Family, and Friends of Lesbians and Gays (PFLAG). It has been suggested that having parents attend support groups such as PFLAG is one of the best interventions to increase parental acceptance of LGB children (Goldfried, 2001). Increasing parental acceptance of their children’s
sexual orientation would likely increase validation and support, and decrease victimization in the home environment.

Additionally, since much non-relative verbal victimization happens in the school and work environment (e.g., GLSEN, 2006) initiatives to reduce this experience in these settings are recommended. Since, a great number of LGB youth experience verbal victimization from peers, they are likely to benefit from attending community centers that are affirming and supportive of LGBT individuals, where they are exposed to positive messages.

Finally, findings indicate that self-criticism mediates the impact of verbal victimization from family members, suggesting that this a potential mechanism by which relative verbal victimization increases risk for trauma-related psychopathology in LGB youth. Youth who experience verbal victimization from their family members may therefore benefit from interventions that target self-criticism. One therapeutic approach that has been shown to be helpful at reducing negative thoughts regarding the self is Cognitive-Behavioral Therapy (CBT). CBT, largely based on Cognitive theory (Beck 1964, 1987), helps clients to challenge maladaptive cognitions, and has also been shown to improve depression and PTSD symptoms (e.g., Butler, Chapman, Foreman, & Beck, 2006). Martel and colleagues (Martell, Safren, & Prince, 2004) have also written a guide to CBT with LGB individuals, taking into account the marginalization and stigmatization experienced by this group. Additionally, CBT has been adapted to be used specifically with clients who have been the victims of traumatic events, and many of these treatments have been found to be efficacious. Examples of these therapies include, Prolonged
Exposure Therapy (Foa & Rothbaum, 1998; Foa, Crestman, & Gilboa-Schechtman, 2008), Cognitive Processing Therapy, (Resick & Schnicke, 1993), and for younger youth, Trauma Focused CBT (Cohen, Mannarino, & Deblinger, 2006). Although, these treatments were not designed specifically for LGB individuals, they may be beneficial for LGB trauma victims who are struggling with PTSD, depression, and self-criticism.

It should be noted that interventions should always be tailored to the needs of the individual client and should take the client’s context into account. This is important, for example, when working with an LGB individual who is considering disclosing their sexual orientation to others. In some cases this can be very beneficial (i.e., when the person is supportive), but for some individuals, this may not be safe and may lead to increased risk for victimization (D’Augelli, Hershberger, & Pilkington, 1998).

Limitations

The present study certainly has limitations that would suggest viewing the results with caution. The study design was cross-sectional, limiting the ability to make causal inferences. Further, an assumption made when defining a variable as a mediator is that the independent variable occurs earlier in time than the mediator and the dependent variable. Given that the study is cross-sectional, and that the measures of verbal victimization did not specify a specific period of time in which the verbal victimization occurred, there is no way to confirm the timing of the variables. Another limitation is that the size of the sample was relatively small. It is possible that there was not sufficient statistical power to identify all of the meaningful relationships present in the data.
Third, the study relied on self-report measures of all constructs. This may be particularly problematic with respect to verbal victimization, which was assessed retrospectively. Participants were asked to report experiences of verbal abuse over an indefinite period of time, therefore participants may not have accurately recalled the occurrence or frequency of verbal victimization experiences. Also, individuals who were experiencing higher levels of depressive and anxiety symptoms may have been more likely to perceive verbal victimization. Unfortunately, there is not likely to be another way to assess for verbal victimization that occurs throughout one’s life. Longitudinal research that prospectively measures verbal victimization over discrete periods of time is likely to provide valuable information.

Additionally, the measure of non-relative verbal victimization was much less reliable than that of relative verbal victimization. This may have attenuated results with respect to non-relative verbal victimization. With a larger sample size and/or a more reliable measure of non-relative verbal victimization, the relationships between non-relative verbal victimization and the outcome variables would most likely be stronger.

