SEXUAL STIGMA AND MENTAL HEALTH: A STRESS PROCESS APPROACH

A thesis submitted
to Kent State University in partial
fulfillment of the requirements for the
degree of Master of Arts

by

Katharine Marie Gary

August, 2018
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II</td>
<td>LITERATURE REVIEW</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>The Stress Process</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Coping Resources and Social Support</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>The Stress Process and Sexual Stigma</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>METHODS</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Data</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Measures</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Analytic Strategy</td>
<td>16</td>
</tr>
<tr>
<td>IV</td>
<td>RESULTS</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Structural Equation Models</td>
<td>21</td>
</tr>
<tr>
<td>V</td>
<td>DISCUSSION</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Limitations and Future Directions</td>
<td>32</td>
</tr>
<tr>
<td>REFERENCES</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>APPENDIX: SCALE ITEMS</td>
<td></td>
<td>46</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Estimated Structural Equation Models</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>SEM Mediation Model with Internalized Homophobia, Social Support, Self-Esteem, and Depressive Symptoms for those under 35-years-old</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>SEM Mediation Model with Internalized Homophobia, Social Support, And Self-Esteem for Respondents over 35-years-old</td>
<td>26</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Descriptive Statistics</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Correlation Matrix with Exogenous and Endogenous Variables</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>Goodness of Fit Indices for Multigroup Models</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>Direct Effects Decomposition for the Final Model</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>Indirect Effects Decomposition for the Final Model</td>
<td>24</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

This thesis uses the stress process model to examine mental health among sexual minorities. Lesbian, gay, and bisexual individuals (LGB) experience stressors that are unique to those who belong to a minority group (Meyer 1995). Minorities often face rejection, discrimination, and violence as a result of their status (Allport 1954; Meyer 1995). Approximately half of LGB individuals in the United States experience verbal harassment and about a fifth experience stigma-related hate crimes (Herek 2009). In other words, sexual minorities endure chronic stress related to stigma that members of the dominant culture do not experience (Meyer 1995, 2003).

According to Goffman (1963:3), stigma is any “deeply discrediting” character trait, physical abnormality or group identity that is perceived as socially undesirable. More specifically, stigma is an amalgam of stereotyping, status loss, separation, and discrimination that results from the social distribution of power (Link and Phelan 2001). Mental health scholars argue that stigma has deleterious effects on personal resources such as self-concept, mastery, and self-esteem (Link 1987; Link et al. 1989, 2001; Markowitz 1998; Pearlin 1989; Wright, Gronfein, and Owens 2000). Stigma can also deplete social resources such as social support (Mickelson 2001). Importantly, these resources, which are impacted directly by stigma, may also mediate the relationship between stigma stressors and mental health. For the LGB population, public stigma may result in internalized homophobia, which refers to defining oneself in the
context of sexual stigma (Herek 2004; Herek et al. 2009; Meyer 1995). Sexual stigma is the
shared understanding within a society that non-heterosexuality is undesirable (Herek 2004:15).
As such, internalized homophobia constitutes a stressor that has implications for an individual’s
attitude towards self and well-being (Meyer 1995).

The stress process offers the ideal approach to study the relationship between stigma and
mental health in the LGB population. Specifically, the stress model will allow me to examine
how a stressor such as internalized homophobia affects psychological distress in this population,
as well as explain the extent to which social and personal resources might mediate the impact of
social stress on distress (Pearlin et al. 1981; Pearlin 1989). In the proposed research, I use this
model to address two central questions. First, does internalized homophobia increase self-
reported depressive symptoms among gay, lesbian, and bisexual individuals? Second, do self-
esteeem and social support mediate the adverse effects of internalized homophobia on depressive
symptoms?
CHAPTER II

LITERATURE REVIEW

The Stress Process

The stress process approach to the study of mental health focuses on the psychological impact of stress that occurs in everyday life (Pearlin et al. 1981; Pearlin 1999b). There are three components of the stress process model: stressors, stress mediators, and psychological outcomes (Pearlin et al. 1981; Pearlin 1999b). Stress refers to any state that invokes the “adaptive machinery of the individual” (Pearlin 1999a:163). Stressors have been operationalized as life events, daily hassles, or chronic strains (Aneshensel 1992; Meyer 1995; Pearlin 1989; Thoits 1995; Turner, Wheaton, and Lloyd 1995). Life events (e.g., moving, job loss) and daily hassles (e.g., traffic, paying a fine) involve acute events that require major adjustments or minor adjustments, respectively (Aneshensel 1992; Pearlin 1989; Thoits 1995; Turner et al. 1995). By contrast, chronic strains are recurring demands over a long period of time (Aneshensel 1992; Pearlin 1989; Thoits 1995; Turner et al. 1995). Examples of chronic stress are barriers in achieving life goals, inequity regarding insufficient rewards in relation to qualification in invested effort, frustration with role expectations, or a deprivation of resources (Aneshensel 1992). According to mental health scholars, there is reason to believe that stressors, particularly chronic strains, are unequally distributed across social statuses and roles such as gender, age, socioeconomic status and martial status (e.g., Thoits 1995; Turner et al. 1995). In addition to factors that might differentially expose individuals to stressors, researchers have also shown that
individuals may be differentially reactive (or vulnerable) to stressors depending on their access to personal and social resources (Thoits 1995).

**Coping Resources and Social Support**

Coping resources are social or personal resources that protect individuals from stress (Aneshensel 1992; Pearlin 1989; Pearlin and Schooler 1978; Thoits 1995). Specifically, access to coping resources can lessen (or mediate) the adverse impact of chronic strains, life events, and daily hassles (Pearlin and Schooler 1978; Pearlin et al. 1981). The most commonly studied personal resources in the stress research are self-esteem and mastery (Pearlin and Schooler 1978; Thoits 1995). *Mastery* refers to the extent to which an individual feels control over their “life-chances” (Pearlin and Schooler 1978:5), whereas *self-esteem* refers to the degree to which an individual views his/herself positively or negatively (Rosenberg 1965).

While there is a good deal of theory and research to suggest that self-esteem and mastery influence the relationship between stressors and well-being, the findings regarding exactly how they influence the stress process are mixed (Thoits 1995). Personal resources can buffer psychological distress and physical illness (Pearlin 1989; Thoits 1995). In other words, stressors may be ameliorated or weakened by high levels of these resources. Conversely, lack of access to these resources can also exacerbate the impact of a stressor on psychological well-being (Thoits 1995). Finally, personal resources can change the stressful situation itself, reduce the threatening meaning of a stressful situation, or restrict stress symptoms to being manageable (Pearlin 1989). While mastery and self-esteem are both considered personal resources in the context of the stress process, I will focus on self-esteem in this study.

