10

Prejudice and Discrimination as Social Stressors

Ilan H. Meyer

1 Introduction

Lesbians, gay men, and bisexuals (LGBs) vary in sociodemographic characteristics such as cultural, ethnic or racial identity, age, education, income, and place of residence as well as in the degree to which their LGB identities are central to their self-definition, their level of affiliation with other LGB people, and their rejection or acceptance of societal stereotypes about and prejudice against homosexuality. In that diversity, it is difficult to describe many common themes. Despite the many differences that separate them, LGB people share remarkably similar experiences related to prejudice, stigma, discrimination, rejection, and violence directed toward them across cultures and locales (Espin, 1993; Fullilove & Fullilove, 1999; Herek, 2000; Diaz et al., 2001). Even after a historic U.S. Supreme Court ruling that the criminalization of homosexuality is unconstitutional, gay men and lesbians continue to be subjected to legal discrimination in housing, employment, and basic civil rights—most prominent in recent years are discrimination related to family law, including marriage and adoption.

Within this social context, LGB people have responded to prejudice and discrimination with resilience and resolve, forming communities as varied and diverse as the LGB individuals that comprise them. These communities have provided safe spaces for LGBs to congregate; and within these communities LGBs have developed norms and values and created institutions where LGB identities and relationships are acknowledged, supported, and respected (D'Emilio, 1983).

The social environment plays an important role in the health of LGBs. Prejudice affects the health of LGB people in many ways. Direct routes are easily discernible: They include exposure to violence and

---

Portions of this chapter are adapted from Meyer I.H. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* 2003;129:674–697.

discrimination. Indirect routes are less visible but more pervasive: They include inadequate attention to health concerns of LGB people, lack of knowledge and insensitivity regarding the cultural aspects of LGB groups, barriers to accessing health care, and poor quality of care (Garnets et al., 1990; Malebranche et al., 2004).

That social conditions characterized by prejudice, rejection, and discrimination are stressful has been suggested regarding various social categories, including groups defined by race/ethnicity, gender, and sexual orientation (Barnett & Baruch, 1987; Mirowsky & Ross, 1989; Pearlin, 1999; Swim, 2001; Meyer, 2003); heavyweight people (Miller & Myers, 1998); people with stigmatizing physical illnesses such as acquired immunodeficiency syndrome (AIDS) and cancer (Fife & Wright, 2000); and people who have taken on stigmatizing attributes, or "marks," as psychologists call the targets of stigma, such as body piercing (Jetten et al., 2001).

The U.S. Public Health Service declared its goal of eliminating disparities in health in the United States (U.S. Department of Health and Human Services, 2000). Anticipating and accompanying this work, there has been increased interest in the minority stress model for explaining causes of disparities in health outcomes, for example, and in particular as it applies to the social environment of African Americans' experience of stress related to racism (Allison, 1998; Clark, 1999). Social psychology theory has begun to explicitly incorporate these experiences into stress discourse (Allison, 1998; Miller & Major, 2000). Researchers and the Healthy People 2010 document have also identified LGBT (with the T representing transgender) populations at risk and identified disparities in health outcomes between them and the general U.S. population. Such disparities have been explained by social stressors (Dean et al., 2000; Gay and Lesbian Medical Association, 2001).

Krieger discussed the ways that discrimination becomes embodied, relating to the multiple ways that such social conditions affect the health of minority populations (Krieger, 2001). Here, I present a conceptual model that describes social conditions as stressors and describe their putative effect on mental health. The model specifies some of the stressful social processes that affect risk for mental disorders and opportunities for well-being in LGB populations but also accounts for resilience and coping, which may buffer the stress.

2 A Conceptual Model: Prejudice and Discrimination as Minority Stress

When developing the concept of minority stress, researchers' underlying assumptions are that minority stress is (1) unique—that is, minority stress is additive to general stressors that are experienced by all people, and therefore that stigmatized people require an adaptation effort above that required of similar others who are not stigmatized; (2) chronic—that is, minority stress is related to relatively stable underlying social and cultural structures; and (3) socially based—that is, it

stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors, or biologic, genetic, or other nonsocial characteristics of the person or the group. Applied to lesbians, gay men, and bisexuals, a minority stress model posits that sexual prejudice is stressful and may lead to adverse mental health outcomes (Brooks, 1981; Meyer, 1995, 2003; Krieger & Sidney, 1997; DiPlacido, 1998; Cochran, 2001; Mays & Cochran, 2001). A more recent contribution is the interest of stress researchers in the relation of identity with stress. Reviewing the literature on stress and identity, Thoits called the investigation of stressors related to minority identities a "crucial next step" in the study of identity and stress (Thoits, 1999, p. 361). Understanding identity may help researchers formulate hypotheses about the interaction of stress and identity—for example, whether stress in a gay-related area has more impact on a health outcome in individuals with high versus low commitment to gay identity.

2.1 Minority Stress Processes in LGB Populations

There is no consensus about specific stress processes that affect LGB people, but psychological theory, stress literature, and research on the health of LGB populations provide some ideas for articulating a minority stress model. A distal-proximal distinction can help with cataloguing minority stress processes. The distal-proximal dimension relies on stress conceptualization that seems most relevant to minority stress and its concern with the impact of external social conditions and structures on individuals. Lazarus and Folkman (1984) described social structures as "distal concepts whose effects on an individual depend on how they are manifested in the immediate context of thought, feeling, and action—the proximal social experiences of a person's life" (p. 321). Distal social attitudes gain psychological importance through cognitive appraisal and become proximal concepts with psychological importance to the individual. Crocker et al. (1998) make a similar distinction between "objective reality," which includes prejudice and discrimination, and "states of mind that the experience of stigma may create in the stigmatized." They noted that "states of mind have their grounding in the realities of stereotypes, prejudice, and discrimination," again echoing Lazarus and Folkman's (1984) conceptualization of the proximal, subjective appraisal as a manifestation of distal objective environmental conditions.

I described minority stress processes along a continuum: from distal stressors, which are typically defined as objective events and conditions, to proximal personal processes, which are by definition subjective because they rely on individual perceptions and appraisals. I have suggested that specific processes of minority stress are relevant to lesbians, gay men, and bisexuals (Meyer, 1995, 2003; Meyer & Dean, 1998). From distal to proximal they are (1) external objective stressful events and conditions (chronic and acute), (2) expectations of such events and the vigilance this expectation requires, (3) concealment of one's sexual orientation, and (4) the internalization of negative societal attitudes. It

should be noted that additional processes may be added that are general to all LGB individuals or that are unique to some populations, such as women, ethnic minorities, and so on.

Distal minority stressors can be defined as *objective stressors* in that they do not depend on the person's perceptions or appraisals, although certainly their report depends on perception and attribution (Kobrynowicz & Branscombe, 1997; Operario & Fiske, 2001). As objective stressors, distal stressors can be seen as independent of personal identification with the assigned minority status (Diamond, 2000). For example, a woman may have a romantic relationship with another woman but not identify as a lesbian (Laumann et al., 1994). Nevertheless, she may be perceived as a lesbian by others and as such may suffer from stressors associated with prejudice toward LGB people (e.g., antigay violence). In contrast, the more proximal stress processes are *subjective* and are therefore more affected by one's self-identity as lesbian, gay, or bisexual. Thus, because subjective stressors are more closely related to identities, and because identities vary in the social and personal meanings that are attached to them, variability in identity could lead to variability in health outcomes in the face of stress.

2.2 Stress and Identity

There are specific characteristics of minority identity (e.g., the prominence of minority identity in the person's sense of self) that may be related to minority stress and its impact on health outcomes. Group identities are essential for individual emotional functioning as they address conflicting needs for individuation and affiliation (Brewer, 1991).

Characteristics of identity may be related to mental health both directly and in interaction with stressors. A *direct effect* mechanism suggests that identity characteristics themselves can cause distress. For example, Burke (1991) said that feedback from others that is incompatible with one's self-identity—a process he called "identity interruptions"—can cause distress. An *interactive effect* with stress suggests that characteristics of identity would modify the effect of stress on health outcomes. For example, Linville (1987) found that subjects with more complex self identities were less prone to depression in the face of stress. Another mechanism was suggested by Thoits (1999, p. 346), who explained, "Since people's self conceptions are closely linked to their psychological states, stressors that damage or threaten self concepts are likely to predict emotional problems." This suggests that a stronger commitment to a gay identity may enhance the impact of stressors in gay-related areas. The reverse is also plausible: Stronger identity may ameliorate the impact of stress. This may be the case if a stronger minority identity leads to stronger affiliations with one's community. Stronger affiliations in the minority community and social support, in turn, may aid in buffering the impact of stress (Crocker & Major, 1989; Branscombe et al., 1999b; Brown et al., 1999). I discuss below prominence, valence, and integration of identities (Rosenberg & Gara, 1985; Thoits, 1991, 1999; Deaux, 1993).