Finally, although one of this study’s strengths is that it was conducted with a sample in great need of research attention, the sample was very specific. The present study provides valuable information regarding LGB youth who are victims of trauma; however, the specificity of the sample restricts the ability to generalize findings to other groups of youths as well as the general population. Further, the sample of LGB youth described in the current study was recruited from LGBT community center that primarily serves youths who are members of ethnic/racial minority groups and who are from urban
lower SES neighborhoods. While LGB youth who are members of ethnic/racial minority groups are understudied and therefore this study adds to a small number of research studies with this population, the current sample may not be an accurate representation of the experiences of LGB youth in general.

**Future Directions**

Despite these limitations, this was the first study to examine psychological mechanisms in the relationship between verbal victimization and psychopathology among LGB youth who had experienced traumatic events. More research is needed to help clarify the nature of the relationships investigated in the current study.

Future studies would benefit from using a longitudinal design with a larger, more representative sample of LGB youth. In particular, recruiting from places other than LGBT community centers, such as schools, would likely reach a wider range of LGB youth and improve generalizability of the findings. Additionally, future research would benefit from inclusion of transgender youth. While there is a need for research with LGB populations in general, there have been even fewer research studies involving transgender individuals.

More comprehensive measures of verbal victimization should be considered in future research with LGB youth. The measure used in the current study to assess for verbal victimization consisted of only four questions. There are bound to be several other experiences that were not assessed that could be considered aspects of verbal victimization. Additionally, measures of verbal victimization related to sexual orientation would be particularly relevant for this population, as little is known about
psychological mechanisms linking this more specific form of verbal victimization to psychopathology.

While this study focused on depression and PTSD as consequences of trauma, there are many other outcome variables that would be important to study. For example, victims of trauma, particularly individuals who have experienced childhood trauma or multiple traumatic events, report a host of difficulties in addition to depression and PTSD. These difficulties are frequently referred to as Complex PTSD or Disorders of Extreme Stress (DESNOS), and include problems with: regulating emotions and impulses, memory and attention, self-perception, interpersonal relations, somatization, and systems of meaning (van der Kolk et al., 2005). These additional sequelae of trauma can have numerous consequences for the mental and physical health of LGB youth, and their study would help to inform prevention and treatment programs for this population.

Further, research has demonstrated that trauma can increase risk for externalizing behavioral difficulties, for example, substance use and high-risk sexual behavior (e.g., (e.g., Kalichman et al., 2004; Kilpatrick et al., 2000; Rotheram-Borus et al., 1996). These behaviors should be a focus of future research with this population.

Additionally, the overwhelming majority of youth who participated in this study identified their race/ethnicity to be African American. There are likely to be culture-specific variables that would be important to investigate in future studies with African American LGB youths. While LGB youth are at risk for victimization due to other’s reactions to their sexual orientation, African American LGB youth may be at even higher risk for victimization due to potential race-related victimization. Additionally, research
has indicated significant stigma related to being LGB in the African American community (Fullilove & Fullilove, 1999). As such, many African American LGB individuals report feeling torn between loyalty to the African American community and LGB community (Green, 1994). This could explain why African American LGB youth have been found to be less likely than other ethnic minority and Caucasian youth to disclose their sexual orientation (Rosario et al., 2001). This stigma and how it may precipitate and interfere with the treatment of psychological distress, including trauma, should be studied further.

Conclusion

Consistent with prior research, the current study showed that LGB youth are at high risk for many forms of victimization, and demonstrated this population’s continued need for research attention. Notably, data from this study suggest that self-criticism is a mediator in the relationship between verbal victimization by family members and depression and PTSD. Clinically, this highlights the importance of addressing self-criticism in LGB youth presenting for treatment who have experienced trauma and verbal victimization. Additionally, preventative measures may be taken by working to improve family relationships, thereby reducing verbal victimization, as well as providing affirming environments (e.g., programming at LGBT community centers) that support the development of a healthy view of the self. Continued research is needed that identifies psychological mechanisms related to victimization experiences and psychopathology among LGB youth.
REFERENCES


APPENDICES
APPENDIX A

VERBAL CONSENT SCRIPT
You are being asked to spend about 45 minutes filling out a survey that deals with issues and situations that you may be dealing with. You will be compensated $10 for your time. Just a reminder, your answers will be kept confidential and your name will not be tied to your responses in any way. Once you've completed the survey, there will be absolutely no way for us to connect your responses to you.

