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Multisexual Identities And Mental Health: Mitigating Factors Of Minority Stress

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MULTISEXUAL IDENTITIES AND MENTAL HEALTH: MITIGATING FACTORS OF MINORITY STRESS

by

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This dissertation, submitted by Kimberly Jorgensen in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.

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ABSTRACT

Much of the current literature about sexual minorities examines the experiences of lesbian- and gay-identified individuals. The current study was designed to facilitate increased understanding of sexuality for people who have multi-gendered attractions and sexual identities (e.g., bisexual, queer). This work extends beyond discrete binary categories and labels for sexual orientation, such as straight, gay, and lesbian. In the current examination of this expanded category, labeled as *multisexual*, it becomes important to shift not only the conceptualization of sexual orientation but also the nature of minority stress, from examining homophobia and heterosexism, to *biphobia* and *monosexism*. Under circumstances when an individual may have very little control over the stressor, such as prejudicial attitudes and discrimination, there is research to suggest that emotion-focused coping (specifically forgiveness) mitigates harmful mental health outcomes. The current study sought to address gaps in the current literature on LGB identities, including clearly assessing sexual identity, increased specificity in defining the population of study, and examining multidimensional relationships between variables (Diamond, 2003a). This study sought to estimate the fit of self-report data to a model of minority stress adapted from Meyer (2003), examining the interplay of minority stress, coping, and consequent health outcomes of people who are identify between and beyond the heterosexual and homosexual. Additionally, the study examined the ability of forgiveness and other styles of coping, including individual and LGBTQ community social support, to mitigate the expected negative association between minority stress and

mental health and well-being. Participants (N = 207) identified with labels that embrace a more fluid concept of emotional, romantic, or sexual relationships (e.g., bisexual, pansexual, omnisexual, PoMoSexual, questioning, unlabeled) and provided self-report data online. While the observed data did not provide a strong statistical fit with the hypothesized model of minority stress (Meyer, 2003), supplementary multiple regression analyses suggested a unique contribution of forgiveness in mitigating the detrimental relationship between oppression-related stress and mental health and well-being. The results of this study have significant implications for the intentional coping strategies of multisexual people and for mental health counselors providing such interventions. Implications for theory, research, and clinical practice are discussed.

CHAPTER I

INTRODUCTION

Cultural and social language regarding sexual identity labels has been conceptualized as problematic in many contexts (Balsam & Mohr, 2007; Ochs, 2007). The word *bisexual* generally connotes the presence of two gender choices for emotional, sexual, or romantic partnering: female and male. We recognize significant variation, however, across gender expressions (Leavitt & Bridges, 2007; Rosario, Schrimshaw, Hunter, & Levy-Warren, 2009; Sánchez, Westefeld, Liu, & Vilain, 2010) along with transgender and genderqueer identities, many of which are neither recognized nor affirmed by binary sexual orientation models (Ward, 2010). Additionally, bisexuality is often considered a transitional identity within a sexual binary, or two endpoints of a continuum between gay/lesbian and heterosexual.

While many individuals have embraced progressive definitions of bisexuality that do not infer binary notions of gender and sexuality, others choose self-labels that avoid implied binaries (e.g., *queer, pansexual*). This group may be referred to as *non-monosexual*, as the term *monosexual* is used to categorize the single-gender attractions of straight and gay or lesbian people. Non-monosexual individuals may feel attraction for both male and female partners, and may also feel attraction for people with non-binary gender identities (e.g., *transgender, genderqueer, gender non-conforming*). To avoid labeling the population of interest as something they are *not* (e.g., a label such as *non-monosexual*), the term *multisexual* will refer to individuals who choose self-labels that

embrace a concept of emotional, romantic, or sexual relationships with people of multiple gender identities. The preferred definition of this sexual orientation category comes from an explanation of bisexuality by Ochs (2007), while also acknowledging that not all multisexual people identify as bisexual and not all bisexual-identified people may accept the label or category of multisexuality. While Ochs emphasizes the range of expression within bisexuality, her definition (noted in Chapter II) also fits well for other many people who identify with other labels outside of a gay-straight binary.

Dodge and Sandfort (2007) in a meta-analytic study, provide evidence to highlight that many empirical studies do not include bisexual men or women in their participant samples for the sake of simplicity in measurement or the inability to acquire an adequate number of bisexual participants to produce statistically powerful results. Another option is to combine data from bisexual-identifying individuals with that of gay and lesbian people (Bagley & Tremblay, 1997; D'Augelli, Hershberger, & Pilkington, 2001; Hershberger, Pilkington, & D'Augelli, 1997; Safren & Heimberg, 1999). Research methodologies also differ in their identification of bisexual participants either by self-determined identity label (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Paul et al., 2002; Warner et al., 2004) or behaviorally identified label (Robin et al., 2002; Udry & Chantala, 2002). Therefore, we have much less reliable data specifically regarding bi- and multisexual participants, particularly regarding their experiences of discrimination and its impact on mental health.

Dodge & Sandfort (2007) summarize that studies combining lesbian, gay and bisexual participants together resulted in higher incidence of mental health concerns (i.e., depression, anxiety, suicidality) than studies of heterosexual participants, specifically

focusing on individuals who engage in same-sex sexual behavior (in contrast to bisexual individuals who engage in "heterosexual" behavior). While it may be assumed that all members of the lesbian, gay, and bisexual (hereafter LGB) community have similar experiences of mental health symptoms, another study showed that bisexual men had higher levels negative life events than gay men, though the groups' data were combined to improve statistical power (Peterson, Folkman, & Bakeman, 1996). Another study identified symptoms experienced by gay and bisexual men, though labeled the group as "homosexual males," comparing them to a sample of heterosexual males (French, Story, Remafedi, Resnick & Blum, 1998). Such clustering of identities may be masking the true picture of mental health for gay and bisexual men, given their different set of stressors (Dodge & Sandfort). Given this closer look at research methods and practices, there is reason to believe that the experiences of bisexual people may prompt mental health outcomes that are distinct from those of gay/lesbian identified people and/or all people who engage in same-sex relationships and sexual behaviors. This begins to provide evidence in favor of studying self-identification of sexual orientation identity rather than (or in addition to) behavioral measures of sexuality.