Labeling scholars have highlighted the importance of self-esteem as a resource that is at risk when individuals perceive devaluation (e.g., Link 1987; Link et al. 1989; Link and Phelen
Global self-esteem, which refers to one’s “positive or negative attitudes” toward the self as an object (Owens 1994; Rosenberg 1965:30), and is considered particularly relevant to psychological well-being (Rosenberg et al. 1995). Self-esteem is developed through reflected appraisals and through social comparisons. Reflected appraisals refer to our perceptions of how others see us (Cooley 1902; Mead 1934). These perceptions can come from society more generally (generalized other) or from specific individuals in our lives (significant others).

According to identity scholars, reflected appraisals are often compared to self-views in an effort to maintain consistency between the two. When such consistency is not achieved, individuals may suffer mental health consequences (e.g., Burke 1991, 1996). Social comparisons also form our self-concept, and refer to how individuals view themselves as better or worse to others (Rosenberg 1986; Singer 1981). For instance, girls who identify with “white” media images can develop negative feelings that harm them via taking the role of the other (Milkie 1999).

Nonetheless, social comparisons are usually made in reference to similar others that an individual has some freedom in choosing. For this reason, in the example above, many minority girls do not share these same negative feelings (Milkie 1999).

In sum, both perceptions of others and direct comparisons to others can have an impact on self-esteem and psychological well-being. Those who value others over their self are more at risk for internalizing disorders of mental illness such as depression or anxiety (Rosenfield, Lennon, and White 2005). Moreover, low self-esteem can make an individual more vulnerable to caustic influences in their social psychological context and cause them to have a more pessimistic view toward both self and society (Owens and Stryker 2006). On the other hand, high self-esteem protects individuals against life changes and increases emotional well-being (Owens
and Stryker 2006). A rational being would be more likely protect the self, because they view this object as deserving love and acceptance (Owens and Stryker 2006).

Social support is also considered a coping resource among mental health scholars (e.g., Thoits 1995). Specifically, social support is conceptualized as a social resource that individuals can “draw” upon in times of stress (Thoits 1986, 1995:64). Social support refers to the access of other individuals, groups, or organizations that provide assistance with coping (Pearlin et al. 1981:340; Thoits 1986, 1995) and has been conceptualized in a variety of ways, including perceived support (support that is believed to be available), received support (support received during a given timeframe), and structural support (how embedded one is in their social network) (Thoits 1995). While all three types of support have been linked to mental health outcomes, perceived support has received the most attention and the strongest empirical support (Thoits 1995).

Social support has long been connected to health and well-being (Durkheim 1951[1897]; Cobb 1976; Thoits 1995; Turner 1981). According to Cobb (1976), social support has direct affect on health, and has also been found to protect people from a wide range of health concerns such as depression, alcoholism, low birth weight, and even death. Specifically regarding mental health, social support has the potential to impact psychological well-being (Thoits 1995; Turner 1981). Similar to personal resources, perceiving high levels of social support can reduce the impact of stress (Thoits 1995). Nevertheless, the most potent form of support may be whether an individual has an intimate confidant (Thoits 1995). According to Thoits (1995), having a close, intimate confidant has a direct and positive effect on psychological well-being. Furthermore, empathic understanding, meaning that there are contextual and sociocultural commonalities
between the person experiencing stress and the supportive person, is a crucial factor in effacious social support (Thoits 1986).

*The Stress Process and Sexual Stigma*

The stress process model provides an ideal theoretical perspective for understanding LGB populations, as it articulates a relationship between status based stress (i.e., minority stress) and mental health (Meyer 1995). From conversion therapy to the pathologization of homosexuality in early editions of the *Diagnostic Statistical Manual of Mental Disorders* (DSM), the study of mental health among LGB populations has involved a stigmatization of homosexuality (Bailey 1999; Bayer and Spitzer 1982; Meyer 2003). Rather than pathologizing homosexuality, minority stress researchers seek to prevent further stigmatization of homosexuality by considering how social factors impact mental health among sexual minorities (Frost, Lehavot, and Meyer 2015; Frost and Meyer 2009; Meyer 1995, 2003). The premise of the minority stress concept is that LGB individuals experience chronic social stress unique to being a minority in a dominantly heteronormative society (Mays and Cochran 2001; Meyer 1995, 2003). Minority stress occurs when an individual is forced to adapt to the conflict between their values as a minority and the dominant values of their social environment (Meyer 1995). The dominant culture values heterosexuality, resulting in social stress for LGB individuals (Lazarus and Folkman 1984; Meyer 1995). Consequently, sexual minorities have to endure greater instances of stigma and discrimination, which may ultimately result in internalized homophobia (Meyer 1995). This type of stress constitutes a chronic strain, because minorities are often forced to remain alert with expectations of rejection, discrimination, and violence (Allport 1954; Meyer 1995). In other words, minority stress is any chronic social stress associated with *stigma* (Meyer 1995).
Stigma involves any character trait, physical abnormality, or group identity that is socially undesirable (Goffman 1963). According to Goffman (1963), stigma discredits the bearer of a socially tainted identity and results in the experience of shame. Stigma begins with a labeling of differences that others link to be undesirable on the basis of dominant values (Link and Phelan 2001). This process creates an “us-versus-them” mentality that leads to unequal outcomes and stereotypes (Link and Phelan 2001). Thus, stigma is a synthesis of stereotyping, status loss, separation, and discrimination that is dependent on the social distribution of power (Link and Phelan 2001). Among sexual minorities, sexual stigma is of significant concern. *Sexual stigma* is defined as “the shared knowledge of society’s negative regard for any non-heterosexual behavior, identity, relationship, or community” (Herek 2004:15; Herek et al. 2009). An estimated 20% of LGB individuals report experiencing a stigma-related hate crime and about 50% experience stigma-related verbal harassment (Herek 2009).

The internalization of sexual stigma that affects self is referred to as *internalized homophobia* (Meyer 1995; Herek 2004; Herek et al. 2009). George Weinberg (1972:83) was the first to coin the term “internalized homophobia” to describe the self-hatred that many homosexual individuals had as a result of the stigmatization of their sexual orientation (Herek 2004). The nature and extent of homophobia has changed across time in conjunction with historical events of gay liberation, but nonetheless, discrimination and stigma still persists (Floyd and Bakeman 2006; Herek 2004, 2009). As sexual minorities begin to develop their sexual identity, they often start to self-label as lesbian, gay, bisexual, transgender, queer, intersexual, asexual, etc. (LGBTQIA+) (Meyer 1995). Unfortunately, self-labeling often brings with it the internalization of the negative attitudes associated with that stigma (Meyer 1995; Thoits 1985). Thus, the concept of internalized homophobia involves the internalization of how a society
collectively views homosexuality, and whether these negative perceptions cause an individual to have a negative view of self as well (Herek 2004; Herek et al. 2009).