Prominence (or salience) of an identity may exacerbate stress because "the more an individual identifies with, is committed to, or has highly developed self-schemas in a particular life domain, the greater will be the emotional impact of stressors that occur in that domain" (Thoits, 1999, p. 352). In coming-out models and in some models of racial identity, there has been a tendency to see minority identity as prominent and ignore other personal and social identities (de Monteflores & Schultz, 1978; Cross, 1995; Eliason, 1996), but this is not necessarily the case. Minority identities, which may seem prominent to observers, are often not endorsed as prominent by minority group members themselves, leading to variability in identity hierarchies of minority persons (Massey & Ouellette, 1996). For example, Brooks (1981) noted that the stress process for lesbians is complex because it involves both sexual orientation and gender identities. Similarly, research on African American and Latino LGBs has shown that they often confront homophobia in their racial/ethnic communities and alienation from their racial/ethnic identity in the lesbian/gay community (Espin, 1993; Loiacano, 1993; Diaz et al., 2001). LGB members of racial/ethnic minorities thus manage diverse identities. Unlike the more simplistic picture painted by identity models, then, it is plausible that salience of minority identities—including race/ethnic, sexual orientation, and gender, among others—are dynamic. Rather than view identity as stable, researchers now view identity structures as fluid, with prominence of identity often shifting with the social context (Brewer, 1991; Deaux & Ethier, 1998; Crocker & Quinn, 2000).

Valence refers to the evaluative features of identity and is tied to self-validation. Negative valence has been described as a good predictor of mental health problems, with an inverse relation to depression (Woolfolk et al., 1995; Allen et al., 1999). Identity valence is a central characteristic of coming-out models, as internalized homophobia diminishes and self-acceptance increases. Thus, overcoming negative self-evaluation is the primary aim of the LGB person's development in coming out and is a central theme of gay-affirmative therapies (Coleman, 1982; Maylon, 1982; Troiden, 1989; Loiacano, 1993; Rotheram-Borus & Fernandez, 1995; Meyer & Dean, 1998; Diaz et al., 2001). Negative valence is most likely related to increased impact of the stressor in the relevant area. For example, Meyer and Dean (1998) found that in the face of antigay violence gay men who had more positive self-perceptions of their gay identity fared better than gay men who had more negative self-perceptions of their gay identity in terms of mental health outcomes. The authors explained that gay men with negative self-perceptions may have had fewer internal resources to cope with the antigay experience, in a sense identifying with the antigay aggression.

Distinct identities are interrelated through a hierarchal organization (Rosenberg & Gara, 1985; Linville, 1987). *Integration* of identities refers to the relationship of the minority identity and other identities of the person. In coming-out models, integration of the minority identity with the person's other identities is seen as the optimal stage of identity development. For example, Cass (1979) saw the last stage of coming out as "identity synthesis," where the gay identity becomes merely one

part of this integrated total identity. During optimal identity development, various aspects of the person's self, including but not limited to other minority identities, such as those based on gender or race/ethnicity, are integrated (Eliason, 1996).

For example, Crawford et al. (2002) see in gay Black men's identities a conflict between two cultures with unique and sometimes conflicting stressors and resources. Crawford and colleagues suggested a model for understanding the experiences of African American gay and bisexual men as a dual minority. The authors described four types of potential adaptation to the challenges of the intersection of the sexual and racial identities: (1) *assimilation*, high racial/ethnic identification and low sexual orientation identification; (2) *integration*, both racial/ethnic and sexual orientation identifications are high; (3) *separation*, low racial/ethnic identification and high sexual orientation identification; and (4) *marginalization*, both racial/ethnic and sexual orientation identifications are low. Consistent with identity development models, Crawford and colleagues hypothesized that the *integration* type of identification would be associated with more positive outcomes, including self-esteem, symptoms of mental disorders, and responsiveness to human immunodeficiency virus (HIV) prevention efforts. The authors found evidence in support of this hypothesis and concluded (Crawford et al., 2002, p. 186): "The fusion of ethnic and sexual identity into an integrated whole that is characterized by holding positive attitudes toward one's ethnic group, homosexuals and homosexuality, and engaging in social participation and cultural practice in the African-American and gay subcultures appear to be key to this process."

3 LGB Minority Stress Model

Based on the distal-proximal distinction, I propose a minority stress model that incorporates the elements discussed above. When developing the model I emulated Dohrenwend's stress model to highlight minority stress processes. Dohrenwend has described the stress process within the context of strengths and vulnerabilities in the larger environment and within the individual. For the purpose of succinctness, I have included in my discussion only those elements of the stress process unique to or necessary for the description of minority stress. It is important to note, however, that the elements I omitted—including advantages and disadvantages in the wider environment, personal predispositions, biologic background, ongoing situations, appraisal and coping—are integral parts of the stress model and are essential for a comprehensive understanding of the stress process (Dohrenwend, 2000).

The model (Fig. 10.1) depicts stress and coping and their impact on mental health outcomes (box i). Minority stress is situated in general environmental circumstances (a), which may include advantages and disadvantages related to factors such as socioeconomic status. An important aspect of these circumstances in the environment is the person's minority status (e.g., gay or lesbian) (b). These are depicted as

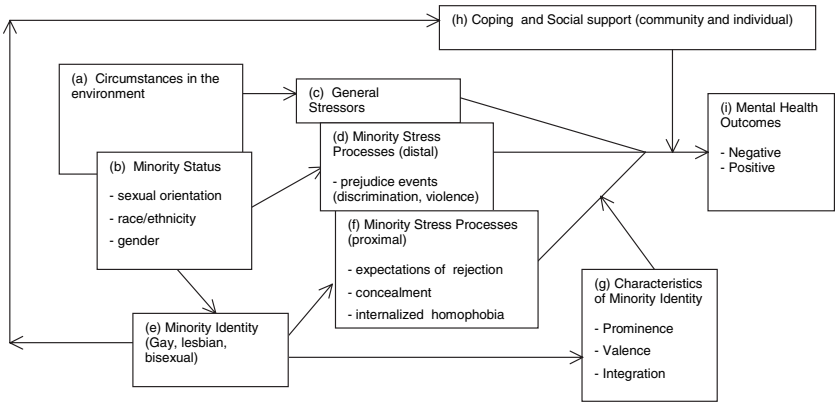

Figure 10.1 Stress, coping, and mental health in LGB populations.

overlapping boxes in the figure to indicate the close relation to other circumstances in the person's environment. For example, minority stressors for a gay man who is poor would undoubtedly be related to his poverty; together, these characteristics would determine his exposure to stress and coping resources (Diaz et al., 2001). Circumstances in the environment lead to exposure to stressors, including general stressors such as job loss or death of an intimate (c); and minority stressors unique to minority group members, such as discrimination in employment (d). Similar to their source circumstances, the stressors are depicted as overlapping as well, representing their interdependence (Pearlin, 1999). For example, an experience of antigay violence (d) is likely to increase vigilance and expectations of rejection (f). Often minority status leads to personal identification with one's minority status (e). In turn, such minority identity leads to additional stressors related to the individual's perception of self as a stigmatized and devalued minority (Miller & Major, 2000). Because they involve self-perceptions and appraisals, these minority stress processes are more proximal to the individual, including, as described above for LGB individuals, expectations of rejection, concealment, and internalized homophobia (f).

Of course, minority identity is not only a source of stress but also an important effect modifier in the stress process. First, characteristics of minority identity can augment or weaken the impact of stress (g). For example, minority stressors may have a greater impact on health outcomes when the LGB identity is prominent than when it is secondary to the person's self-definition (Thoits, 1999). Second, LGB identity may also be a source of strength (h) when it is associated with opportunities for affiliation, social support, and coping that can ameliorate the impact of stress (Crocker & Major, 1989; Branscombe et al., 1999b; Miller & Major, 2000).

3.1 Minority Stress Processes

Many researchers have studied minority stress processes—not necessarily classifying or labeling them as I do—and have often demon-

strated that such stress affects the mental health of LGB individuals. These studies have typically measured mental health outcomes using psychological scales (e.g., depressive symptoms) rather than the criteria-based mental disorders (e.g., major depressive disorder). These studies concluded that minority stress processes are related to an array of mental health problems including depressive symptoms, substance use, and suicide ideation (D'Augelli & Hershberger, 1993; Cochran & Mays, 1994; Meyer, 1995; Rosario et al., 1996; Waldo, 1999; Diaz et al., 2001). Such studies have shown, for example, that stigma leads LGB persons to experience alienation, lack of integration with the community, and problems with self-acceptance (Greenberg, 1973; Maylon, 1982; Massey & Ouellette, 1996; Frable et al., 1997; Grossman & Kerner, 1998; Stokes & Peterson, 1998).