Beyond bisexuality, even less is understood about the lived experiences of individuals who identify their sexual orientation as something other than straight, gay, lesbian, or bisexual. These identity labels include, but are not limited to *queer, pansexual, omnisexual, pomosexual* (i.e., *Post-Modern Sexuality*) and *same-gender-loving*. Other individuals may embrace identities that fuse or combine other labels, such as *lesbian-identified bisexual*. Reasons for identifying in this way may be in attempt to find the most

congruent self-label for one's internal sense of self or a rejection of binary thinking about sexual and gender identities.

Multisexual people may also choose to avoid or reject taking a self-label due to the restrictions that language places on identity, particularly with respect to changes in sexual attraction or desire across time (Diamond, 2008b; Ochs, 2007). To respect similar nuances regarding gender identity and expression, the current study will measure the experiences of people who identify as female, male, or gender identities between and beyond traditional binary categories. Just as other sexual identity labels rely on identifying the gender identities of one individual and the genders their partners or potential partners, multisexuality indicates that an individual may be attracted to individuals of multiple genders and may, themselves, shift or identify with multiple gender identity labels.

Multisexuality is intended for use as an umbrella identity label, one encompassing several individual identity labels. This term is used intentionally as one that is seldom found in published psychological research, though the concept of sexual fluidity and transgression of binaries has been widely theorized and written about in the humanities and other behavioral sciences under similar terms and concepts such as *queerness* and *post-modern sexuality* (Nestle, Wilchins, & Howell, 2002; Queen & Schimmel, 1997). The term *queer* can be used as an umbrella term for marginalized sexual identities (i.e., "queer people") as well as one's individual identity label (i.e., "I identify as queer."). The current paper will use the term *queer* to reflect marginalized sexual identities as well as an example of one type of multisexual identity, attempting to clarify which definition of *queer* is being used. As the closest existing approximation, the literature review in the

following chapter utilizes the predominant research on bisexual or LGB experiences, given the lack of psychological research reporting data and theory regarding omnisexual, pansexual, pomosexual, and queer people.

Bowman (2003) voiced a call to counseling psychology for more empirical research regarding the concerns of LGB people and communities. Bowman criticized the paucity of empirical work that does exist in that it often lacks theoretical grounding, lessening the impact and utility of resulting conclusions. Bowman evaluated that, "[w]ell-written, well-designed, empirically based, theoretically sound articles published on their own and not as part of a special issue will signify that [LGB] issues are part of the counseling psychology mainstream" (p. 64). Bowman noted that LGB research that is particularly theoretical in nature is beginning to increase in the field of counseling psychology (e.g., identity development stages, coming out processes, career trajectories) though still calls for more theory driven empirical research with LGB communities. Bowman also noted that the number of studies dedicated solely to bisexuality is "relatively imperceptible" (p. 63). The lack of depth in the extant literature neglects to fill gaps in understanding unique and vital concerns for bisexual people that cannot and should not be extrapolated from the research conclusions of lesbian or gay studies.

Concerns about population sensitivity and specificity, or clearly defining who belongs within one group and the unique characteristics of that group versus another (Diamond, 2003a), also extend to clinical practice. Much research regarding bisexuality often includes only female participants (Diamond, 2008a; Ochs, 2007) or combines the experiences of bisexual men with gay men or of bisexual women with lesbian women (Eisenberg & Resnick, 2006; Floyd & Stein, 2002; Herek & Glunt, 1995). A recent study

suggested that "bisexual women and men seek help for sexual orientation issues less frequently and rate their services as less helpful with sexual orientation concerns than gay and lesbian participants in comparable research" (Page, 2004, p. 137). This type of outcome implies a need for increased understanding and improved methods of treatment and education regarding bisexuality and multisexuality, specifically, in contrast to monosexuality (i.e., having attractions for one gender of partner rather than multiple genders). In the current study, contributions to existing literature will include the examination of not only bisexual but other multisexual people of many genders.

Educators, counselors, and therapists should be aware that sexual orientation itself is not always salient to the presenting concerns of sexual minority individuals. As DiPlacido (1998) points out, evidence exists that many lesbian, gay, or bisexual individuals are well-adjusted and have good mental health in spite of the stressful experiences related to subsequent stigma and oppression. Regardless, the experience of discrimination and prejudice, including the heterosexism felt by LGB people, continues to be associated with negative mental health outcomes (Herek, Gillis, & Cogan, 1999; Eisenberg & Resnick, 2006). DiPlacido concludes that it is important to investigate what factors might interfere in the relationship between minority identity status and mental health or well-being. DiPlacido highlight that both social support and personal characteristics of resilience to be variables are shown to play a protective role in heath and wellness outcomes.