Internalized homophobia, as conceptualized by Weinberg (1972) and measured by Meyer (1995), overlaps to some extent with concepts within the stigma literature, including internalized shame and social isolation, or withdrawal (Fife and Wright 2000; Link et al. 1989). Internalized shame refers to a dimension of stigma that addresses the extent to which an individual blames themselves for being rejected and feeling different (Fife and Wright 2000); whereas social isolation or withdrawal emphasizes the need to cope with the negative effects of public stigma by withdrawing from social interactions (Fife and Wright 2000, Link et al. 1989). According to Fife and Wright (2000), both internalized shame and social isolation have been shown to negatively impact self-esteem and personal control among individuals who suffer from HIV/AIDS. Nonetheless, internalized shame is not necessarily static. The participation in or being aware of social movements can help convert shame to pride (Britt and Heise 2000). Similar to internalized shame, a chronic strain such as minority or sexual stigma may be as detrimental or more so to mental and physical health than acute stressors such as life events (Aneshensel 1992, 2009; Meyer 1995, 2003; Newcomb and Mutanski 2010; Turner et al. 1995). In particular, sexual stigma has been associated with increased psychological distress, such as depressive symptoms, demoralization, guilt, sexual problems, suicidality, and distress related to the AIDS epidemic (Frost, Parsons, and Nanin 2007; Meyer 1995).

Research examining the relationship between stigma and resources suggests that there is a relationship between stigma-related stressors and self-concept, as well as stigma and social support. In other words, stigma has been found to have a direct effect on self-esteem and social support, that in turn has implications for mental health (Link 1987; Link et al. 1989, 2001;
Markowitz 1998; Mickelson 2001; Wright et al. 2000). For instance, there is evidence that stigma-related stressors regarding the mental illness identity have a relationship with psychological well-being that is mediated by measures of coping (e.g., Markowitz 1998; Mickelson 2001; Pearlin 1989; Thoits and Link 2016). Specifically, the more that individuals expect to be devalued and discriminated against, the more threatened they feel around others (Link et al. 1989). These fears lead to social isolation, which in turn erodes social support networks and increases self-deprecation (Link et al. 1989). Moreover, dimensions of stigma such as social rejection (Wright et al. 2000) and internalized shame (Fife and Wright 2000) have been associated with increases in self-deprecation and a reduction of mastery.

While the relationships among stigma, personal resources, and social resources demonstrate the patterns advanced in stress theory, research examining the relationships among sexual stigma, social support, and personal resources is relatively scant. Extrapolating from Fife and Wright (2000), this study addresses an important form of stigma (i.e., internalized shame) that has previously been understudied in the context of the stress process. Only a few studies have examined this dimension of stigma (e.g., Hughes et al. 2015; Wright and Perry 2006). For instance, Hughes et al. (2015) explored the relationship between internalized negative racial stereotypes, esteem, mastery and depressive symptoms from a social identity and internalized racism perspective. Furthermore, Wright and Perry (2006) found that sexual identity distress, a dimension of internalized homophobia, increases psychological distress but decreases substance and alcohol use. However, Wright and Perry’s (2006) study does not use a stress process theory approach, and Hughes et al. (2015) had a different population of interest.

Hypotheses
Previous research has shown that internalized homophobia is negatively related to mental health outcomes (e.g., Barnes and Meyer 2012; Frost and Meyer 2009; Meyer 1995; Meyer 2003; Newcomb and Mutanski 2010). In this study, I examine this relationship in the context of depression. Specifically, I propose the following hypothesis:

**H1**: There will be a positive relationship between the social stress of internalized homophobia and self-reported depressive symptoms.

Although scholars have not examined this particular stressor in the context of the stress model to date, studies examining different forms of stigma provide a basis to expect that internalized homophobia will be negatively associated with coping resources such as self-esteem, mastery, and social support (Link 1987; Link et al. 1989, 2001; Markowitz 1998; Mickelson 2001; Pearlin 1989; Wright et al. 2000). While social and personal resources can be treated as moderators and/or mediators in the stress process, I focus here on the mediating influence of these resources as suggested in previous literature (e.g., Link et al 1989; Mickelson 2001). Given the potential for sexual stigma to weaken self-concept and one’s perceptions of social support, I propose the following hypotheses:

**H2**: Self-esteem will mediate the relationship between internalized homophobia and depressive symptoms.

**H3**: Social support will mediate the relationship between internalized homophobia and depressive symptoms.
CHAPTER III

METHODS

Data

The data are from the Project STRIDE dataset (Meyer et al. 2016), a longitudinal\(^1\) survey that combines both qualitative and quantitative measures during the years 2004-2005. This is an ideal dataset for examining social stress among sexual minorities because it includes variables regarding minority identity, social stressors, coping, social support, and mental health outcomes. The respondents consist of New York City residents between the ages 18-59. Research workers personally recruited lesbian, gay, bisexual, and straight potential respondents through venue-based ethnographic immersion. For the purposes of this study, I include only self-identified gay, lesbian, or bisexual individuals (\(N=396\)). The venues consist of bars, outdoors (e.g., parks), groups (e.g., sports or political groups), non-bar establishments (e.g., gyms or sex shops, events (e.g., Gay Pride), and/or snowball sampling through letters of invitation from respondents to friends and family. These venues are classified as a general venue (general NYC population), a mixed venue (about equal straight and LGB individuals) or a mostly LGB venue (LGB specific establishments or events). The researchers utilize a representative case quota sampling method (Shontz 1965) so that the distribution of respondents are approximately the same across gender, race, and age groups. Although this was a non-random sample, sampling venues in which those

---

\(^1\) The analysis reported in this thesis was performed with the first wave of data (2004). I performed an additional pathway analyses controlling for the first wave, but given that the waves were only a year apart, these analyses were insignificant.
with mental health disorders may be overrepresented were not included (e.g., therapeutic
groups) to help alleviate selection bias by reducing the likelihood that those with mental illness
are oversampled.

Measures

*Internalized Homophobia.* Internalized homophobia is the primary independent variable
for this study and represents my measure for sexual stigma. Project STRIDE uses a 9-item
internalized homophobia (IHP) scale originally developed by Martin and Dean (1987). The scale
is comprised of items derived from the DSM-III to assess ego-dystonic homosexuality. The items
examine the extent that individuals reject their sexual orientation, are uncomfortable about their
sexual desires toward the same sex, and avoid their homosexual attractions and feelings (Martin
and Dean 1987; Meyer 1995). Some examples of interview items consist of: “You have felt that
being [respondent’s self-described sexual orientation] is a personal shortcoming”, and “You have
tried to become more sexually attracted to [the opposite sex].” Respondents answer to these
items with either (1) often, (2) sometimes, (3) rarely, or (4) never. Scores were coded so that
higher scores suggest higher instances of self-reported internalized homophobia. Summary
scores were divided by the number of scale items in order to obtain a mean score for each
individual. This scale has good baseline sample reliability (α=0.84) and other studies
demonstrate this scale’s reliability with alphas ranging from 0.79 to 0.83 (e.g., Frost and Meyer
2009; Herek et al. 1998; Lewis et al. 2003; Meyer 1995; Meyer and Dean 1998). In addition, a
study by Herek et al. (1998) demonstrates that this scale has convergent validity due to
statistically significant correlations with individual and collective self-esteem. This scale is also
highly correlated with the Nungesser Homosexuality Attitudes Inventory (Nungesser 1983),
which is a commonly used measure of internalized homophobia (Shildo 1994; as cited by Frost
and Meyer 2009). Appendix A displays the full list of the items in the Internalized Homophobia scale.