3.1.1 Prejudice Events

Researchers have described antigay violence and discrimination as core stressors affecting gay and lesbian populations (Garnets et al., 1990; Herek & Berrill, 1992; Herek et al., 1999; Kertzner, 1999). Antigay prejudice has been perpetrated throughout history: institutionalized forms of prejudice, discrimination and violence ranged from Nazi extermination of homosexuals to enforcement of sodomy laws punishable by imprisonment, castration, torture, and death (Adam, 1987). With the formation of a gay community, as LGB individuals became more visible and more readily identifiable by potential perpetrators, they increasingly became targets of antigay violence and discrimination (Herek & Berrill, 1992; Badgett, 1995; Safe Schools Coalition of Washington, 1999; Human Rights Watch, 2001). In 2001 Amnesty International reported that LGBT people are subject to widespread human rights abuses, torture, and ill-treatment ranging from loss of dignity to assault and murder. Many of these abuses are conducted with impunity—sanctioned by the state and society through formal mechanisms such as discriminatory laws and informal mechanisms, including prejudice and religious traditions (Amnesty International, 2001).

Surveys have documented that lesbians and gay men are disproportionately exposed to prejudice events, including discrimination and violence. For example, in a probability study of U.S. adults, LGB people were twice as likely as heterosexuals to have experienced a life event related to prejudice, such as being fired from a job (Mays & Cochran, 2001). In a study of LGB adults in Sacramento, California, approximately one-fifth of the women and one-fourth of the men experienced victimization (including sexual assault, physical assault, robbery, and property crime) related to their sexual orientation (Herek et al., 1999). Some research has suggested variation by ethnic background as well, although the direction of the findings is not clear. Thus, among urban adults aged 25 to 37 who reported same-sex sexual partners, Krieger and Sidney (1997) found that one-half of Whites compared with one-third of Blacks reported discrimination based on sexual orientation. On the other hand, in a study of HIV-positive gay men in New York City, Siegel and Epstein (1996) found that African American and Puerto

Rican men had significantly more gay-related minority stressors than Caucasian men.

Research has suggested that LGB youth are even more likely than adults to be victimized by antigay prejudice events, and the psychological consequences of their victimization may be more severe. Surveys of schools in several regions of the United States showed that LGB youth are exposed to more discrimination and violence events than their heterosexual peers. Several such studies, conducted on population samples of high school students, converge in their findings and show that the social environment of sexual minority youth in U.S. high schools is characterized by discrimination, rejection, and violence (Faulkner & Cranston, 1998; Garofalo et al., 1998). Compared with heterosexual youth, LGB youth are at increased risk for being threatened and assaulted, are more fearful for their safety at school, and miss school days because of this fear (Safe Schools Coalition of Washington, 1999). For example, in a random sample of Massachusetts high schools students, LGB students more often than heterosexual students had property stolen or deliberately damaged (7% vs. 1%), were threatened or injured with a weapon (6% vs. 1%), and were in a physical fight requiring medical treatment (6% vs. 2%). A national survey of LGBT youth conducted by the advocacy organization Gay, Lesbian, and Straight Education Network (GLSEN) reported that youth experienced verbal harassment (61%), sexual harassment (47%), physical harassment (28%), and physical assault (14%). Most LGBT youth (90%) sometimes or frequently heard homophobic remarks at their schools, and many (37%) reported hearing these remarks from faculty or school staff (GLSEN, 1999).

Gay men and lesbians are also discriminated against in the workplace. Waldo (1999) demonstrated a relation between employers' organizational climate and the experience of heterosexism in the workplace, which was subsequently related to adverse psychological health, and job-related outcomes in gay, lesbian, and bisexual employees. Badgett's (1995) analysis of national data showed that gay and bisexual male workers earned 11% to 27% less than heterosexual male workers with the same experience, education, occupation, marital status, and region of residence.

Garnets and colleagues (1990) described psychological mechanisms that could explain the association between victimization and psychological distress. The authors noted that victimization interferes with a person's perception of the world as meaningful and orderly. In an attempt to restore order to their perception of the world, survivors ask "Why me?" and often respond with self-recrimination and self-devaluation. More generally, experiences of victimization take away the victim's sense of security and invulnerability. Health symptoms of victimization include "sleep disturbances and nightmares, headaches, diarrhea, uncontrollable crying, agitation and restlessness, increased use of drugs, and deterioration in personal relationships" (Garnets et al., 1990, p. 367). Antigay bias crimes had a greater mental health impact on LGB persons than did similar crime's not related to bias and that bias-crime victimization may have short- or long-term conse-

quences, including severe reactions such as posttraumatic stress disorder (Herek et al., 1999; McDevitt et al., 2001).

3.1.2 Stigma: Expectations of Rejection and Discrimination

Goffman (1963) discussed the anxiety with which the stigmatized individual approaches interactions in society. Such an individual "may perceive, usually quite correctly, that whatever others profess, they do not really 'accept' him and are not ready to make contact with him on 'equal grounds' " (p. 7). Allport (1954) described vigilance as one of the traits that targets of prejudice develop for defensive coping. This concept helps explain the stressful effect of stigma. Like other minority group members, gay men, lesbians, and bisexuals learn to anticipate—indeed expect—negative regard from members of the dominant culture. To ward off potential negative regard, discrimination, and violence, they must maintain vigilance. The greater one's perceived stigma, the greater is the need for vigilance in interactions with dominant group members. By definition, such vigilance is chronic in that it is repeatedly and continually evoked in the everyday life of the minority person. Crocker and colleagues (1998, p. 517) described this as the "need to be constantly 'on guard' . . . alert, or mindful of the possibility that the other person is prejudiced." Jones and colleagues (1984) described the effect of societal stigma on the stigmatized individual as creating a conflict between self-perceptions and others' perceptions. As a result of this conflict, self-perception is likely to be at least somewhat unstable and vulnerable. Maintaining the stability and coherence of self-concept is likely to require considerable energy and activity.

This exertion of energy in maintaining one's self-concept is stressful and would increase as the perceptions of others' stigmatization increase. Branscombe et al. (1999a) described four sources of threat relevant to the discussion of stress due to stigma: *Categorization threat* involves the threat that the person will be categorized by others as a member of a group against his or her will, especially when group membership is irrelevant in the particular context (e.g., categorization as a woman when applying for a business loan). *Distinctiveness threat* is an opposite threat, relating to denial of distinct group membership when it is relevant or significant (also Brewer, 1991). *Threats to the value of social identity* involves undermining the minority group's values, such as its competence and morality. A fourth threat, *threat to acceptance*, emerges from negative feedback from one's ingroup and the consequent threat rejection by the group. For example, Ethier and Deaux (1994) found that Hispanic American students at an Ivy League university were conflicted, divided between identification with white friends and their culture and the desire to maintain an ethnic cultural identity.

Research evidence on the impact of stigma on health, psychological, and social functioning comes from a variety of sources. Link (1987; Link et al., 1997) showed that in mentally ill individuals perceived stigma was related to adverse effects in mental health and social functioning. In a cross-cultural study of gay men, Ross (1985) found that anticipated social rejection was more predictive of psychological distress outcomes

than actual negative experiences. However, research on the impact of stigma on self-esteem, a main focus of social psychological research, has not consistently supported this theoretical perspective: Such research often fails to show that members of stigmatized groups have lower self-esteem than others (Crocker & Major, 1989; Crocker et al., 1998; Crocker & Quinn, 2000). One explanation for this finding is that, along with its negative impact, stigma has self-protective properties related to group affiliation and support that ameliorate the effect of stigma (Crocker & Major, 1989). This finding is not consistent across various ethnic groups: Although African Americans have scored higher than Whites on measures of self-esteem, other ethnic minorities have scored lower (Twenge & Crocker, 2002).

Experimental social psychological research has highlighted other processes that can lead to adverse outcomes. This research may be classified as somewhat different from that related to the vigilance concept discussed above. Vigilance is related to fear of possible (even if imagined) negative events and may therefore be classified as more distal along the continuum ranging from the environment to the self. Stigma threat, as described below, relates to internal processes that are more proximal to the self. This research has shown that expectations of stigma can impair social and academic functioning of stigmatized persons by affecting their performance (Farina et al., 1968; Steele & Aronson, 1995; Steele, 1997; Crocker et al., 1998; Pinel, 2002). For example, Steele (1997, p. 614) described stereotype threat as the "social-psychological threat that arises when one is in a situation or doing something for which negative stereotype about one's group applies" and showed that the emotional reaction to this threat can interfere with intellectual performance. When situations of stereotype threat are prolonged they can lead to "disidentification," whereby a member of a stigmatized group removes a domain that is negatively stereotyped (e.g., academic success) from his or her self-definition. Such disidentification with a goal undermines the person's motivation—and therefore effort—to achieve in this domain. Unlike the concept of life events, where stress stems from some concrete offense (e.g., antigay violence), here it is not necessary that any prejudice event has actually occurred. As Crocker (1999) noted, because of the chronic exposure to a stigmatizing social environment, "[t]he consequences of stigma do not require that a stigmatizer in the situation holds negative stereotypes or discriminates" (p. 103). As Steele (1997) described it, for the stigmatized person there is "a threat in the air."