The current study will investigate the statistical fit of self-reported experiences of multisexual people with the minority stress framework and conceptual model proposed by Meyer (2003b). Meyer's adaptation of similar research by Dohrenwend (2000) makes

an attempt at understanding the health implications of unique stresses experienced by people with marginalized sexual identities (Beaber, 2008). This examination is particularly important as it addresses underrepresentation in the literature of the multisexual population, perhaps a covert method of devaluing this particular identity. The review of extant literature in the next chapter includes some discussion of bisexual or LGB people's shared experiences yet attempts to elucidate stress and coping as it is unique to multisexual people. Meyer's conceptual model purports that minority identity variables are related to minority stress, subsequent coping mechanisms, and resulting mental health and well-being for sexual minority individuals. This study will examine differences in health and well-being outcomes relative to participants' use of forgiveness as a strategy for coping with minority stress.

This expansion on existing research includes a unique investigation of the role of forgiveness as a potentially effective emotion-focused coping strategy for oppressive forces that may not be easily ameliorated by problem-focused coping mechanisms. Forgiveness can play significant roles in fostering aspects of successful coping, as it has been shown to decrease symptoms of mental illness and protect physical health (Maltby, Macaskill, & Day, 2001; Toussaint, Williams, Musick, & Everson, 2001; Witvliet, Ludwig, & Vander Laan, 2001). In service of expanding the current literature to include complexity of identities, acknowledging systems of oppression and their impact on mental health and service provision, this empirical investigation aims to increase current understandings about the stress, coping, and consequent health outcomes of people who identify, verbally or behaviorally, as multisexual.

CHAPTER II

LITERATURE REVIEW

Stress impacts all humans in a variety of ways with a variety of consequences. According to Dohrenwend (2000) and Meyer (2003b) many individuals experience additional life stress as a result of minority[1] or multiple minority identities that are stigmatized, marginalized and oppressed by individuals, groups and systems. As noted by Meyer, people with marginalized sexual identities experience stressors as a function of their true or perceived sexual identity. The current study additionally explored the extent to which others are aware of these sexual identities (i.e., being "out") as a function of minority stress. A review of extant literature follows for each of four major components of a theoretical model of minority stress proposed by Meyer (2003b). This includes each of three predictor variables (sexual orientation identity, stress, coping and social support) in relation to the criteria (mental health and well-being), followed by a review of how these criteria are understood and measured in the current study.

Sexual Orientation and Identity

In current psychological research, Diamond (2008b) rigorously examines human

[1] Use of the word "minority" to discuss a group can be perceived as oppressive, given connotations of inferiority. The preferred language in this study is to refer to "marginalized" groups (those who experience discrimination based on their group membership). The term "minority" will be used here to refer to the theoretical concept of minority stress in keeping with the language used by originators of the model. The term "marginalization" also seems to be a more accurate predictor of the origins of so-called minority stress rather than simply holding an identity that is a statistical minority.

sexuality both empirically and theoretically, particularly same-sex sexual orientation and fluid expressions of sexuality. Diamond provides definitions and rationale to support the understanding of sexual orientation, sexual identity, same-sex sexuality, and sexual fluidity in the current study. The current paper will apply Diamond's use of this terminology, unless otherwise noted as attributable to other authors.

To begin, *sexual orientation* is defined as a "consistent, enduring pattern of sexual desire for individuals of the same sex, the other sex, or both sexes, regardless of whether this pattern of desire is manifested in sexual behavior" (Diamond, 2008b, p. 12). Diamond notes that most scientists understand sexual desire rather than sexual behavior as the critical marker of sexual orientation. She extrapolates that *same-sex sexuality* encompasses "same-sex desire, romantic affection, fantasy and behavior, regardless of whether the individual(s) experiencing them have a nonheterosexual orientation or identity" (Diamond, 2003a, p. 491). Diamond distinguishes *sexual identity* from sexual orientation as how one perceives or labels one's own self, such as lesbian, bisexual, or straight. She reiterates that sexual identity labels may not necessarily imply one's sexual behaviors or desire. Diamond views sexual identities as self-determined and representative of an individual's view of self, which may be informed by desire, behaviors, cultural influences (e.g., compulsory heterosexuality, knowledge about sexuality, religious beliefs, political beliefs), or any combination of these and other factors.

To most fully understand sexual orientation, it is imperative to first clearly define biological sex and gender identity and expression. Delineating sex and gender provides a foundation for understanding sexual orientation due to the construction of sexual

orientation/identity labels based on sex or gender relationship pairings (e.g., gay = two men, straight = one man, one woman). Humans tend to be understood as either male or female, according to their primary and secondary sex characteristics, and masculine or feminine in their gender expression. Biological sex is marked by the anatomical reproductive characteristics resulting from genetic, chromosomal, and hormonal factors, and is often estimated at birth via external reproductive organs. Exceptions to these possibilities include a category of medical conditions known intersex conditions or by other communities as disorders of sexual development (Accord Alliance, 2008). *Intersex* is an umbrella term for a set of genetic, hormonal, or chromosomal conditions that impact the physical appearance or internal reproductive system in a way that does not match with the usual expectations of male or female individuals (Intersex Society of North America, 1993). This leads to an acknowledgement of more than two sexes, or a spectrum of sex identity, as more biologically accurate. Within the scope of the current study, it therefore becomes important to refer to *same-sex* and *other-sex*, rather than "*opposite sex*" (which denotes only two options, diametrically opposed).

The concept of gender is distinct from biological sex, though the two are often discussed interchangeably. A person's *gender identity*, not unlike sexual identity, is the socially influenced conceptualization of one's own sense of maleness, femaleness, or experiences between or beyond these categories. That same person's gender expression is represented by the way they depict their sense of gender identity to the world, regardless of whether this is congruent with their internal sense of gender identity. Components of gender expression may include hair, clothing, accessories, and posture. There is often an

expectation that one's gender identity will match one's biological sex (i.e., gender essentialism) and people for whom this does not occur may identify as *transgender*.