Do you understand what we are asking you to do?

Do you have any questions about the survey?

Does the survey sound like something you would be interested in completing?

Thank you for agreeing to participate. Remember, you can stop at any time without penalty and you don't have to answer any question that makes you feel uncomfortable.

At completion of survey, the following script was read to participants:

Thank you for your time. We appreciate your honest responses and would like to reward you for your time and effort with $10.00. Please take a few minutes to think about what you will tell people if they ask you where the money came from. Thanks again for your time.
APPENDIX B

SURVEY SUMMARY
SURVEY SUMMARY

The purpose of this study is to gain a better understanding of how adolescents and young adults like yourself feel about important issues that you may be facing. We would also like to know about some experiences that you may have encountered throughout your life. This research provides us with information that may guide future programs that could benefit you.

We will not ask you to identify yourself and your name will not be in any way connected to your responses to the questions. We have also obtained a certificate of confidentiality which protects us from being subpoenaed by a court or other governmental authority. This means that we are not required to release any information that you provide to us even if the information is requested by a court of law.

You may experience distress when answering some of the questions in the survey. You are free to leave any question blank that you do not feel comfortable answering without penalty.

You will not be penalized for choosing not to participate in this survey. Participation is completely voluntary and you can stop participating at any time during the survey.

If you would like additional information regarding the survey, please contact:

Dr. Douglas L. Delahanty
144 Kent Hall
Kent State University
Kent, OH 44242
330-672-2395

For questions regarding Kent State University’s rules for research, please contact:

Dr. Peter C. Tandy, Vice President for Research
330-672-3012
APPENDIX C

MEASURES
Sociodemographics and Health Status

First, we would like to know a little bit about you.

1. What is your age? ______________

2. What is your gender? _____ Male _____ Female

3. What is your race or ethnic background (check all that apply)?
   _____ Black/African American
   _____ White/Caucasian
   _____ Hispanic/Latino/Chicano
   _____ Asian or Asian American
   _____ Native American or American Indian
   _____ Other: Please specify ___________________________

4. What is the highest grade or year of school that you have completed?
   _____ 5\textsuperscript{th} or less
   _____ 6\textsuperscript{th}-11\textsuperscript{th}
   _____ 12\textsuperscript{th} or GED
   _____ Some college
   _____ College degree

5. What is your current employment status (check all that apply)?
   _____ Working full time (more than 35 hours/week)
   _____ Working part time (less than 35 hours/week)
   _____ Student
   _____ Unemployed
   _____ Other: Please specify ___________________________

6. Who do you currently live with?
   _____ Parent(s)
   _____ Other family member: Please specify ______________
   _____ Friend
   _____ On your own
   _____ Do not have a place to live
7. How many people currently live with you? ______

8. Do you have any children? ______ Yes ______ No
   If yes: How many children do you have? ______
   How many of your children live with you? ______

9. What is your marital or relationship status?
   _____ Single
   _____ Married
   _____ Divorced
   _____ Separated
   _____ Cohabiting/living with partner
   _____ Serious relationship with 1 person exclusively but not living together
   _____ Dating numerous people

10. How long has this been your relationship status? ________________

11. On a scale from 1 (exclusively homosexual/gay) to 10 (exclusively heterosexual/straight), where do you consider yourself?

   1   2   3   4   5   6   7   8   9
   Exclusively Homosexual/ Gay
   Exclusively Bisexual
   Heterosexual/ Straight

12. How long have you self-identified yourself in this way? ______

13. Have you told people that you self-identify yourself in this way?
   _____ Yes _____ No
   If yes, how many people have you told? __________
   How accepting have these people been?

   1   2   3   4   5   6   7   8   9
   Not at all Accepting
   Indifferent
   Completely Accepting
14. Have you ever been tested for HIV/AIDS? _____ Yes _____ No

15. Have you ever test positive for any sexual transmitted diseases (STDs)?
   _____ Yes _____ No

   If yes, what have you tested positive for?
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________

16. In the past, have you ever thought about suicide? _____ Yes _____ No

17. In the past, have you ever attempted suicide? _____ Yes _____ No
We want to know more about some of your experiences. Please read each sentence. Then, circle a number between 0-4 that tells how often you have experienced the following events.