3.1.3 Concealment Versus Disclosure

Another area of research on stigma, moving more proximally to the self, concerns the effect of concealing one's stigmatizing attribute. Paradoxically, concealing one's stigma is often used as a coping strategy, aimed at avoiding negative consequences of stigma, but it is a coping strategy that can backfire and become stressful (Miller & Major, 2000). In a study of women who felt stigmatized by abortion, Major and Gramzow (1999) demonstrated that concealment was related to suppressing thoughts about the abortion, which led to intrusive

thoughts about it, and resulted in psychological distress. Smart and Wegner (2000) described the cost of hiding one's stigma in terms of the resultant cognitive burden involved in the constant preoccupation with hiding. They described complex cognitive processes, both conscious and unconscious, that are necessary to maintain secrecy regarding one's stigma, and called the inner experience of the person who is hiding a concealable stigma a "private hell" (p. 229).

Gay men, lesbians and bisexuals may conceal their sexual orientation in an effort to protect themselves from real harm (e.g., being attacked, getting fired from a job) or out of shame and guilt (D'Augelli & Grossman, 2001). Concealment of one's homosexuality is an important source of stress for gay men and lesbians (DiPlacido, 1998). Hetrick and Martin (1987) described "learning to hide" as the most common coping strategy of gay and lesbian adolescents and noted that "individuals in such a position must constantly monitor their behavior in all circumstances: How one dresses, speaks, walks, and talks become constant sources of possible discovery. One must limit one's friends, one's interests, and one's expression, for fear that one might be found guilty by association. . . . The individual who must hide of necessity learns to interact on the basis of deceit governed by fear of discovery. . . . Each successive act of deception, each moment of monitoring which is unconscious and automatic for others, serves to reinforce the belief in one's difference and inferiority" (pp. 35–36).

Hiding and fear of being identified do not end with adolescence. For example, studies of the workplace experience of lesbians, gay men, and bisexuals found that fear of discrimination and concealment of sexual orientation are prevalent (Croteau, 1996), and that they have adverse psychological, health, and job-related outcomes (Waldo, 1999). These studies showed that gay men, lesbians, and bisexuals engage in identity disclosure and concealment strategies that address fear of discrimination on one hand and a need for self-integrity on the other. These strategies range from "passing," which involves lying in order to be seen as heterosexual; covering, which involves censoring clues about one's self so the gay/lesbian identity is concealed; being implicitly "out," which involves telling the truth without using explicit language that discloses one's sexual identity; and being explicitly "out" (Griffin, 1992; in Croteau, 1996).

Another source of evidence comes from psychological research that has shown that expressing emotions and sharing important aspects of one's self with others—through confessions and disclosures involved in interpersonal or therapeutic relationships, for example—are important factors in maintaining physical and mental health (Pennebaker, 1995). Studies showed that suppression, such as hiding secrets, is related to adverse health outcomes, and that expressing and disclosing traumatic events or characteristics of the self improve health by reducing anxiety and promoting assimilation of the revealed characteristics (Bucci, 1995; Stiles, 1995). In one class of studies, investigators have shown that repression and inhibition affect immune function and health outcome, whereas expression of emotions, such as writing about traumatic experiences, produces improved immune function, fewer

physician visits, and diminished symptoms for diseases such as asthma and arthritis (Petrie et al., 1995; Smyth et al., 1999). Research evidence for gay men supports these formulations. Cole and colleagues found that HIV infection advanced more rapidly among gay men who concealed their sexual orientation than those who were open about it (Cole et al., 1996b). In another study, among HIV-negative gay men, those who concealed their sexual orientation were more likely to have had health problems than those who were open about their sexual orientation (Cole et al., 1996a).

In addition to suppressed emotions, concealment prevents LGB people from identifying and affiliating with others who are gay. The psychology literature has demonstrated the positive effect of affiliation with other similarly stigmatized persons on self-esteem (Jones et al., 1984; Crocker & Major, 1989; Postmes & Branscombe, 2002). This effect has been demonstrated by Frable et al. (1998) in day-to-day interactions. The researchers assessed self-perception and well-being in the context of the immediate social environment. College students with concealable stigmas, such as homosexuality, felt better about themselves when they were in an environment with others who are like them than when they were with others who are not similarly stigmatized. In addition, if LGB people conceal their sexual orientation, they are not likely to access formal and informal support resources in the LGB community. Thus, by concealing their sexual orientation LGB people suffer from the health-impairing properties of concealment and lose the ameliorative self-protective effects of being "out."

3.1.4 Internalized Homophobia

In the most proximal position along the continuum from the environment to the self, internalized homophobia represents a form of stress that is internal and insidious. In the absence of overt negative events, and even if one's minority status is successfully concealed, lesbians and gay men may be harmed by directing negative social values toward the self. Thoits (1985, p. 22) described such a process of self-stigmatization, explaining: "[R]ole-taking abilities enable individuals to view themselves from the imagined perspective of others. One can anticipate and respond in advance to others' reactions regarding a contemplated course of action."

Clinicians use the term *internalized homophobia* to refer to the internalization of societal antigay attitudes in lesbians and gay men (e.g., Malyon, 1982). Meyer and Dean (1998) defined internalized homophobia as "the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161). After they accept their stigmatized sexual orientation, gay men, lesbians, and bisexuals begin a process of coming out. Optimally, through this process they come to terms with their homosexuality and develop a healthy identity that incorporates their sexuality (Cass, 1979, 1984; Coleman, 1982; Troiden, 1989). Internalized homophobia signifies failure of the coming-out process to ward off stigma and thoroughly overcome negative self-perceptions and attitudes (Morris et al., 2001). Although it is most acute early during the

coming-out process, it is unlikely that internalized homophobia completely abates even when the person has accepted his or her homosexuality. Because of the strength of early socialization experiences and continued exposure to antigay attitudes, internalized homophobia remains an important factor in the gay person's psychological adjustment throughout life. Gay people maintain varying degrees of residual antigay attitudes that are integrated into their self-perception that can lead to mental health problems (Malyon, 1982; Nungesser, 1983; Hetrick & Martin, 1984; Cabaj, 1988). Gonsiorek (1988, p. 117) termed such residual internalized homophobia "covert," and said: "Covert forms of internalized homophobia are the most common. Affected individuals appear to accept themselves, yet sabotage their own efforts in a variety of ways."

Williamson (2000) reviewed the literature on internalized homophobia and described the wide use of the term in gay and lesbian studies and gay-affirmative psychotherapeutic models. He noted the intuitive appeal of internalized homophobia to "almost all gay men and lesbians" (p. 98). Much of the literature on internalized homophobia has come from theoretical writings and clinical observations, although some research has been published. Despite significant challenges to measuring internalized homophobia and lack of consistency in its conceptualization and measurement (Shidlo, 1994; Ross & Rosser, 1996; Mayfield, 2001; Szymanski & Chung, 2001), research showed that internalized homophobia is a significant correlate of mental health, including depression and anxiety symptoms, substance use disorders, and suicide ideation (DiPlacido, 1998; Meyer & Dean, 1998; Williamson, 2000). Research has also suggested a relation between internalized homophobia and various forms of self-harm, including eating disorders (Williamson, 2000) and HIV risk-taking behaviors (Meyer & Dean, 1998), although some studies failed to show this relation (Shidlo, 1994). Nicholson and Long (1990) showed that internalized homophobia was related to self-blame and poor coping in the face of HIV infection/AIDS. Other research showed that internalized homophobia was related to difficulty with intimate relationships and sexual functioning (Dupras, 1994; Rosser et al., 1997; Meyer & Dean, 1998).

3.1.5 Stress-Ameliorating Factors

As early as 1954, Allport suggested that minority members respond to prejudice with coping and resilience. Modern writers agree that positive coping is common and beneficial to members of minority groups (Clark et al., 1999). Therefore, minority status is associated not only with stress but with important resources such as group solidarity and cohesiveness that protect minority members from the adverse mental health effects of minority stress (Kessler et al., 1985; Crocker & Major, 1989; Shade, 1990; Branscombe et al., 1999b; Clark et al., 1999; Miller & Major, 2000; Postmes & Branscombe, 2002). Empirical evidence supports these contentions. For example, in a study of African American participants, Branscombe et al. (1999b) found that attributions of prejudice were directly related to negative well-being and hostility toward Whites but also, through the mediating role of enhanced in-group

identity, to positive well-being. In a separate study, Postmes and Branscombe (2002) found that among African Americans a segregated racial environment contributed to greater in-group acceptance and improved well-being and life satisfaction.

The importance of coping with stigma has also been asserted in LGB populations. Weinberg and Williams (1974, pp. 150–151) noted that "occupying a 'deviant identity' need not necessarily intrude upon [gay men's] day-to-day functioning" and urged scientists to "pay more attention to the human capacity for adaptation." Through coming out LGB people learn to cope with and overcome the adverse effects of stress (Morris et al., 2001). Thus, stress and resilience interact in predicting mental disorder. Gay men, lesbians, and bisexuals counteract minority stress by establishing alternative structures and values that enhance their group (D'Emilio, 1983; Crocker & Major, 1989). In a similar vein, Garnets et al. (1990, p. 367) suggested that although antigay violence creates a crisis with potential adverse mental health outcomes it also presents "opportunities for subsequent growth." Among gay men, personal acceptance of one's gay identity and talking to family members about AIDS showed the strongest positive associations with concurrent measures of support and changes in support satisfaction (Kertzner, 2001). Similarly, in a study of LGB adolescents, family support and self-acceptance ameliorated the negative effect of antigay abuse on mental health outcomes (Hershberger & D'Augelli, 1995).