**Social Support.** Social support is measured using an instrument by Fisher (1977), which examines several dimensions of support ranging from assistance with money to social companionship. The interviewees provide initials of people in their life who may have been helpful or supportive. Responses were coded continuously with a number that matched the amount of supportive persons provided and if no one was provided it was coded as 0. The interview items range from inquiring about who a respondent can share their private feelings with to who they can count on for favors. These items have been shown to demonstrate good reliability among LGB respondents. In order to differentiate perceived support (which is my focus) from received support, I use six of the ten items of this scale. For the items that measured perceived support, the Chronbach’s alpha is 0.89. Appendix A shows the full list of items in the social support scale.

**Self-Esteem.** This study utilizes Rosenberg’s (1965) 10-item scale to measure self-esteem. Responses are coded on a 4-point scales from “strongly agree” to “strongly disagree.” Items range from, “I feel that I have a number of good qualities”, to “I certainly feel useless at times.” These items have good reliability (α=0.86). The items are summed to form a scale where the higher scores suggest greater self-esteem. Summary scores are also divided by the number of items to create a mean score for each participant. This scale is widely utilized as a reliable measure and has also shown convergent and discriminant validity (Blascovich and Tomaka 1991). Appendix A displays the full Rosenberg Self-Esteem scale.

**Depressive Symptoms.** Project STRIDE utilizes The Center for Epidemiological Studies 20-item depression scale (CES-D). The researchers read the prompt, “Now I’m going to read a
list of the ways you might have felt or behaved in the last week. Please tell me how often if at all you have felt the following ways during the last week.” Participants respond the interview questions with a 4-point Likert scale ranging from (0) “rarely or none of the time” to (3) “most or all of the time.” This measure has good baseline sample reliability ($\alpha = 0.92$). The items inquire about different depressive symptoms like poor appetite, restless sleep, feelings of sadness, and loneliness. This scale is commonly used and is considered a reliable and valid measure (Radloff 1997; Roberts and Vernon 1983). Summed scores were coded so that higher scores reflect greater depressive symptoms and were divided by the number of items to obtain a mean score for each respondent. Appendix A provides a full list of items for the depressive symptoms scale.

Controls. Because stressors, coping resources and distress are not distributed equally across the social statuses, I controlled for several demographic variables in my study, including gender, race, age, and socioeconomic status (Pearlin and Schooler 1978; Thoits 1995; Turner et al. 1995). Specifically, individuals with lower social status report greater instances of chronic stress (Thoits 1995; Turner et al. 1995); racial minorities, women, unmarried individuals, and those with lower education report less sense of control (Thoits 1995); and there is some evidence to believe that there are social status differences in self-esteem and perceived social support (Thoits 1995).

With the exception of age, I dummy coded the categorical variables to make them continuous variables for the analysis. Gender is coded as (1) male and (0) female, and race is coded as (1) Black/Latino/Hispanic and (0) White. Age is coded categorically as (1) under 21 years, (2) 21-25 years, (3) 26-30 years, (4) 31-35 years, (5) 36-40 years, (6) 41-45 years, (7) 46-50 years, and (8) over 50 years.
Socioeconomic status is measured with two variables: education and household income. Education is coded categorically from (1) never attended to (11) doctoral degree. Yearly household income is coded categorically from (0) no income to (34) $1,000,000 or more. Individuals with lower social status experience a greater degree of chronic stress (Thoits 1995).

Discrimination often acts as a stressor similar to stigma regarding its effect on psychological wellbeing (Meyer 1995), therefore I controlled for everyday discrimination. Everyday discrimination is measured with an 8-item instrument that assesses chronic, routine, and covert occurrences of unfair treatment. Responses were coded so that higher scores indicated more everyday discrimination and summed scores were divided by items in order to acquire a mean score for each participant.

Finally, because research suggests that non-affirming religion increases internalized homophobia among the LGB population (Barnes and Meyer 2012), I will control for religion and spirituality. About half the respondents in the sample reported no religion and, consequently, religion is coded as (0) no religion and (1) has a religion. Spirituality is coded continuously with (0) not at all, (1) slightly, (2) moderately, and (3) very in response to the interview question, “To what extent do you consider yourself a spiritual person.”

**Analytic Strategy**

The analysis of the data took place in two phases using STATA 14. In **phase one**, I created a correlation matrix to assess for statistically significant bivariate relationships between these variables. In **phase two**, I utilized Multigroup Structural Equation Modeling (SEM) to test the stress process model. Multigroup pathway analysis for two age groups (i.e., below and above age 35) was performed to assess if internalized homophobia varies across cohort and the lifespan. The multigroup analysis was performed in order to examine variation (or changes) in
public sexual stigma and discrimination that occur across time (e.g., Bailey 1999; Bayer and Spitzer 1982; Meyer 2003). The understanding of homophobia has evolved across generations in conjunction with the increase of gay liberation spurred by the Civil Rights Movement in the 1960s, the introduction of the official term “homophobia” by psychologist George Weinberg in 1972, and the removal of homosexuality from the DSM-III in 1973 (Herek 2004). The observance of homophobia has dated as far back as ancient Greece, but the use of the term itself is a more recent development (Herek 2004). Furthermore, age and historical context shapes the process of developing a sexual orientation identity (Floyd and Bakeman 2006). Thus, it is necessary to account the recent developments in gay liberation that occur across time that can impact internalization of homophobia across cohort and the lifespan.

Although there are other methods such as the Baron-Kenny test or the Sobel test that might be used to test the proposed models, these models do not allow a simultaneous examination of multiple mediators as clearly as more advanced methods such as SEM (Hayes 2009; Kline 2005). For instance, when testing a model of mediation that has multiple mediators, the specific role of each mediator in the model is clearer when using SEM, and coping mediators can be highly correlated with one another (Pearlin 1999b; Preacher and Hayes 2004). SEM allows me to account for measurement error for each parameter while simultaneously assessing the overall model fit for the estimated equations unlike typical regression analysis (Hayes 2009; Kline 2005; Preacher and Hayes 2004).
Note: I control for gender, age, race/ethnicity, yearly household income, education, religion, spirituality, and discrimination are controlled.