While many theories exist, no single factor has been determined to define an individual's sexual orientation. Rather than determination of causality per se, many activists and researchers advocate for the study of healthy developmental processes and reduction of the harmful effects of stigma and oppression (Ford, 2003; Jordan & Deluty, 1998; Thompson & Johnston, 2003). It is likely that environmental, social, *and* biological factors all play a role in sexual orientation development. The following review will outline only a few major conceptualizations of sexual orientation, sexual fluidity, and unique aspects of bisexual and multisexual identities.

Conceptualizing sexual orientation. Researchers and activists have attempted to label, define and explain the existence of sexual orientations in a variety of ways. Such labels and their respective definitions regarding sexual orientation assessment do vary among researchers, though the explanatory mechanisms and core concepts overlap in many areas (e.g., Chung & Katayama, 1996; Diamond, 2008b; Stein, 1999). In a content analysis of original empirical articles from the *Journal of Homosexuality* between 1974 and 1993, Chung and Katayama examined 144 articles for their measurement and methodology related to recruiting lesbian, gay, and bisexual samples. These authors outline six types of sexual orientation assessment, including self-report of the participants' (a) label, (b) behaviors, and (c) preferences across (d) one or (e) more dimensions of sexuality, with or without inferences or categorizations being made by the investigators. The sixth type of assessment identified by Chung and Katayama was categorized as "unsure," because many studies within this review either did not

specifically assess participant sexual orientation or did not provide clear information about the assessment methods used.

Stein (1999) provided an overview of three models of the dimensionality of sexual orientation. When orientations other than heterosexual are acknowledged, the first and simplest is a binary model. This includes heterosexuality and its perceived opposite, homosexuality, as two discrete orientation options. It is largely assumed that people exist as male or female, masculine or feminine, and they are attracted to gendered beings that are like them (homosexual) or those that are unlike them (heterosexual). As such, this bipolar model is frequently measured in research via participant self-report in response to being offered these two choices (Chung & Katayama, 1996).

An extension of the binary model allows for flexibility between same-sex and other-sex sexuality. This view, according to Stein (1999), expands on ideas about sexuality credited to pioneers such as Alfred Kinsey. "A bipolar view sees sexual orientation as *continuous*, each person's sexual orientation falls somewhere on a one-dimensional scale between two extreme poles – exclusive homosexuality and exclusive heterosexuality– on the basis of his or her relative attraction to men and women" (Stein, p. 52). A bisexual orientation and bisexual behaviors could be conceptualized simplistically as those which exist between heterosexual and gay/lesbian identities, including any behavior or self-identification that falls outside of these two options. Chung and Katayama (1996) refer to this style of assessment as utilizing a *single dimension*, such as sexual behaviors or sexual preferences, along a linear continuum. The most prominent example of a linear continuum is the Kinsey Scale, placing sexual

behavior or attraction on a scale of zero (heterosexual) to six (homosexual; Kinsey, Pomeroy, & Martin, 1948).

Finally, a two-dimensional view is demonstrated in Michael Storms' measurement scale with "one dimension representing the degree of attraction to people of the same sex-gender and the other dimension representing the degree of attraction to people of a different sex-gender" (Stein, 1999, p.55). Stein goes on to point out that humans have a great degree of sexual interests that extend beyond desires characterized by sexual orientation (including "genital sex, gender, race, body size, hair color, personality-type, profession, venue;" p. 66). The Klein Sexual Orientation Grid (KSOG) allows for multidimensional measurement of sexual orientation including change over time (i.e., past, present, ideal) and multiple facets of sexuality (i.e., sexual attraction, sexual behavior, sexual fantasies, emotional preference, social group, lifestyle, self-identification). Unfortunately, multidimensional KSOG scores are also frequently averaged and simplified into one numerical rating (0-6 or 1-7) that aligns with the Kinsey Scale (see further analysis of this measure in Chapter III).

Stein (1999) delineates three views of determining one's sexual orientation, including behavioral, self-identification, and dispositional. The behavioral view allows determination of orientation based on the sex and/or gender (Stein uses the term "sex-gender") of one's sexual partner(s). In contrast, the self-identification theory defines sexual orientation based on the individual's own description or feelings about their sexuality. The dispositional view is the most complex and the one favored by Stein. Of this view, Stein says, "A person's sexual orientation is based on his or her sexual desires and fantasies and the sexual behaviors he or she is disposed to engage in under ideal

conditions…Conditions are ideal if there are no forces to prevent or discourage a person from acting on his or her desires, that is, when there is sexual freedom and a variety of appealing sexual partners available" (p. 45).

Along these lines, Diamond (2008b) uses the term *sexual identity* as the concept of self-identification or self-determination of one's own label for their sexual orientation; and *sexual orientation* as a core orientation toward one particular gender or multiple genders of partners. While Diamond and Stein identify *similar* theories with different labeling mechanisms, they continue to be distinct, each with respective assets. While the dispositional view (Stein) highlights the importance of ideal versus non-ideal (or biased) environmental conditions, defining sexual identity within Diamond's view does not necessarily indicate a match between one's self-determined identity and one's most preferred identity in ideal sociopolitical conditions. Diamond's concept of sexual orientation, rather than sexual identity, may fit more closely with Stein's dispositional view.

Stein (1999) cites both popular criticisms and his own objections about the views listed above. First, the behavioral view limits discussion of sexual orientation to two discrete options: heterosexuality and homosexuality. It also places emphasis on the sex-gender of an individual's partner rather than the sex-gender of the individual. He writes, "With respect to sexual orientation, the behavioral view is committed to the idea that anyone who can observe my sexual activity knows as much as I possibly could about my own sexual orientation" (pp. 42-43). This of course does not account for a person's ability to restrain true sexual desires, a notion that is better accounted for by the

dispositional view. Further, the behavioral view assumes that individuals do not have a sexual orientation until sexual acts have occurred.