A distinction between personal and group resources is often not addressed in the coping literature. It is important to distinguish between resources that operate on the individual level (e.g., personality), in which members of minority groups vary, and resources that operate on a group level and are available to all minority members (Branscombe & Ellemers, 1998). Like other individuals who cope with general stress, lesbians, gay men, and bisexuals utilize a range of personal coping mechanisms, resilience, and hardiness to withstand stressful experiences (Antonovsky, 1987; Ouellette, 1993; Masten, 2001). In addition to such personal coping, group-level social-structural factors can have mental health benefits (Peterson et al., 1996). Jones and colleagues (1984) described two functions of coping achieved through minority group affiliations: to allow stigmatized persons to experience social environments in which they are not stigmatized by others and to provide support for negative evaluation of the stigmatized minority group. Social evaluation theory suggests another plausible mechanism for minority coping (Pettigrew, 1967). Members of stigmatized groups who have a strong sense of community cohesiveness evaluate themselves in comparison with others who are like them rather than with members of the dominant culture. The group may provide a reappraisal of the stressful condition, yielding it less injurious to psychological well-being. Through reappraisal, the group validates deviant experiences and feelings of minority persons (Thoits, 1985). Indeed, reappraisal is at the core of gay-affirmative, black-affirmative, and feminist psychotherapies that aim to empower the minority person

(Smith & Siegel, 1985; Shade, 1990; Garnets & Kimmel, 1991; Hooks, 1993).

The distinction between personal and group-level coping may be somewhat complicated because even group-level resources (e.g., services of a gay-affirmative church) need to be accessed and utilized by individuals. Whether individuals can access and use group-level resources depends on many factors, including personality variables. Nevertheless, it is important to distinguish between group-level and personal resources because when group-level resources are absent even otherwise resourceful individuals have deficient coping. Group-level resources may therefore define the boundaries of individual coping efforts. Thus, "minority coping" may be conceptualized as a group-level resource, related to the group's ability to mount self-enhancing structures to counteract stigma. This formulation highlights the degree to which minority members may be able to adopt some of the group's self-enhancing attitudes, values, and structures rather than the degree to which individuals vary in their personal coping abilities. Using this distinction, it is conceivable that an individual has efficient personal coping resources but lacks minority coping resources. For example, a lesbian or gay member of the U.S. Armed Forces, where a "don't ask, don't tell" policy discourages affiliation and attachments with other LGB persons, may be unable to access and utilize group-level resources and is therefore vulnerable to adverse health outcomes regardless of his or her personal coping abilities. Finally, it is important to note that coping can also have a stressful impact (Miller & Major, 2000). For example, concealing one's stigma is a common way of coping with stigma and avoiding negative regard, yet it takes a heavy toll on the person using this coping strategy (Smart & Wegner, 2000).

4 Discussion

I have suggested a conceptual model that describes sexual prejudice as the social environmental context within which to examine the mental health of LGB individuals. The model can serve as a guide for directing research of LGB mental health by identifying areas of investigation. It can also aid in suggesting areas for intervention. The model is not meant to be finite or all-inclusive. Other stress and ameliorative processes could be added, depending on particular issues of the population studied. The model might elaborate different areas when applied to LGBs who are young versus older, White versus ethnic minorities, and men versus women. For example, when studying African American men, Crawford et al. (2002) highlighted aspects of identity and affiliation related to and conflicts among Black and sexual orientation identities. Fieland and colleagues (Chapter 11) described history and spirituality as resources with unique significance for two-spirit American Indian/Alaskan Natives.

Similarly, generational differences affect the stress process. Although oppression of LGB youth, including discrimination and violence,

continues to be a serious challenge to public health and public policy, there are new opportunities for LGB youth that have never been present before and that may affect the shape of stressors and the opportunities for resilience and coping (Herdt & Boxer, 1996; Cohler & Galatzer-Levy, 2000). Individuals born during the late 1980s and 1990s, are being raised in a period where legal barriers are falling and social institutions—most remarkably, marriage—that previous generations of LGB individuals could not fathom are becoming available. Such social environmental changes should result in changes in conceptual and theoretical formulations of LGB development such as described by Eliason and Schope (see Chapter 1) and Savin-Williams and Cohen (see Chapter 2).

For example, social changes in the meaning of other minority statuses, such as race/ethnicity, have opened new possibilities, most significantly the possibility that multiple identities can complement one another rather than compete, and that identification and connections with different communities can coexist (see Chapter 1). These concepts are inconsistent with current conceptual models of LGB youth. Coming-out models typically envision a transformation where one sheds a prior identity and replaces it with an LGB identity. Postmodern conceptions of identity make it clear that this is rarely the case. Identity is now understood by theorists as multifaceted and contextual (Ashmore et al., 2004). Youth are more likely to enact various identities and confront struggles and challenges in multiple fronts; for example, they may integrate race/ethnic and sexual minority identities in ways that prior generations could not conceive. Therefore, stress processes related to sexual orientation and race/ethnicity may need to be viewed as more integrated and more contextual. This means, for example, that for Black LGBs sexual prejudice and racism are not, as older generations have described it, parallel concerns that shift with the social environment but an amalgama that travels with them everywhere they go. Such questions need to be answered as research addresses more complex LGB identities and related coping.

4.1 Intervention and Treatment

Kitzinger (1997) warned against relying on the stress model, seeing "stress" as a subjective, individually focused concept that can lead to ignoring the need for important political and structural changes: "If [psychologists'] aim is to decrease 'stress' and to increase the 'ego strength' of the victim," she asked, "do they risk forgetting that it is the perpetrator, not the victim, who is the real problem? What political choices are they making in focusing on the problems of the oppressed rather than on the problem of the oppressor?" This is an important reminder that public health should pay attention to, but it fails to take into account the full range of, and the variety of interventions implied by, the stress model. As a construct, the stress model can be useful not only for helping articulate the various components—or stress processes, as I described them—that affect health but also point out to areas of intervention. Utilizing the stress model more fully, researchers and policy makers should attend to the full spectrum of interventions

implied by the model (Ouellette, 1998): The stress model points to both distal and proximal causes and should direct us to relevant interventions at both the individual and structural levels.

It is important for public health to focus on distal causes of distress by eliminating sources of stress in the social environment. For that, public health and public policy interventions are necessary that would eliminate prejudice and discrimination, reduce antigay violence, and create a supportive social environment for LGB individuals. Many initiatives address this need. Such initiatives include political action by individuals and groups and the establishment of organizations and facilities that combat sexual prejudice, homophobia, and heterosexism. For example, LGB organizations work on a national and local level to lobby legislators and mobilize the gay community to political action (e.g., the Human Rights Campaign, National Gay and Lesbian Task Force), to challenge laws that discriminate against LGBs (e.g., Lambda Legal Defense and Education Fund, National Center for Lesbian Rights), and to fight homophobia and advocate for more accepting social environments for LGBTs (Gay, Lesbian and Straight Education Network; Senior Action in Gay Environment). For example, GLSEN brings LGB and straight students and educators together in schools across the country to work toward the elimination of antigay discrimination and the incorporation of LGB issues into school curricula (GLSEN, 2004). Other efforts use scientific work to have an impact on legal battles that affect LGBT rights via *amicus curiae* (friends of the court) briefs filed in important court cases. For example, in the case before the Supreme Court that led it to strike down sodomy laws in the United States (Lawrence & Garner v. Texas, 2003), an amicus brief led by the American Public Health Association directly addressed the implication of the stress model as described above. Responding to claims that sodomy laws *promote* public health and HIV prevention, the brief not only rejected that notion but also affirmed that sodomy laws adversely affect the physical and mental health of LGB persons (American Public Health Association, 2003).

The stress model also points to individual-level interventions. Denying individual agency and resilience would ignore an impressive body of social psychological research that demonstrates the importance and utility of coping with stigma (Crocker & Major, 1989; Branscombe & Ellemers, 1998; Miller & Myers, 1998; Miller & Major, 2000). Individual-level interventions include prevention programs that would enhance LGB youth's sense of self and help them with coming out and clinical interventions that would help LGB individuals with issues related to internalized homophobia, antigay violence, and rejection and discrimination (American Psychological Association, 2000). The individual and the social environment are highlighted in the minority stress model I described, and both need to be addressed in regard to prevention and intervention (Minkler, 1999). Ignoring the social environment would erroneously place the burden on the individual, suggesting that minority stress is only a personal problem for which individuals must be treated (Hobfoll, 1998). However, neglecting individual-based interventions that enhance coping and resilience of LGB individuals and

communities is also wrong. It would go against a rich history of resistance and self-reliance that has characterized the history of LGB groups in the United States (D'Emilio, 1983).