**Figure 1. Estimated Structural Equation Models**
<table>
<thead>
<tr>
<th>Table 1: Descriptive Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Variable</strong></td>
</tr>
<tr>
<td>Internalized Homophobia</td>
</tr>
<tr>
<td>1.41</td>
</tr>
<tr>
<td><strong>Mediating Variables</strong></td>
</tr>
<tr>
<td>Self-esteem</td>
</tr>
<tr>
<td>Social Support</td>
</tr>
<tr>
<td><strong>Dependent Variable</strong></td>
</tr>
<tr>
<td>Depressive Symptoms</td>
</tr>
<tr>
<td><strong>Control Variables</strong></td>
</tr>
<tr>
<td>Gender (Female=1)</td>
</tr>
<tr>
<td>Age&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Race/Ethnicity (Non-White=1)</td>
</tr>
<tr>
<td>Yearly Household Income&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Race/Ethnicity (Non-White=1)</td>
</tr>
<tr>
<td>Yearly Household Income&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Religion&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Spirituality</td>
</tr>
<tr>
<td>Discrimination</td>
</tr>
</tbody>
</table>

<sup>a</sup> Age is dummy coded as (0) Under 35-years-old to (1) over 35-years-old for Multigroup Pathway Analysis

<sup>b</sup> Household income is measured categorically from (0) no income to (34) 1,000,000 or more a year

<sup>c</sup> Religion is coded as (0) no religion and (1) religion.
Table 2: Correlation Matrix with Exogenous and Endogenous Variables

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalized Homophobia</td>
<td>-0.31 ***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
<td>-0.22 ***</td>
<td>0.12 *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Symptoms</td>
<td>0.22 ***</td>
<td>-0.55 ***</td>
<td>-0.16 **</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (Female=1)</td>
<td>-0.06</td>
<td>-0.02</td>
<td>0.07</td>
<td>0.12 *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.09</td>
<td>0.03</td>
<td>0.05</td>
<td>0.02</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity (Non-White=1)</td>
<td>0.17 ***</td>
<td>0.02</td>
<td>-0.36 ***</td>
<td>0.10 †</td>
<td>0.00</td>
<td>-0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yearly Household Income(^a)</td>
<td>-0.10 †</td>
<td>0.09 †</td>
<td>0.16 **</td>
<td>-0.17 **</td>
<td>-0.01</td>
<td>0.07</td>
<td>-0.24 ***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-0.21 ***</td>
<td>0.07</td>
<td>0.28 ***</td>
<td>-0.14 **</td>
<td>0.01</td>
<td>0.23 ***</td>
<td>-0.34 ***</td>
<td>0.36 ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion(^b)</td>
<td>0.11 *</td>
<td>0.01</td>
<td>-0.06</td>
<td>0.02</td>
<td>-0.09 †</td>
<td>0.13 *</td>
<td>0.21 ***</td>
<td>-0.02</td>
<td>-0.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>-0.09</td>
<td>0.15 **</td>
<td>0.02</td>
<td>-0.04</td>
<td>-0.10 †</td>
<td>0.24 ***</td>
<td>0.15 **</td>
<td>0.07</td>
<td>0.01 **</td>
<td>0.15 **</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>0.14 **</td>
<td>-0.28 ***</td>
<td>-0.08</td>
<td>0.31 ***</td>
<td>-0.02</td>
<td>-0.01</td>
<td>0.14 **</td>
<td>-0.03</td>
<td>0.06</td>
<td>0.04</td>
<td>0.12 *</td>
</tr>
</tbody>
</table>

\(^{a}\)Household income is measured categorically from (0) no income to (34) 1,000,000 or more a year

\(^{b}\)Religion is coded as (0) no religion and (1) religion

\(^{c}\)Age is coded categorically as (1) under 21 to (8) over 50 years

***p<.001; **p<.01; *p<.05; †<.10
TABLE IV

RESULTS

Table 1 displays the descriptive statistics for the key independent, dependent, and control variables. On average, reported internalized homophobia and depressive symptoms were on the lower end of the ordinal scales ($\bar{x}=1.41$, $SD=0.51$), whereas the mean for self-esteem was relatively high ($\bar{x}=3.31$, $SD=0.56$). Moreover, respondents typically reported a total of 20 initials of persons across all the items that provided a variety of social support. Table 2 reports the bivariate correlations for both the key variables and the control variables. Reported internalized homophobia has statistically significant bivariate correlations with the coping variables ($p=0.00$, $\alpha=0.05$). All the bivariate correlations between each coping variable are also significant at the 0.05 confidence level. Furthermore, reported depressive symptoms had statistically significant bivariate correlations with all the key variables ($p=0.00$, $\alpha=0.05$). For every standard deviation increase in internalized homophobia, depressive symptoms increase by 0.22.

Structural Equation Models

A multigroup path analysis was performed to compare two age groups on the key variables. Figure 1 shows the estimated structural equation models for the base model and the mediation model that I utilized to test the hypotheses. Given the large number of control variables, I did not display these variables and their paths in the figures for the sake of visual simplicity. Age was coded (0) Below 35-years old and (1) Above 35-years-old. A constrained, unconstrained, and partially constrained model were all performed. Table 3 displays the
Table 3: Goodness of Fit Indices for Multigroup Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Chi-square</th>
<th>df</th>
<th>p</th>
<th>Chi-square/df</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
<th>RMSEA CI</th>
<th>AIC</th>
<th>BIC</th>
<th>CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unconstrained</td>
<td>2.65</td>
<td>2.00</td>
<td>0.27</td>
<td>1.33</td>
<td>0.94</td>
<td>1.00</td>
<td>0.04</td>
<td>0.00-0.17</td>
<td>10705.87</td>
<td>11288.76</td>
<td>0.46</td>
</tr>
<tr>
<td>Constrained</td>
<td>100.48</td>
<td>36.00</td>
<td>0.00</td>
<td>2.79</td>
<td>0.77</td>
<td>0.66</td>
<td>0.10</td>
<td>0.08-0.13</td>
<td>10735.70</td>
<td>11188.20</td>
<td>0.29</td>
</tr>
<tr>
<td>Partially Constrained</td>
<td>20.41</td>
<td>20.00</td>
<td>0.43</td>
<td>1.02</td>
<td>1.00</td>
<td>1.00</td>
<td>0.01</td>
<td>0.00-0.07</td>
<td>10687.62</td>
<td>11201.49</td>
<td>0.43</td>
</tr>
</tbody>
</table>