The self-identification view, as opposed to the behavioral view, allows for contradiction between sexual or affectionate *behaviors* and sexual orientation *labels* (Stein, 1999). Both self-identification and dispositional views allow for more diverse sexual orientation options (e.g., bisexual, queer, same-gender-loving, pansexual). To pick up where the behavioral view stops short, the dispositional view allows sexual orientation to exist before sexual acts occur *and* that individuals may not know their sexual orientation. Stein acknowledges the struggle to assess this circumstance. Within current U.S. culture there are many barriers to imagining "complete sexual freedom" (p. 46).

Given the above methods of measurement, Chung and Katayama (1996) suggested further limitations to each of these. These authors found that differences exist between emotional and physical attractions. They proposed a method of assessing same-sex and other-sex affinity across (a) affective attraction and (b) physical/sexual preference. Additionally, Chung and Katayama called for more thorough assessment of sexual orientation, inclusion of more bisexual and female-identified participants in psychological research, and assessment of heterosexuality (which is frequently assumed and therefore absent) when these participants are included as a comparison group.

Sexual fluidity. Diamond (2008b) summarizes her theory of sexual fluidity with four conclusions. She asserted first that women have a sexual orientation that indicates a stable affinity for one or more particularly genders of partner and, second, that this is distinct from their capacity for change in their behaviors or self-identification over time. Diamond provides evidence (supported by other studies, e.g., Rieger, Chivers, & Bailey,

2005; Weinrich & Klein, 1996) that women have a stronger capacity than men for *sexual fluidity*. That is, "sensitivity to situations and relationships that might facilitate erotic feelings…or exposure to environments that provide positive experiences with same-sex relationships. Fluidity can trigger either same-sex or other-sex attractions" (p. 84). In her third conclusion, Diamond goes on to note that sexually fluid attractions may be short-lived or much longer depending on the presence or absence of the facilitating variables named above (e.g., being in a college environment that supports same-sex relationships or employed in a company that provides more opportunities for other-sex relationships). Finally, Diamond highlights that not all women possess the same type or extent of sexual fluidity. In the remainder of this manuscript, the term *fluidity* will be used in the context of Diamond's (2008b) empirically driven work.

Same-sex sexuality. Empirical and theoretical examinations of marginalized sexual identity groups are increasingly being viewed as important, with topics of interest including sexual orientation disclosure (i.e., coming out; Waldner & Magruder, 1999), identity development processes (e.g., Floyd & Stein, 2002), and risk of suicidality (e.g., Eisenberg & Resnick, 2006). More recently, there has been a shift in media coverage of LGBTQ youth suicides due to stigma and bullying online and in schools (Haas et al., 2011). This increase in media coverage implies increased prevalence in suicide rates for this population, though this may not be statistically true given the complexity of many types of measurement with cultural groups who may or may not be visibly identified as such.

The psychological study of bisexual people is often combined with those of lesbians and gay men (Burckell & Goldfried, 2006; Thompson & Johnston, 2003) and the

inclusion of non-binary sexual and gender identity groups is limited in scientific research. Further, some studies include or claim to be inclusive of the experiences of transgender people without proper acknowledgement of gender identity and its distinction from sexual orientation (Fassinger & Arseneau, 2007). While LGB people as a community do share many life events or stresses that heterosexual individuals do not, the experiences of lesbian, gay, and bisexual people should be measured appropriately and understood as separate and unique.

At times it is useful or convenient to consider sexual minority participants as a single cultural group. Balsam and Mohr (2007), however, advise researchers and clinicians to consider the appropriate similarities and important differences among lesbian, gay, and bisexual identities and prejudices against these identities. Similarities between these orientations often focus on same-sex desires or relationships, and include coming out about one's sexual orientation, experiencing bias related to romantic or sexual relationships, and discrepancies in legal protections regarding housing and employment. Differences in bisexual experiences often focus on the potential for heterosexual-appearing relationships and receiving bias from heterosexual *and* lesbian/gay communities for neither being "straight enough" nor "gay enough."

According to Fassinger and Arseneau, "studies of lesbians have lagged behind studies of gay men, and bisexuals often have been dismissed entirely or included sloppily in LG studies, without clear attention given to bisexuals' unique characteristics and issues" (2007, p.24). Diamond (2003a) identifies this lack of specificity as a significant problem in sexual minority research. She notes that many young people are also beginning to explore identities between and beyond a straight – gay continuum or reject

specific labels for their sexual orientation in effort to express a sexual identity uninhibited by subjective labels that carry many cultural and assumed meanings.

Sexual orientation, particularly for sexual minorities, is often described in terms of its associated sexual behaviors. Lesbian, gay, and bisexual individuals must overcome bias and discrimination *and* challenge the notion that sexual orientation identities exist solely to describe sexual behavior. Non-sexual aspects of sexual orientation, including social, emotional, and lifestyle preferences (Klein, 1993), are often overlooked by both lay people and academics. In addition, bisexual people must combat the misunderstanding of their orientation by others. For example, the previously mentioned study by Rieger and colleagues chose to examine bisexuality in terms of sexual "feelings," defined to be "strong sexual attraction and arousal to both sexes" (p.580). They measured this concept using genital arousal and self-reported subjective arousal. This argument predicates itself on a definition of bisexuality that is limited to sexual attraction and arousal and assumes that self-identified bisexual women or men necessarily become sexually aroused or attracted to male and female stimuli regardless of potential mediating factors (e.g., attractiveness, type of sexual behavior, physical ability to become aroused).