References

Adam, B.D. (1987) *The rise of a gay and lesbian movement*. Twayne Publishers, Boston.

Allen, L.A., Woolfolk, R.L., Gara, M., and Apter, J.T. (1999) Possible selves in major depression. *Journal of Nervous and Mental Disease* 184:739–745.

Allison, K.W. (1998) Stress and oppressed social category membership. In: Swim, J.K., and Stangor, C. (eds) *Prejudice: the target's perspective*. Academic Press, San Diego, pp. 145–170.

Allport, G.W. (1954) *The nature of prejudice*. Addison-Wesley, Reading, MA.

American Psychological Association. (2000) Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist* 55:1440–1451.

American Public Health Association. (2003) Amicus brief filed in Lawrence v. Texas (date filed: January 16, 2003).

Amnesty International. (2001) *Crimes of hate, conspiracy of silence: torture and ill-treatment based on sexual identity*. Amnesty International, London.

Antonovsky, A. (1987) *Unraveling the mystery of health: how people manage stress and stay well*. Jossey-Bass, San Francisco.

Ashmore, R.D., Deaux, K., and McLaughlin-Volpe, T. (2004) An organizing framework for collective identity: articulation and significance of multidimensionality. *Psychological Bulletin* 130:80–114.

Badgett, L.M.V. (1995) The wage effects of sexual orientation discrimination. *Industrial and Labor Relations Review* 48:726–739.

Barnett, R.C., and Baruch, G.K. (1987) Social roles, gender, and psychological distress. In: Barnett, R.C., Biener, L., and Baruch, G.K. (eds) *Gender and stress*. Free Press, New York, pp. 122–143.

Branscombe, N.R., and Ellemers, N. (1998) Coping with group-based discrimination: individualistic versus group-level strategies. In: Swim, J.K., and Stangor, C. (eds) *Prejudice: the target's perspective*. Academic Press, San Diego, pp. 243–266.

Branscombe, N.R., Ellemers, N., Spears, R., and Doosje, B. (1999a) The context and content of social identity threats. In: Ellemers, N., Spears, R., and Doosje, B. (eds) *Social identity: context, commitment, and content* Blackwell, Oxford, pp. 35–58.

Branscombe, N.R., Schmitt, M.T., and Harvey, R.D. (1999b) Perceiving pervasive discrimination among African Americans: implications for group identification and well-being. *Journal of Personality and Social Psychology* 77:135–149.

Brewer, M.B. (1991) The social self: on being the same and different at the same time. *Personality and Social Psychology Bulletin* 17:475–482.

Brooks, V.R. (1981) *Minority stress and lesbian women*. Lexington Books Lexington, MA.

Brown, T.N., Sellers, S.L., Brown, K.T., and Jackson, J. (1999) Race, ethnicity, and culture in the sociology of mental health. In: Aneshensel, C.S., and Phelan, J.C. (eds) *Handbook of the sociology of mental health*. Kluwer Academic/Plenum Publishers, New York, pp. 167–182.

Bucci, W. (1995) The power of the narrative: a multiple code account. In: Pennebaker, J.W. (ed) *Emotion, disclosure, & health*. American Psychological Association, Washington, DC, pp. 93–122.

Burke, P. (1991) Identity processes and social stress. *American Sociological Review* 56:836–849.

Cabaj, R.P. (1988) Homosexuality and neurosis: considerations for psychotherapy. In: Ross, M.W. (ed) *The treatment of homosexuals with mental health disorders*. Harrington Park Press, New York, pp. 13–23.

Cass, V.C. (1979) Homosexual identity formation: a theoretical model. *Journal of Homosexuality* 4:219–235.

Cass, V.C. (1984) Homosexual identity formation: testing a theoretical model. *Journal of Sex Research* 20:143–167.

Clark, R., Anderson, N.B., Clark, V.R., and Williams, D.R. (1999) Racism as a stressor for African Americans: a biopsychosocial model. *American Psychologist* 54:805–816.

Cochran, S.D. (2001) Emerging issues in research on lesbians' and gay men's mental health: does sexual orientation really matter? *American Psychologist* 56:931–947.

Cochran, S.D., and Mays, V.M. (1994) Depressive distress among homosexually active African-American men and women. *American Journal of Psychiatry* 151:524–529.

Cohler, B.J., and Galatzer-Levy, R.M. (2000) *The course of gay and lesbian lives: social and psychoanalytic perspectives*. Chicago: Chicago University Press.

Cole, S.W., Kemeny, M.E., Taylor, S.E., and Visscher, B.R. (1996a) Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychology* 15:243–251.

Cole, S.W., Kemeny, M.E., Taylor, S.E., Visscher, B.R., and Fahey, J.L. (1996b) Accelerated course of human immunodeficiency virus infection in gay men who conceal their homosexual identity. *Psychosomatic Medicine* 58:219–231.

Coleman, E. (1982) Developmental stages of the coming out process. *Journal of Homosexuality* 7:31–43.

Crawford, I., Allison, K.W., Zamboni, B.D., and Soto, T. (2002) The influence of dual-identity development on the psychosocial functioning of African-American gay and bisexual men. *Journal of Sex Research* 39:179–189.

Crocker, J. (1999) Social stigma and self-esteem: situational construction of self-worth. *Journal of Experimental Social Psychology* 35:89–107.

Crocker, J., and Major, B. (1989) Social stigma and self-esteem: the self-protective properties of stigma. *Psychological Review* 96:608–630.

Crocker, J., and Quinn, D.M. (2000) Social stigma and the self: meanings, situations, and self-esteem. In: Heatherton, T.F., Kleck, R.E., Hebl, M.R., and Hull, J.G. (eds) *The social psychology of stigma*. Guilford Press, New York, pp. 153–183.

Crocker, J., Major, B., and Steele, C. (1998) Social stigma. In: Gilbert, D., Fiske, S.T., and Lindzey, G. (eds) *The handbook of social psychology*, 4th ed. McGraw-Hill, Boston, pp. 504–553.

Cross, W. (1995) The psychology of nigrescence: revising the cross model. In: Ponterotto, J.G., Casa, J.M., Suzuki, L.A., and Alexander, C.M. (eds) *Handbook of multicultural counseling*. Sage Publications, Thousand Oaks, CA, pp. 93–122.

Croteau, J.M. (1996) Research on the work experience of lesbian, gay, and bisexual people: an integrative review of methodology and findings. *Journal of Vocational Behavior* 48:195–209.

D'Augelli, A.R., and Grossman, A.H. (2001) Disclosure of sexual orientation, victimization, and mental health among lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence* 16:1008–1027.

D'Augelli, A.R., and Hershberger, S.L. (1993) Lesbian, gay, and bisexual youth in community settings: personal challenges and mental health problems. *American Journal of Community Psychology* 21:1–28.

Dean, L., Meyer, I.H., Sell, R.L., Sember, R., Silenzio, V., Bowen, D.J., et al. (2000) Lesbian, gay, bisexual, and transgender health: findings and concerns. *Journal of the Gay and Lesbian Medical Association* 4:101–151.

Deaux, K. (1993) Reconstructing social identity. *Personality and Social Psychology Bulletin* 19:4–12.

Deaux, K., and Ethier, K. (1998) Negotiating social identity. In: Swim, J.K., and Stangor, C. (eds) *Prejudice: the target's perspective*. Academic Press, San Diego, pp. 301–323.

D'Emilio, J. (1983) *Sexual politics, sexual communities: the making of a homosexual minority in the United States, 1940–1970*. University of Chicago Press, Chicago.

De Monteflores, C., and Schultz, S.J. (1978) Coming out: similarities and differences for lesbians and gay men. *Journal of Social Issues* 34:59–72.

Diamond, L.M. (2000) Sexual identity, attractions, and behavior among young sexual-minority women over a 2-year period. *Developmental Psychology* 36:241–250.

Diaz, R.M., Ayala, G., Bein, E., Jenne, J., and Marin, B.V. (2001) The impact of homophobia, poverty and racism on the mental health of Latino gay men. *American Journal of Public Health* 91:927–932.

DiPlacido, J. (1998) Minority stress among lesbians, gay men, and bisexual: a consequence of heterosexism, homophobia, and stigmatization. In: Herek, G.M. (ed) *Stigma and sexual orientation: understanding prejudice against lesbians, gay men, and bisexuals*, Vol. 4. Sage, Thousand Oaks, CA, pp. 138–159.

Dohrenwend, B.P. (2000) The role of adversity and stress in psychopathology: some evidence and its implications for theory and research. *Journal of Health and Social Behavior* 41:1–19.

Dupras, A. (1994) Internalized homophobia and psychosexual adjustment among gay men. *Psychological Reports* 75:23–28.

Eliason, M.J. (1996) Identity formation for lesbian, bisexual, and gay persons: beyond a "minoritizing" view. *Journal of Homosexuality* 30:31–58.