*Note: CD = Coefficient of Determination
<table>
<thead>
<tr>
<th>Table 4. Direct Effects Decomposition for the Final Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Esteem</strong></td>
</tr>
<tr>
<td><strong>Below 35-years-old</strong></td>
</tr>
<tr>
<td><strong>Social Support</strong></td>
</tr>
<tr>
<td><strong>Below 35-years-old</strong></td>
</tr>
<tr>
<td><strong>Depressive Symptoms</strong></td>
</tr>
<tr>
<td><strong>Below 35-years-old</strong></td>
</tr>
<tr>
<td>Internalized Homophobia -0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Self-esteem</td>
</tr>
<tr>
<td>-0.04 † 0.05</td>
</tr>
<tr>
<td>Social Support</td>
</tr>
<tr>
<td>Gender (Female=1)</td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Race/Ethnicity (Non-White=1)</td>
</tr>
<tr>
<td>-0.03 † 0.06</td>
</tr>
<tr>
<td>Yearly Household Income <strong>b</strong></td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Religion†</td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Spirituality</td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
<tr>
<td>Discrimination</td>
</tr>
<tr>
<td>-0.32 *** 0.07 -0.31 ** 0.09</td>
</tr>
</tbody>
</table>

Note: SE=Standard Error  
***p<.001; **p<.01; *p<.05  
† Denotes an equality constraint
Table 5. Indirect Effects Decomposition for the Final Model

<table>
<thead>
<tr>
<th></th>
<th>Depressive Symptoms</th>
<th>Above 35-years-old</th>
<th>SE</th>
<th>b</th>
<th>SE</th>
<th>(p&lt;.001)</th>
<th>(p&lt;.01)</th>
<th>(p&lt;.05)</th>
<th>(\dagger)</th>
<th>(\dagger)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalized Homophobia</td>
<td>0.15 **</td>
<td>0.14 **</td>
<td>0.03</td>
<td>0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (Female=1)</td>
<td>0.02 (\dagger)</td>
<td>0.03 (\dagger)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity (Non-White=1)</td>
<td>-0.05</td>
<td>-0.07</td>
<td>0.03</td>
<td>0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yearly Household Income(b)</td>
<td>0.00 (\dagger)</td>
<td>0.00 (\dagger)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>0.00</td>
<td>0.00</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion(c)</td>
<td>0.01 (\dagger)</td>
<td>0.01 (\dagger)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>-0.04 (\dagger)</td>
<td>-0.04 (\dagger)</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>0.16 **</td>
<td>0.06 *</td>
<td>0.04</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: SE=Standard Error

\(***p<.001; **p<.01; *p<.05\)

\(\dagger\) Denotes an equality constraint for both indirect and direct effects
Figure 2. SEM Mediation Model with Internalized Homophobia, Social Support, Self-Esteem, and Depressive Symptoms for those under 35-years-old

***p<.001; **p<.01; *p<.05; †=equality constraint
Note: All models control for gender, age, race/ethnicity, yearly household income, education, religion, spirituality, and discrimination.
Figure 3. SEM Mediation Model with Internalized Homophobia, Social Support, and Self-Esteem for Respondents over 35-years-old
Goodness of Fit Indices for the multigroup models. The constrained model did not fit the data well ($\chi^2=100.48$, $p=0.00$; TLI=0.77; CFI=0.66; RMSEA=0.10). The total model accounted for a satisfactory amount of variance ($r^2=0.29$), but the observed variable of support is not accounting for adequate variance ($r^2=0.00$). Many of the standardized covariance residuals were also relatively high for the esteem and support variables. There is also a trivial pathway from perceived social support to depressive symptoms for both age groups. However, this pathway was not deleted, because it is theoretically supported that lack of social support can decrease depressive symptoms (Thoits 1995). On the other hand, the unconstrained model that allowed all the parameters to differ across the age groups had satisfactory goodness of fit statistics ($\chi^2=2.65$, $p=0.27$; TLI=0.94; CFI=1.00; RMSEA=0.04). Furthermore, the standardized residuals were satisfactory with values below 2.00, and the full model accounted for a good amount of variance ($r^2=0.46$). Thus, the unconstrained model fits better than the constrained model suggesting that there are differences between the two age groups. Furthermore, the likelihood-ratio test between the unconstrained and constrained model was significant ($p=0.00$) signifying that the some of the parameters differ between age groups.

In order to account for which parameters differ, I performed a partially constrained model. The postestimation command (estat ginvariant) was utilized to assess for parameter invariance between groups (Acock 2013). This command utilizes a Wald test and score tests to determine which pathways had statistically significant differences between the two age groups (Acock 2013). The results from this analysis suggest that there are pathway differences from some of the exogenous variables (i.e., internalized homophobia, ethnicity, education, and everyday discrimination) going to the mediating variables (i.e., social support and self-esteem). Thus, I released these paths to be unconstrained. The partially constrained model has the best
goodness of fit statistics out of all the models ($\chi^2=2.65, \ p=0.27; \ TLI=0.94; \ CFI=1.00; \ RMSEA=0.04$). Additionally, the full model accounted for a good amount of variance ($r^2=0.43$) and the observed variables did as well with $r^2$ values ranging from 0.18-0.31. The standardized residuals were also satisfactory with values below or near 2.00. Furthermore, the partially constrained model was also the most parsimonious of the models (AIC=10687.62, BIC=11201.49). Therefore, the partially constrained model will be the final model, given that it fits the data better overall.

Table 4 displays the direct effects for the partially constrained model. Internalized homophobia had a statistically significant direct effect on self-esteem for both age groups (p=0.00). However, the pathways that were constrained to be equal for both age groups from internalized homophobia to depressive symptoms were insignificant (b=0.06, p=0.24). In regards to the indirect effects from internalized homophobia to reported depressive symptoms, they were statistically significant for both age groups via self-esteem and social support (p=0.00). Therefore, there is evidence to support a mediating effect between the association of internalized homophobia and reported depressive symptoms. While this relationship supports theoretical and previous empirical work (Pearlin 1989; Thoits 1995), the results should be interpreted with caution given that temporal order cannot be assessed in this model.

Of the mediating variables, self-esteem shows the strongest support for mediation among both age groups. The direct effects from internalized homophobia to self-esteem were significant for both age groups (p=0.00). Furthermore, the direct effects from self-esteem to depressive symptoms that were constrained to be equal across both groups were also statistically significant (p=0.00). Conversely, internalized homophobia only decreased perceived social support for the respondents that are under the age of 35-years-old (b=-3.00, p=0.02). Moreover, internalized
homophobia did not decrease perceived social support for those above 35-years-old (b=-0.95, p=0.62). The pathways from perceived social support to depressive symptoms that were constrained to be equal for both groups were also insignificant (b=-0.00, p=0.34). This finding suggests that there is not sufficient evidence to suggest that social support mediates the relationship between internalized stigma and depressive symptoms for individuals in the age category of 35 years old and above.