The Rieger, Chivers, and Bailey study (2005) employed questionable procedures for eliciting sexual arousal responses from heterosexual, bisexual, and homosexual self-identified men. In providing pornographic stimuli, these investigators hoped to accurately measure genital arousal indicative of sexual orientation. The films, however, depicted either two men or two women engaging in sex together. None of the visual stimuli represented sex between a man and a woman. This calls into question the notion that

bisexual men should be genitally aroused by both male-male and female-female sexual acts. The investigators further assumed that male genital response to female-female sexual acts was indicative of heterosexual orientation. While anecdotal evidence may confirm this idea, a great diversity exists regarding types of stimuli that are sexually arousing to individuals. Rieger and colleagues did not discuss relevant arousal factors such as the type of sexual act being performed or the body-type or race of the actors.

Other criticisms of this study include the exclusion of data from individuals whose genital response fell below threshold arousal criteria (2-mm). Investigators made several assumptions. First, it was assumed that so-called "nonresponders" lacked genital response due to awkward measurement paraphernalia (e.g., "penile mercury-in-rubber gauge" [p. 581]). While this seems possible, investigators also assumed that a particular type of visual sexual stimuli would be physically arousing to these men and that genital arousal *should* match subjective arousal ratings. They believed that for bisexual men "on average, their arousal to both male and female stimuli should be substantial" (p. 581). Interestingly, the self-identified bisexual men in this study "did report a distinctively bisexual pattern of subjective sexual arousal" though they did not, by the investigators' standards and definitions, achieve a congruent pattern of genital sexual arousal (p. 581).

Rieger, Chivers, and Bailey (2005) conclude that "future research should also explore nonsexual reasons why some men might prefer a bisexual identity to a homosexual or heterosexual identity" (p. 582-583). They perhaps correctly identify that "male bisexuality is not simply the sum of, or the intermediate between, heterosexual and homosexual orientation" but go on to contradict this notion by saying that, based on their data, "it remains to be shown that male bisexuality exists" (p. 582). They explain

divergence from expected sexual patterns by citing studies that embrace rather negative circumstances such as lack of other-sex opportunity during imprisonment, the limits of stigma and oppression, and prostitution.

Multisexual Identities

The current study aims to advance the empirical investigation of individuals who identify with a multisexual identity. That is, people who are attracted to or interested in having sexual or romantic relationships with partners of more than one gender (e.g., bisexual, queer, pansexual, omnisexual). While the category of multisexual orientations includes a wide variety of labels, almost no psychological literature examines the experiences of individuals who identify as something other than bisexual, the most frequently assumed expression of multisexuality. Consequently, the review of literature will continue by starting with the body of literature that does exist regarding bisexuality.

Bisexuality. Bisexuality has been defined in a variety of ways and may take on very personal meanings and manifestations by individuals or groups. Despite continued debate and strong opinions, a single accepted definition of bisexuality has not emerged. Some would endorse this uncertainty or lack of a unified definition to be most appropriate, given that romantic and sexual partnerships may look different over time for bisexual individuals and even that bisexuality, at its essence, defies categorization.

Ochs (2007) writes, "I call myself bisexual because I acknowledge in myself the capacity to be attracted to and sexual with people of more than one sex, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (p. 84). This definition encompasses the possibility that bisexual people may be attracted

to and intimate with many types of people, without necessarily feeling restricted by traditional binary markers of male or female sex and gender.

Diamond (2008a) outlines three sentiments within theoretical disputes about bisexuality: Bisexuality is "(a) a temporary stage of denial, transition, or experimentation; (b) a 'third type' of sexual orientation, characterized by fixed patterns of attraction to both sexes; (c) a strong form of all individuals' capacity for sexual fluidity" (p.5). To add further complexity, great variety exists in the ways bisexual identities manifest in terms of relationship structures, sexual and affectionate behaviors, and group identification. Bisexual identities are affected by prejudice, discrimination, and oppression in similar and different ways than lesbians and gay men.

Other multisexual identities. While many individuals today reserve the bisexual label for overt sexual behavior with both men and women, it is possible to embrace a different definition of bisexuality. Though women have been given some latitude in fluidity of gender identity and sexuality in the United States (Diamond, 1998), the mere existence of true bisexual orientation has been questioned, especially for men. One particular study has recently perpetuated this skepticism (Rieger, Chivers, & Bailey, 2005). Investigators used both self and physiological (genital) reports of arousal in response to same-sex and opposite-sex stimuli. This study, while contributing to the vast self-report data and sparse physiological arousal data, compared these data in an attempt to reveal any discrepancy between sexual identity and true sexual orientation. The authors concluded that bisexual identification and behaviors do undeniably exist despite physical arousal suggesting only "modest" support for men's sexual arousal to both women and other men.

For some multisexual individuals, emotional and/or physical attraction may not be primarily based on the sex of their potential partner. It is possible to be attracted to a particular gender expression (e.g., butch/femme gender presentation) along with many other variables (e.g., sexual practices, aesthetic or political ideals or interests, hair color, body type), which may not be necessarily tied to gender or sex identity. Other multisexual individuals indicate that they disregard these characteristics when seeking a mate. That is, some people who identify as bi- or multisexual describe their sexual orientation as an attraction for people of a certain gender while others describe their orientation as oblivious to gender (Diamond, 2008b). In a society that values a binary gender system, this notion is quite hard to grasp. In a heteronormative culture, such as the one that exists in the United States, the majority of individuals do not spend time considering that, before all else, they choose a partner based on biological sex. In mate selection this step tends to be assumed, even for homosexual individuals in most cases. For others, it seems feasible to choose a partner without initial regard for gender or sex and they may say, "I'm simply attracted to the person/their personality" (Diamond).