0 = Never  
1 = Rarely  
2 = Sometimes  
3 = Often

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often have you been verbally insulted?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>a. By a parent/step-parent/relative/guardian?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. By a non-relative/non-guardian (e.g., peer, teacher, boss)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. How often have you been sworn at or cursed at?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>a. By a parent/step-parent/relative/guardian?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. By a non-relative/non-guardian (e.g., peer, teacher, boss)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. How often has someone tried to make you upset on purpose?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>a. By a parent/step-parent/relative/guardian?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. By a non-relative/non-guardian (e.g., peer, teacher, boss)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. How often have you been threatened with harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>a. By a parent/step-parent/relative/guardian?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. By a non-relative/non-guardian (e.g., peer, teacher, boss)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
SCI
(Cox, McWilliams, Enns, Clara, 2005)

We want to know more about what you think, how you feel. Please read each sentence. Then, circle a number between 1-4 that tells how true each sentence is for you.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Very true</th>
<th>2</th>
<th>3</th>
<th>Not true at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>There is a big difference between how I am now and how I wish I were.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I wish I could have more respect for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>At times I think I'm no good at all.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>Sometimes I feel like I have an inferiority complex (feel inferior to or less than others).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Many times I feel helpless.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I dwell on mistakes more than I should.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
SID
(WRIGHT & PERRY, 2006)

We want to know more about how you think and feel about your sexual orientation. Please circle the answer that best describes how much you agree or disagree with each of the following statements. There are no right or wrong answers.

0 = Strongly Agree
1 = Agree
2 = Mixed Feelings
3 = Disagree
4 = Strongly Disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Mixed Feelings</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have a positive attitude about being (gay/lesbian/bisexual).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I feel uneasy around people who are very open in public about being</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(gay/lesbian/bisexual).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I often feel ashamed that I am (gay/lesbian/bisexual).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. For the most part, I enjoy being (gay/lesbian/bisexual).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I worry a lot about what others think about my being (gay/lesbian/bisexual).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I feel proud that I am (gay/lesbian/bisexual).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I wish I weren’t attracted to the same sex.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
PDS

Part 1:

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Put a check by ALL of the events that have happened to you or that you have witnessed. Additionally if you have experienced the event, please indicate your age the first time the event happened and how many times you’ve experienced the event.

1. _____ Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident).
   
   Age the first time event happened
   
   How many times has this event happened to you

2. _____ Natural disaster (for example, tornado, hurricane, flood, or major earthquake).
   
   Age the first time event happened
   
   How many times has this event happened to you

3. _____ Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint).
   
   Age the first time event happened
   
   How many times has this event happened to you

4. _____ Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint).
   
   Age the first time event happened
   
   How many times has this event happened to you
5. _____ Sexual assault by a family member or someone you know (for example, rape or attempted rape).
   Age the first time event happened
   How many times has this event happened to you

6. _____ Sexual assault by a stranger (for example, rape or attempted rape).
   Age the first time event happened
   How many times has this event happened to you

7. _____ Military combat or a war zone.
   Age the first time event happened
   How many times has this event happened to you

8. _____ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts).
   Age the first time event happened
   How many times has this event happened to you

9. _____ Imprisonment (for example, prison inmate, prisoner of war, hostage).
   Age the first time event happened
   How many times has this event happened to you

10. _____ Torture
    Age the first time event happened
    How many times has this event happened to you

11. _____ Life-threatening illness
    Age the first time event happened
    How many times has this event happened to you
12. _____ Other traumatic events:
   Please explain the traumatic event: ____________________________
   Age the first time event happened________
   How many times has this event happened to you________

If you marked any of the above, continue with Parts 2-4. If not, skip to the page titled CES-DC.
Part 2

Put a checkmark by the **one** event that bothers you the most. If you marked only one traumatic event in Part 1, mark the same one below.