Regarding comparisons between the two age groups, the results of parameter invariance analysis suggested that the coefficient for internalized homophobia to reported self-esteem was statistically different for each group. As Table 4 displays, internalized homophobia decreased self-esteem for those under 35-years-old (b=-0.32, p=0.00), which is slightly more than for those over 35-years-old (b=-0.31, p=0.00). Similarly, internalized homophobia decreased the number of reported supportive persons by 3.00 for those under 35-years-old (p=0.02), whereas there is not statistical evidence to support that internalized homophobia decreases perceived social support for those above 35-years-old (b=-0.95; p=0.62). Table 5 displays the indirect effects for the model. The indirect effect from internalized homophobia to reported depressive symptoms was also slightly greater for those under 34-years-old (b=0.15, p=0.00) than for those over 34-years old (b=0.14, p=0.00). Other than these aforementioned differences, the results from the multigroup path analysis suggest that all the pathway coefficients were similar for both age groups otherwise.
CHAPTER V

DISCUSSION

This thesis examines how internalized sexual stigma affects the mental health of sexual minorities. Extant research suggests that stigma has an adverse effect on personal resources such as self-esteem (Link 1987; Link et al. 1989, 2001; Markowitz 1998; Pearlin 1989; Wright et al. 2000), and can deplete social resources and affect psychological wellbeing (Meyer 1995; Mickelson 2001). The results from this study supported the notion that internalized sexual stigma is associated with higher levels of depressive symptoms with the addition of controls. Furthermore, there was evidence to support that self-esteem lessens the effect of internalized homophobia on mental health as well. In general, these findings are consistent with theoretical thinking about how internalized homophobia adversely affects mental health (e.g., Meyer 1995, Wright and Perry 2006). It is also consistent with research that suggests that self-esteem can act as a coping resource that lessens mental illness symptoms (Pearlin 1989; Thoits 1995; Owens and Stryker 2006).

Although this study is consistent with previous research, it also challenges current theoretical understanding of how social support impacts mental health. There was not sufficient evidence to suggest that social support is associated with decreased depressive symptoms in this study. As discussed above, social support often acts as a coping resource that lessens symptoms of mental illness (Thoits 1995). Nonetheless, the findings in this study are consistent with previous research by Wright and Perry (2006), which found that the size of support network does
not decrease psychological distress among LGB individuals. Results from this same study also indicated that having a greater amount of LGB supporters is associated with a greater degree of risky sexual behavior. Thus, social support may have a different role regarding mental health for this population of interest than other more commonly studied populations.

Not only does the effect of social support on mental health contest current theoretical expectations in this study, but the differences in age groups do as well. Homophobia and its relationship to identity have transformed alongside historical events of gay liberation (Herek 2004). Thus, we might expect that that sexual stigma and its internalization would have a weaker impact on mental health for younger LGB individuals. However, findings for this study suggest that this is not the case. The effect of the social stress of internalized homophobia has a slightly greater decrease on mental health for those under 35-years-old. Moreover, internalized homophobia only has an association with perceived social support for the younger cohort.

These findings suggest that differences regarding the impact of internalized homophobia may be more of a result of chronological age. Age of coming out may have a significant role, because being out to more individuals in an LGB individual’s support network lessens the intensity of sexual identity distress (Wright and Perry 2006). Furthermore, there is some evidence that rates of mental health concerns and negative self-esteem are lesser for older gay men in comparison their younger counterparts (Bybee et al. 2009). A decrease in chronic shame and guilt across the lifespan may be responsible for this trend (Bybee et al. 2009). Furthermore, coping skills become more developed with age, and individuals may be less likely to feel inclined to conform to social pressures and parental criticism (Landa and Bybee 2007; Bybee et al. 2009).
The results of this study have the potential to contribute to the existing literature on sexual stigma and discrimination. First, it applies sociological theory to this specific social issue that has predominantly been understood with perspectives stemming from psychological roots (Meyer 2003). Secondly, these findings help with developing a better understanding of the mental health consequences of negative attitudes toward sexual minorities. Most stigma researchers focus on public stigma rather than other dimensions of stigma such as internalized shame (e.g., Link 1987; Link et al. 1989, 2001). Dimensions of stigma impact the self differently (Fife and Wright 2000). For instance, the social rejection dimension has been shown to have a greater impact on self-esteem, whereas the financial insecurity dimension has a greater impact on mastery (Fife and Wright 2000). Thus, this thesis further illustrates the importance of the different dimensions in the stigma process. Internalization is only a recent direct focus of stigma research (e.g., Wright and Perry 2006), because most researchers assume that it becomes self-relevant (e.g, Link 1987; Link et al. 1989, 2001). In this way, this study is extending stigma research, and a stress process model is an important theoretical framework in which to accomplish this task. Stigma can act as a stressor that can impacts coping and mental health outcomes (Meyer 1995; Thoits and Link 2016). Furthermore, this thesis extends stress and stigma research to a relatively understudied population. Stress research is often concerned with mental health differences across race, gender, and socioeconomic. It has only been recently that scholars have suggested it be extended to other stigmatized groups such as those with minority sexual orientation (e.g., Thoits and Link 2016).

**Limitations and Future Directions**

While this study provides some insight into the relationship between internalized homophobia and mental health, it is not without limitations, some of which pertain to the data.
First, the data is approximately 10-years-old. As mentioned previously, rates of internalized homophobia vary with cohort and age (Floyd and Bakeman 2006; Herek 2004; Meyer 2003). For this reason, there is not a clear consensus on how to conceptualize and measure internalized homophobia (Herek 2004). Wright and Perry (2006) also suggest that internalized homophobia is a multidimensional concept that includes certain sub-dimensions, but they only pinpoint sexual identity distress as one of the dimensions. Thus, the measure of internalized homophobia used in this study may have some conceptual limitations given that it does not demonstrate the multidimensionality and modernization of this rapidly changing construct. Nonetheless, using group comparisons between age groups helps to account for the conceptual limitations by providing insight into how the impact of internalized homophobia may alter across time.

A limitation of the data was that it is non-random. While an advantage of collecting this way was that the authors of the dataset (Meyer et al. 2016) were able to have control over the sources of recruitment and to be able to better estimate response rates, the disadvantage is that quantitative statistics often assumes randomness (Kline 2005). However, it may be difficult to attain a large random sample of LGB individuals. Because of the high rates of discrimination and stigma this population experiences (e.g., Herek 2009; Meyer 1995), it may be the case that LGB individuals are less willing to participate in these types of studies.