Unique stigma. Individuals who identify as lesbian, gay, or bisexual often experience stigmatization and may be victims of violent crimes motivated by hatred or fear of homosexuality or bisexuality (Fassinger & Arseneau, 2007). For bisexual people, attacks of prejudice and stigma may also be launched from members of lesbian and gay communities (Ochs, 1996). Assumptions and stereotypes about bisexual individuals include engaging in promiscuous sexual behaviors, having or desiring multiple sexual and romantic relationships concurrently, desiring relationships with men and women concurrently, being equally attracted to men 50% of the time and women 50% of the

time, breaking up families by cheating with married persons, and transmitting HIV/AIDS between straight and gay communities (as noted by Diamond, 2008b; Herek, 2002; Ochs, 1996). The attitudes of hetero- and homosexuals are generally harsh toward bisexuality, particularly when these communities are lacking exposure to bisexual individuals or communities. Specifically, Herek (2002) found that heterosexual adults felt less positive about bisexual women and men than nearly every other stigmatized group assessed "—including religious, racial, ethnic, and political groups—except for injecting drug users" (p. 264). Therefore, individuals who identify as bisexual may often experience subtle and overt biphobia or bi-negativity from both heterosexual and homosexual communities. It therefore appears as if there are few reasons for a bisexual person to come out given the need to combat myths and stereotypes.

Marginalized individuals also experience the process of internalizing the myths, stereotypes and negative perceptions of individuals and communities with power and privilege. Due to the socialization of individuals into dominant U.S. cultural beliefs, it is nearly impossible for individuals to avoid internalizing the values of heterosexism, monosexism, biphobia and other cultural "isms" in some way. While many people strive to resist or unlearn these values, they persist in the culture due to their silent perpetuation within larger systems, including government, schools, religion, and media.

Those in the perceived majority are often considered to have a "natural" or "normal" sexual orientation. Bisexual individuals may begin to believe the negative information that constantly bombards them and reinforces the abnormality and inferiority of attraction and relationships with people of more than one gender (Ochs, 1996). This process and outcome may be called *internalized biphobia* or *internalized binegativity*. A

similar process that may occur internally for LGB people, called *internalized heterosexism*, reinforce the belief that heterosexual people are normal or superior to others in some way. Despite advances in acceptance and distribution of equal rights to lesbian and gay communities, a system of *monosexism* continues to oppress multisexual individuals. Monosexism is the notion that choosing one gender for a partner, as with straight or gay/lesbian people, is normal or most valuable. As with internalized biphobia, when the larger culture reinforces this attitude within the systems listed above, multisexual people unknowingly adopt these negative beliefs and attitudes about their own identity and it becomes *internalized*.

In addition to the threat associated with coming out as bisexual and dual discrimination by heterosexuals and homosexuals alike, individuals must choose whether to maintain this controversial label. As noted above, self-identification as bisexual is not always necessary based solely on the sex or gender of one's current partner. Regarding therapy with bisexual clients, Dworkin acknowledges a variety of rationales that have been identified by individuals choosing to call themselves bisexual (2001). These include decreasing cognitive dissonance about a particular same or other sex relationship and a believed potential for attractions to both other and same sex partners. That is, bisexual men or women may choose this label in order to ensure that their beliefs and actions are consistent. They may also find that, while partnered with someone of a particular sex, it is feasible for them to pursue their attraction for another sex-gender.

Outness

Meyer (2003a) highlights that disclosure or concealment of one's sexual orientation is a choice based on internalized social negativity or marginalization. Floyd

and Stein (2002) found that, while the mean age at which individuals first became conscious of a same-gender attraction was 10.39 years (*SD* = 3.39), their self-identified age of "coming out" was 18.07 years (*SD* = 2.9). This discrepancy is likely attributable in large part to the extensive process of self-reflection and potential risks involved in defining one's sexuality and sexual orientation as something other than heterosexual. It is little wonder that an average discrepancy of about 8 years exists between internal and external acknowledgement of this attraction. Bi- and multisexual people have additional stress related to determining their safety in coming out to heterosexual people *and* lesbian/gay people.

Meyer (2003a) provided support from existing literature to say that outness may be conceptualized as a form of stress due to the psychological processes that determine disclosure versus non-disclosure or "hiding." Avoidance of this process (Jordan & Deluty; Waldner & Magruder, 1999) was associated with an increased risk for anxiety and depression, suicidal thoughts and attempts, social stigma and family ostracism, risky drug and sexual behaviors, and a myriad of other ill effects (Ford, 2003; Thompson & Johnston, 2003). Such avoidance may be just as detrimental as some of the potential risks associated with coming out. Due to the historical and systematic oppression of queer people, marginalized individuals risk their mental and physical health, psychological and social well-being for a chance at healthy adjustment to their sexual and gender identity. In short, the impact of coming out on healthy sexual development can be significant. Regarding mitigation of the risks to physical and mental health, the simple ability of individuals to disclose their sexual orientation correlated with, "less anxiety, more positive affectivity, and greater self-esteem" for a sample of lesbian women (Jordan &

Deluty). Additionally, having the support of family, friends – both homosexual and heterosexual, and acquaintances including co-workers proved beneficial (Thompson & Johnston).