- _____ Accident
- _____ Disaster
- _____ Non-sexual assault/someone you know
- _____ Non-sexual assault/stranger
- _____ Sexual assault/someone you know
- _____ Sexual assault/stranger
- _____ Combat
- _____ Sexual contact under 18 with someone 5 or more years older
- _____ Imprisonment
- _____ Torture
- _____ Life-threatening illness
- _____ Other

From this point on, the questions will refer to the event that you marked above as the one event that bothers you the most.

How long ago did the event happen? (circle one)

1. Less than 1 month
2. 1 to 3 months
2. 3 to 6 months
3. 6 months to 3 years
4. 3 to 5 years
5. More than 5 years

For the following questions, circle Y for Yes or N for No.

**During this event:**

1. **Y**  **N**  Were you physically injured?
2. **Y**  **N**  Was someone else physically injured?
3. **Y**  **N**  Did you think that your life was in danger?
4. **Y**  **N**  Did you think that someone else’s life was in danger?
5. **Y**  **N**  Did you feel helpless?
6. **Y**  **N**  Did you feel terrified?
Part 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0 to 3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event that bothers you the most.

0  Not at all or only one time
1  Once a week or less/once in a while
2  2 to 4 times a week/half the time
3  5 or more times a week/almost always

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Once a week or less</th>
<th>2 to 4 times a week</th>
<th>5 or more times a week</th>
<th>How often do you find yourself:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having upsetting thoughts or images about the traumatic event that came in your head when you didn’t want them to.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Having upsetting thoughts or images about the traumatic event that came in your head when you didn’t want them to.</td>
</tr>
<tr>
<td>Having bad dreams or nightmares about the traumatic event.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Having bad dreams or nightmares about the traumatic event.</td>
</tr>
<tr>
<td>Reliving the traumatic event, acting or feeling as if it was happening again.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Reliving the traumatic event, acting or feeling as if it was happening again.</td>
</tr>
<tr>
<td>Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, or guilty, etc.).</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, or guilty, etc.).</td>
</tr>
<tr>
<td>Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast).</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast).</td>
</tr>
<tr>
<td>Trying not to think about, talk about, or have feelings about the traumatic event.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Trying not to think about, talk about, or have feelings about the traumatic event.</td>
</tr>
<tr>
<td>Trying to avoid activities, people, or places that remind you of the traumatic event.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Trying to avoid activities, people, or places that remind you of the traumatic event.</td>
</tr>
<tr>
<td>Not being able to remember an important part of the traumatic event.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Not being able to remember an important part of the traumatic event.</td>
</tr>
<tr>
<td>Having much less interest, or participating much less often, in important activities.</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>Having much less interest, or participating much less often, in important activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Feeling distant or cut off from people around you.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Having trouble falling or staying asleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Feeling irritable or having fits of anger.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Being jumpy or easily startled (for example, when someone walks up behind you).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How long have you experienced the problems that you reported above? (circle ONE).

1  Less than one month  
2  One to three months  
3  Six or more months  

How long after the traumatic event did these problems begin (circle ONE)?

1  Less than 6 months  
2  Six or more months
Below is a list of the ways you might have felt or acted recently. Please circle the number that corresponds to how often you’ve felt this way during the past week.

<table>
<thead>
<tr>
<th>During the past week:</th>
<th>Not at all 0 days</th>
<th>A little 1-2 days</th>
<th>Some 3-4 days</th>
<th>A lot 5-7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was bothered by things that don’t usually bother me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I did not feel like eating, I wasn’t very hungry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I wasn’t able to feel happy, even when my family or friends tried to help me feel better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I felt like I was just as good as other kids.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I felt like I couldn’t pay attention to what I was doing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I felt down and unhappy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I felt like I was too tired to do things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I felt like something good was going to happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I felt like things I did before didn’t work out right.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. I felt scared.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. I didn’t sleep as well as I usually sleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. I was happy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. I was more quiet than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. I felt lonely, like I didn’t have any friends.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. I felt like kids I know were not friendly or that they didn’t want to be with me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. I had a good time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. I felt like crying.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. I felt sad.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. I felt like people didn’t like me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. It was hard to get started doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>