An additional limitation to note is that transgender, queer, intersex, asexual, and so on individuals (TQIA+) were not included in the study. Thus, it is important to refrain from generalizing the results of this study to these populations, because rates of discrimination and sexual stigma may look different for these individuals than LGB individuals. Lastly, another limitation of using an existing dataset is that it did not allow me access to the individual items for the depressive symptoms and esteem scales, and thus, I was not able to check the scales for
discriminant and convergent validity. Nonetheless, the scales still demonstrated sufficient reliability. However, it would have been of theoretical interest to separate the Rosenberg (1965) self-esteem scale items into two subscales that represent a bidimensional measure of self-esteem rather than the unidimensional global measure used here. Splitting the self-esteem items into self-deprecation and positive self-worth subscales may reveal nuances that were overlooked in this study, as previous research suggests that these two dimensions of self-esteem may have a different implications for mental health outcomes (e.g. Owens 1994).

These limitations provide a basis for future directions of research that examine sexual stigma and mental health. As alluded to above, a focus for future research might be to examine how additional personal resources affect the relationship between internalized homophobia and mental health such as mastery, and the self-denigration and positive self-worth dimensions of self-esteem (e.g. Owens 1994; Pearlin and Schooler 1978). Examining additional or alternative measures of social resources may also yield additional interesting insights as well. Perceived size of support network has been shown to have an insignificant effect on mental illness among this population (i.e., Wright and Perry 2006), but parsing out the nuances of these networks with a different measure of social support may help explain this finding. For instance, being out to more individual’s in one’s network decreases sexual identity distress and having more close intimate confidants can lessen the impact of stress (Thoits 1995; Wright and Perry 2006).

Another potential direction for future study that could contribute to the theoretical understanding of stigma is to examine how other dimensions of stigma affect coping resources and mental health. Perhaps social rejection, social isolation, and financial insecurity have a different impact on mental illness for LGB individuals (e.g., Wright and Fife 2000). Similarly, stigma may also have a separate effect on different symptomologies of mental illness. Although
high instances of the internalization of stigma has been shown to increase internalizing symptoms of mental illness (e.g., Hughes et al. 2015, Meyer 1995), this stressor has also been shown to decrease externalizing symptoms of mental illness such as drug and alcohol use (Wright and Perry 2006). Internalizing individuals have schemas that prioritize others over their self, whereas externalizing individuals do the opposite (Rosenfield et al. 2005). Thus, it is important to take note that internalizing individuals may report greater internalization of stigma and internalizing symptoms of mental illness, whereas their externalizing counterparts may report greater instances of public stigma and externalizing symptoms of mental illness. Self-salience and gender determines the likelihood that individuals externalize or internalize their mental health concerns, and their role may be import to consider when studying internalizing stressors and symptoms (Rosenfield et al. 2005).

This study also has some broader implications. For instance, there is stigmatizing heritage between LGB individuals and the field of mental health that needs to be further redefined (e.g., conversion therapy, DSM-III) (Bailey 1999; Bayer and Spitzer 1982; Meyer 2003). Contrary to previous psychological understanding, differences in mental illness among this population may not be a result of individual deficits but rather arise from internalizations of social interactions (Meyer 2003). Findings from this study suggest that internalizing stigma continues to have an impact on the self and mental health of minority groups, which provides further support for research that views stigma as a barrier to potential treatments (Meyer 2003). Some treatments (such as conversion therapy) may very well exacerbate this effect as they seem to build on stigmatizing notions of the LGB community (Meyer 2003). Thus, it is may be important for clinicians to consider therapies that reduce, rather than increase, the likelihood that individuals will internalize negative public perceptions.
REFERENCES


Brady, Teresa J. 2003. “Measures of Self-efficacy, Helplessness, Mastery, and Control: The Arthritis Helplessness Index (AHI)/Rheumatology Attitudes Index (RAI), Arthritis Self-Efficacy Scale (ASES), Children's Arthritis Self-Efficacy Scale (CASE), Generalized Self-Efficacy Scale (GSES), Mastery Scale, Multi-Dimensional Health Locus of Control Scale (MHLC), Parent's Arthritis Self-Efficacy Scale (PASE), Rheumatoid Arthritis Self-Efficacy Scale (RASE), and Self-Efficacy Scale (SES).” Arthritis Care and Research 49:S5.


APPENDIX

SCALE ITEMS

I. INTERNALIZED HOMOPHOBIA

1) You felt it best to avoid personal or social involvement with other people who are [respondent’s self-described sexual orientation].
2) You have tried to stop being attracted to [same sex].
3) If someone offered you the chance to be completely heterosexual this past year, you would have accepted the offer.
4) You have wished you weren’t [respondent’s self-described sexual orientation].
5) You have felt alienated from yourself because of being [respondent’s self described sexual orientation].
6) You have wished that you could develop more erotic feelings towards [opposite sex].
7) You have felt that being [respondent’s self-described sexual orientation] is a personal shortcoming.
8) You would have liked to get professional help in order to change your sexual orientation from [respondent’s self-described sexual orientation] to straight.
9) You have tried to become more sexually attracted to [opposite sex].

II. SOCIAL SUPPORT

1) Who could you count on for everyday favors like household chores, getting a ride somewhere, borrowing a small sum of money (e.g., a couple of dollars), or running errands?
2) Who could you count on to lend you a large sum of money (e.g., several hundred dollars) for an emergency, such as, the rent or a medical emergency?
3) Who have you spent time with in social activities such as having dinner together, going to the movies, or hanging out?
4) Who have you talked with about personal worries, for example worries about your family, money or health?
5) When you have been happy, who have you shared it with – Is there someone who you felt would feel happy for you?
6) Who have you shared your most private feelings with, confided in?
III. MASTERY

1) You have little control over the things that happen to you.
2) There is really no way you can solve the problems you have.
3) There is little you can do to change many of the important things in your life.
4) You often feel helpless in dealing with problems in life.
5) Sometimes you feel that you are being pushed around in life.
6) What happens to you in the future mostly depends on you.
7) You can do just about anything you set your mind to.

IV. SELF-ESTEEM

1) I feel I am a person of worth, at least on an equal basis with others.
2) I feel that I have a number of good qualities.
3) All in all I am inclined to feel that I am a failure.
4) I am able to do things as well as most people.
5) I feel I do not have much to be proud of.
6) I take a positive attitude toward myself.
7) On the whole, I am satisfied with myself.
8) I wish I could have more respect for myself.
9) I certainly feel useless at times.
10) At times I think I am no good at all.

V. DEPRESSIVE SYMPTOMS

1) You were bothered by things that don’t usually bother you.
2) You did not feel like eating; your appetite was poor.
3) You felt that you could not shake off the blues even with help from your family or friends.
4) You felt that you were just as good as other people.
5) You had trouble keeping your mind on what you were doing.
6) You felt depressed.
7) You felt that everything was an effort.
8) You felt hopeful about the future.
9) You thought your life had been a failure.
10) You felt fearful.
11) Your sleep was restless.
12) You were happy.
13) You talked less than usual.
14) You felt lonely.
15) People were unfriendly.
16) You enjoyed life.
17) You had crying spells.
18) You felt sad.
19) You felt that people dislike you.
20) You could not get going.