Espin, O.M. (1993) Issues of identity in the psychology of Latina lesbians. In: Garnets, L.D., and Kimmel, D.C. (eds) *Psychological perspectives on lesbian and gay male experiences*. Columbia University Press, New York, pp. 348–363.

Ethier, K., and Deaux, K. (1994) Negotiating social identity when contexts change. *Journal of Personality and Social Psychology* 67:243–251.

Farina, A., Allen, J.G., and Saul, B.B. (1968) The role of the stigmatized person in affecting social relationships. *Journal of Personality* 36:169–182.

Faulkner, A.H., and Cranston, K. (1998) Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *American Journal of Public Health* 88:262–266.

Fife, B.L., and Wright, E.R. (2000) The dimensionality of stigma: a comparison of its impact on the self of persons with HIV/AIDS and cancer. *Journal of Health and Social Behavior* 41:50–67.

Frable, D.E., Wortman, C., and Joseph, J. (1997) Predicting self-esteem, well-being, and distress in a cohort of gay men: the importance of cultural stigma, personal visibility, community networks, and positive identity. *Journal of Personality* 65:599–624.

Frable, D.E.S., Platt, L., and Hoey, S. (1998) Concealable stigmas and positive self-perceptions: feeling better around similar others. *Journal of Personality and Social Psychology* 74:909–922.

Fullilove, M.T., and Fullilove, R.E. (1999) Stigma as an obstacle to AIDS action. *American Behavioral Scientist* 42:1117–1129.

Garnets, L.D., and Kimmel, D.C. (1991) Lesbian and gay male dimensions in the psychological study of human diversity. In: Garnets, L.D., Jones, J.M.,

Kimmel, D.C., Sue, S., and Tarvis, C. (eds) *Psychological perspectives on human diversity in America*. American Psychological Association, Washington, DC.

Garnets, L.D., Herek, G.M., and Levy, B. (1990) Violence and victimization of lesbians and gay men: mental health consequences. *Journal of Interpersonal Violence*, 5:366–383.

Garofalo, R., Wolf, R.C., Kessel, S., Palfrey, J., and DuRant, R.H. (1998) The association between health risk behaviors and sexual orientation among a school based sample of adolescents. *Pediatrics* 101:895–902.

Gay and Lesbian Medical Association and LGBT Health Experts. (2001) *Healthy people 2010 companion document for lesbian, gay, bisexual, and transgender (LGBT) health*. Gay and Lesbian Medical Association, San Francisco.

GLSEN. (1999) *GLSEN's national school climate survey: lesbian, gay, bisexual and transgender students and their experiences in school.* GLSEN, New York.

GLSEN. (2004) History. http://www.glsen.org/cgi-bin/iowa/all/about/index.html.

Goffman, E. (1963) *Stigma: notes on the management of spoiled identity*. Touchstone, New York.

Gonsiorek, J.C. (1988) Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care* 9:114–122.

Greenberg, J.S. (1973) Study of self-esteem and alienation of male homosexuals. *Journal of Psychology* 83:137–143.

Griffin, P. (1992) From hiding out to coming out: empowering lesbian and gay educators. In: Harbeck, K.M. (ed) *Coming out of the classroom closet*. Harrington Park Press, Binghamton, NY, pp. 167–196.

Grossman, A.H., and Kerner, M.S. (1998) Self-esteem and supportiveness as predictors of emotional distress in gay male and lesbian youth. *Journal of Homosexuality* 35(2):25–39.

Herdt, G., and Boxer, A. (1996) *Children of horizons*. Beacon Press, Boston.

Herek, G.M. (2000) The psychology of sexual prejudice. *Current Directions in Psychological Sciences* 9:19–22.

Herek, G.M., and Berrill, K.T. (1992) *Hate crimes: confronting violence against lesbian and gay men*. Sage, Thousand Oaks, CA.

Herek, G.M., Gillis, J.R., and Cogan, J.C. (1999) Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology* 67:945–951.

Hershberger, S.L., and D'Augelli, A.R. (1995) The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youth. *Developmental Psychology* 31:65–74.

Hetrick, E.S., and Martin, A.D. (1984) Ego-dystonic homosexuality: a developmental view. In: Hetrick, E.S., and Stein, T.S. (eds) *Innovations in psychotherapy with homosexuals.* American Psychiatric Association Press, Washington, DC.

Hetrick, E.S., and Martin, A.D. (1987) Developmental issues and their resolution for gay and lesbian adolescents. *Journal of Homosexuality* 14:25–43.

Hobfoll, S.E. (1998) The social and historical context of stress. In: *Stress, culture, and community: the psychology and philosophy of stress*. Plenum Press, New York, pp. 1–23.

Hooks, B. (1993) *Sisters of the yam: black woman and self-recovery*. South End Press, Boston.

Human Rights Watch. (2001) *Hatred in the hallways: violence and discrimination against lesbian, gay, bisexual, and transgender students in U.S. schools.* Human Rights Watch, New York.

Jetten, J., Branscombe, N.R., Schmitt, M.T., and Spears, R. (2001) Rebels with a cause: group identification as a response to perceived discrimination from the mainstream. *Personality and Social Psychology Bulletin* 27:1204–1213.

Jones, E.E., Farina, A., Hestrof, A.H., Markus, H., Miller, D.T., and Scott, R.A. (1984) *Social stigma: the psychology of marked relationships*. W.H. Freeman, New York.

Kertzner, R.M. (1999) Self-appraisal of life experience and psychological adjustment in midlife gay men. *Journal of Psychology and Human Sexuality* 11:43–64.

Kertzner, R.M. (2001) The adult life course and homosexual identity in midlife gay men. *Annual Review of Sex Research* 12:75–92.

Kessler, R.C., Price, R.H., and Wortman, C.B. (1985) Social factors in psychopathology: stress, social support, and coping processes. *Annual Review of Psychology* 36:572.

Kitzinger, C. (1997) Lesbian and gay psychology: a critical analysis. In: Fox, D., and Prilleltensky, I. (eds) *Critical psychology: an introduction*. Sage, Thousand Oaks, CA, pp. 202–216.

Kobrynowicz, D., and Branscombe, N.R. (1997) Who considers themselves victims of discrimination? Individual difference predictors of perceived gender discrimination in women and men. *Psychology of Women Quarterly* 21:347–363.

Krieger, N. (2001) Theories for social epidemiology in the 21st century: an ecosocial perspective. *International Journal of Epidemiology* 30:668–677.

Krieger, N., and Sidney, S. (1997) Prevalence and health implications of anti-gay discrimination: a study of black and white women and men in the CARDIA cohort. *International Journal of Health Services* 27:157–176.

Laumann, E.O., Gagnon, J.H., Michael, R.T., and Michaels, S. (1994) *The social organization of sexuality: sexual practices in the United States*. University of Chicago Press, Chicago.

Lazarus, R.S., and Folkman, S. (1984) *Stress, appraisal, and coping*. Springer, New York.

Link, B.G. (1987) Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. *American Sociological Review* 52:96–112.

Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., and Nuttbrock, L. (1997) On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior* 38:177–190.

Linville, P. (1987) Self-complexity as a cognitive buffer against stress related illness and depression. *Journal of Personality and Social Psychology* 52:663–676.

Loiacano, D.K. (1993) Gay identity among black Americans: racism, homophobia, and the need for validation. In: Garnets, L.D., and Kimmel, D.C. (eds) *Psychological perspectives on lesbian and gay male experiences*. Columbia University Press, New York, pp. 364–375.

Major, B., and Gramzow, R.H. (1999) Abortion as stigma: cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology* 77:735–745.

Malebranche, D.J., Peterson, J.L., Fullilove, R.E., and Stackhouse, R.W. (2004) Race and sexual identity: perceptions about medical culture and healthcare among black men who have sex with men. *Journal of the National Medical Association* 96:97–107.

Malyon, A.K. (1982) Psychotherapeutic implications of internalized homophobia in gay men. *Journal of Homosexuality* 7:59–69.

Massey, S., and Ouellette, S.C. (1996) Heterosexual bias in the identity self-portraits of gay men, lesbians, and bisexuals. *Journal of Homosexuality* 32:57–76.

Masten, A.S. (2001) Ordinary magic: resilience processes in development. *American Psychologist* 56:227–238.
Mayfield, W. (2001) The development of an internalized homonegativity inventory for gay men. *Journal of Homosexuality* 4:53–76.
Mays, V.M., and Cochran, S.D. (2001) Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health* 91:1869–1876.
McDevitt, J., Balboni, J., Garcia, L., and Gu, J. (2001) Consequences for victims: a comparison of bias- and non-bias-motivated assaults. *American Behavioral Scientist* 45:697–713.
Meyer, I.H. (1995) Minority stress and mental health in gay men. *Journal of Health and Social Behavior* 36:38–56.
Meyer, I.H. (2003) Prejudice, social stress and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin* 129:674–697.
Meyer, I.H., and Dean, L. (1998) Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek, G.M. (ed) *Stigma and sexual orientation: understanding prejudice against lesbians, gay men, and bisexuals*. Sage, Thousand Oaks, CA, pp. 160–186.
Miller, C.T., and Major, B. (2000) Coping with stigma and prejudice. In: Heatherton, T.F., Kleck, R.E., Hebl, M.R., and Hull, J.G. (eds) *The social psychology of stigma*. Guilford Press, New York, pp. 243–272.
Miller, C.T., and Myers, A.M. (1998) Compensating for prejudice: how heavyweight people (and others) control outcomes despite prejudice. In: Swim, J.K., and Stangor, C. (eds) *Prejudice: the target's perspective*. Academic Press, San Diego, pp. 191–218.
Minkler, M. (1999) Personal responsibility for health? A review of the arguments and the evidence at century's end. *Health Education & Behavior* 26:121–140.
Mirowsky, J., and Ross, C.E. (1989) *Social causes of psychological distress*. Aldine De Gruyter, Hawthorne, NY.
Morris, J.F., Waldo, C.R., and Rothblum, E.D. (2001) A model of predictors and outcomes of outness among lesbian and bisexual women. *American Journal of Orthopsychiatry* 71:61–71.
Nicholson, W.D., and Long, B.C. (1990) Self-esteem, social support, internalized homophobia, and coping strategies of HIV+ gay men. *Journal of Consulting and Clinical Psychology* 58:873–876.
Nungesser, L.G. (1983) *Homosexual acts, actors, and identities*. Praeger, New York.
Operario, D., and Fiske, S.T. (2001) Ethnic identity moderates perceptions of prejudice: judgments of personal versus group discrimination and subtle versus blatant bias. *Personality and Social Psychology Bulletin* 27:550–561.
Ouellette, S.C. (1993) Inquiries into hardiness. In: Goldbeger, L., and Breznitz, S. (eds) *Handbook of stress: theoretical and clinical aspects*, 2nd ed. Free Press, New York, pp. 77–100.
Ouellette, S.C. (1998) The value and limitations of stress models in HIV/AIDS. In: Dohrenwend, B.P. (ed) *Adversity, stress, and psychopathology*. Oxford University Press, New York, pp. 142–160.
Pearlin, L.I. (1999) The stress process revisited: reflections on concepts and their interrelationships. In: Aneshensel, C.S., and Phelan, J.C. (eds) *Handbook of the sociology of mental health*. Kluwer Academic/Plenum Publishers, New York, pp. 395–415.
Pennebaker, J.W. (1995) *Emotion, disclosure, and health*. American Psychological Association, Washington, DC.

Peterson, J.L., Folkman, S., and Bakeman, R. (1996) Stress, coping, HIV status, psychosocial resources, and depressive mood in African American gay, bisexual, and heterosexual men. *American Journal of Community Psychology* 24:461–487.

Petrie, K.J., Booth, R.J., and Davison, K.P. (1995) Repression, disclosure, and immune function: recent findings and methodological issues. In: Pennebaker, J.W. (ed) *Emotion, disclosure, & health*. American Psychological Association, Washington, DC, pp. 223–237.

Pettigrew, T.F. (1967) Social evaluation theory: convergencies and applications. In: Levine, D. (ed) *Nebraska symposium on motivation*, 15th ed. University of Nebraska Press, Lincoln, pp. 241–304.

Pinel, E.C. (2002) Stigma consciousness in intergroup contexts: the power of conviction. *Journal of Experimental Social Psychology* 38:178–185.

Postmes, T., and Branscombe, N.R. (2002) Influence of long-term racial environmental composition on subjective well-being in African Americans. *Journal of Personality and Social Psychology* 83:735–751.

Rosario, M., Rotheram-Borus, M.J., and Reid, H. (1996) Gay-related stress and its correlates among gay and bisexual male adolescents of predominantly Black and Hispanic background. *Journal of Community Psychology* 24:136–159.

Rosenberg, S., and Gara, M. (1985) The multiplicity of personal identity. In: Shaver, P.R. (ed) *Self, situations, and social behavior: review of personality and social psychology*. Sage Publications, Beverly Hills, CA, pp. 87–113.

Ross, M.W. (1985) Actual and anticipated societal reaction to homosexuality and adjustment in two societies. *Journal of Sex Research* 21:40–55.

Ross, M.W., and Rosser, S.B.R. (1996) Measurement and correlates of internalized homophobia: a factor analytic study. *Journal of Clinical Psychology* 52:15–21.

Rosser, B., Metz, M., Bockting, W., and Buroker, T. (1997) Sexual difficulties, concerns and satisfaction in homosexual men: an empirical study with i mplications for HIV prevention. *The Journal of Sex and Marital Therapy* 23:61–73.

Rotheram-Borus, M.J., and Fernandez, M.I. (1995) Sexual orientation and developmental challenges experienced by gay and lesbian youths. *Suicide and Life-Threatening Behavior* 25:26–34.

Safe Schools Coalition of Washington. (1999) *Eighty-three thousand youth: selected findings of eight population-based studies as they pertain to anti-gay harassment and the safety and well-being of sexual minority students.* Safe Schools Coalition of Washington, Seattle.

Shade, B.J. (1990) Coping with color: the anatomy of positive mental health. In: Ruiz, D.S. (ed) *Handbook of mental health and mental disorder among Black Americans*. Greenwood Press, New York.

Shidlo, A. (1994) Internalized homophobia: conceptual and empirical issues in measurement. In: Greene, B., and Herek, G.M. (eds) *Lesbian and gay psychology: theory, research and clinical applications*, Vol. 1. Sage, Thousand Oaks, CA, pp. 176–205.

Siegel, K., and Epstein, J.A. (1996) Ethnic-racial differences in psychological stress related to gay lifestyle among HIV-positive men. *Psychological Reports* 79:303–312.

Smart, L., and Wegner, D.M. (2000) The hidden costs of stigma. In: Heatherton, T.F., Kleck, R.E., Hebl, M.R., and Hull, J.G. (eds) *The social psychology of stigma*. Guilford Press, New York, pp. 220–242.

Smith, A.J., and Siegel, R.F. (1985) Feminist therapy: redefining power for the powerless. In: Rosewater, L.R., and Walker, L.E.A. (eds) *Handbook of feminist therapy: women's issues in psychotherapy.* Springer, New York.

Smyth, J.M., Stone, A.A., Hurewitz, A., and Kaell, A. (1999) Effects of writing about stressful experiences on symptom reduction in patients with asthma or rheumatoid arthritis. *Journal of the American Medical Association* 281:1304–1309.

Steele, C.M. (1997) A threat in the air: how stereotypes shape intellectual identity and performance. *The American Psychologist* 52:613–629.

Steele, C.M., and Aronson, J. (1995) Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology* 69:797–811.

Stiles, W.B. (1995) Disclosure as a speech act: is it psychotherapeutic to disclose? In: Pennebaker, J.W. (ed) *Emotion, disclosure, & health*. American Psychological Association, Washington, DC, pp. 71–91.

Stokes, J.P., and Peterson, J.L. (1998) Homophobia, self-esteem, and risk for HIV among African American men who have sex with men. *Aids Education and Prevention* 10:278–292.

Swim, J.K., Hyers, L.L., Cohen, L.L., and Ferguson, M.J. (2001) Everyday sexism: evidence for its incidence, nature, and psychological impact from three daily diary studies. *Journal of Social Issues* 57:31–53.

Szymanski, D.M., and Chung, Y.B. (2001) The lesbian internalized homophobia scale: a rational/theoretical approach. *Journal of Homosexuality* 41:37–52.

Thoits, P. (1985) Self-labeling processes in mental illness: the role of emotional deviance. *American Journal of Sociology* 91:221–249.

Thoits, P. (1991) On merging identity theory and stress research. *Social Psychology Quarterly* 54:101–112.

Thoits, P. (1999) Self, identity, stress, and mental health. In: Aneshensel, C.S., and Phelan, J.C. (eds) *Handbook of the sociology of mental health*. Kluwer Academic/Plenum Publishers, New York, pp. 345–368.

Troiden, R.R. (1989) The formation of homosexual identities. *Journal of Homosexuality* 17:45–73.

Twenge, J.M., and Crocker, J. (2002) Race and self-esteem: meta-analyses comparing Whites, Blacks, Hispanics, Asians, and American Indians and comment on Gray-Little and Hafdahl (2000). *Psychological Bulletin* 128:371–408.

U.S. Department of Health and Human Services. (2000) *Healthy people 2010: understanding and improving health.* U.S. Department of Health and Human Services, Government Printing Office, Washington, DC.

Waldo, C.R. (1999) Working in a majority context: a structural model of heterosexism as minority stress in the workplace. *Journal of Counseling Psychology* 46:218–232.

Weinberg, M.S., and Williams, C.J. (1974) *Male homosexuals: their problems and adaptations*. Oxford University Press, New York.

Williamson, I.R. (2000) Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research* 15:97–107.

Woolfolk, R.L., Novalany, J., Gara, M.A., Allen, L.A., and Polino, M. (1995) Self-complexity, self-evaluation, and depression: an examination of form and content within the self-schema. *Journal of Personality and Social Psychology* 68:1108–1120.