New research has worked to better understand intervening or mediating variables in the association between marginalized sexual identity and mental health and well-being. Several risk and protective factors do exist for the healthy development of any person's sexual identity. A few of these concerns include extreme lack of social support, infrequent positive interactions, and chronic stress; all leading to problem behaviors for many lesbian/gay adolescents (Thompson & Johnston, 2003). Walters and Hayes (1998) note that this type of disclosure may incite criticism of the youth. The extreme effects of social isolation, ostracism, stress, and infrequency of positive interactions include substance use and abuse, risky sexual behavior with increased incidence of sexual transmitted diseases, and suicidality (Thompson & Johnston, 2003). Additionally, Thurlow cites that "the relentless, careless use of homophobic pejoratives will most certainly continue to compromise the psychological health of young homosexual and bisexual people by insidiously constructing their sexuality as something wrong, dangerous, or shameworthy" (2001, p. 27).

For young gay men, lesbian women, and bisexual men or women it seems that suicide is very common and is likely to cause the most deaths (Eisenberg & Resnick, 2006). Gay and lesbian youth are two to three times more prone to attempt suicide than their heterosexual counterparts and as many as 20-35% of gay youth have contemplated suicide (Thompson & Johnston, 2003). These same authors point out that youth are

driven to find their social support in environments with increased availability and exposure to drugs and alcohol with consequent risky sexual behavior.

The above views appear to assume that all non-disclosing LGB people are *hiding* their sexual identity due to internalized shame related to socially enforced heterosexist beliefs. Many LGB people may chose not to disclose their sexual identity for any variety of reasons, though it is certainly difficult to disentangle this from the subtle and insidious nature of internalized heterosexism and monosexism. This perspective also does not account for those individuals who disclose their sexual orientation *despite* highly internalized negative experiences. They, perhaps, possess intervening coping variables (e.g., social support, resilient personality factors) that allow them to disclose their sexual orientation and/or dismiss past negative experiences.

The rationale for including outness in the current study is two-fold. First, some evidence points to positive correlations between outness and healthy ego identity development, mental, and physical health (Jordan & Deluty, 1998). Second, being identified within a marginalized sexual orientation status (i.e., known to be multisexual by others) or perceived as such may prompt experiences of discrimination, whereas "passing" or being unknown to others as multisexual may protect one from overt discrimination or hate crimes. For example, D'Augelli, Hershberger, and Pilkington (1998) found higher levels of suicidality and experiences of verbal and physical abuse by family members for "out" youth than closeted youth.

Mixed results exist in the current literature about the nature of outness as a predictor of mental health and well-being. According to Legate, Ryan, and Weinstein (2012), likelihood of disclosure increased when an individual experienced an

environment supportive of their autonomy. Rather than a distinct stress process, the current study conceptualized outness as a critical component of sexual orientation identity that correlates with overt heterosexist and monosexist events and internalized stigma. Outness, therefore, may mediate or moderate the connection between sexual identity and experiences of minority stress.

Minority Stress

Individuals with marginalized cultural identities experience stress that is unique and additive to the general stress experienced by all humans. Understanding LGB communities and other marginalized populations requires an analysis of systemic, group, and individual oppressions as detrimental to these communities due to the extra emotional and psychological strain present in their environment (Meyer, 2003a). Meyer (2003b) proposed a model of minority stress applicable to the experiences of lesbian, gay, and bisexual populations. Meyer highlighted that this type of model culminated from cross-disciplinary theories of prejudice, stress, and coping (2003b). His proposed explanatory model includes minority stress processes, more specifically delineated as "experience of prejudice events, expectations of rejection, hiding, and concealing, internalized homophobia, and ameliorative coping processes" (p. 675). In response, the experience of prejudice, expectation of rejection, concealment of identity, and internalization of oppression have significant negative impact on the health and well-being of those who are subject to it.

More specifically, a sense of identity incongruence, negative self-regard, and social devaluation are the mechanisms connecting minority stress to harmful impacts on mental health and overall well-being (Meyer, 2003a). Additionally, intentional or

unintentional outness is critical for understanding the experience of different types of stress, including distal and proximal stress, particularly when marginalized identities or perceived identities are invisible or change over time. The current section will provide a brief summary of psychological conceptualizations of stress, review of conceptual and empirical study of components of minority stress, and an overview of Meyer's model.

In conceptualizing the nature of stress, Lazarus and Folkman (1984) reject views that characterize stress as an environmental circumstance (stimulus) or a state of being (response) in favor of a relational definition. This view considers *both* individual factors and environmental circumstances, involving one's appraisal of these variables in terms of the demand on personal means of coping. These authors conceptualize the social environment as a set of objective *distal* variables that are subjectively interpreted by the individual, becoming *proximal* psychological variables for the individual (Meyer, 2003a). That is, individuals experience circumstances in their environment to which they assign affective or cognitive meaning which subsequently impacts their view of themselves and the world. These views are internalized and will be demonstrated below to have significant impact on the health and well-being of the individual.

Given the variety of available definitions, stress has been measured in terms of occurrence of life-events (Turner & Wheaton, 1997), daily hassles (DeLongis, Folkman, & Lazarus, 1988), and perceptions of stressful events (Cohen, Kamarck, & Mermelstein, 1983). These stresses are expected for every human being and have been repeatedly shown to impact both physical and mental health (DeLongis et al., 1988). Extensions of stress research posit that members of cultural groups and subgroups experience stress

related to their minority status and oppression that is additive and perhaps even multiplicative to general stress, as further reviewed below.

For example, the effects of marginalization have been shown to account for disparities in physical health. Troxel, Matthews, Bromberger, and Sutton-Tyrrell (2003) considered the effects of racial minority stress on subclinical levels of carotid artery disease. In a sample of African American and Caucasian participants they measured composite stress, stressful life events, ongoing stressors, economic hardship, unfair treatment, and racial discrimination. They also gave participants a carotid ultrasound. Troxel and colleagues cited evidence from previous studies that persistent stress that persistent stress leads to hypervigilence and hyperarousal, and these effects tax the cardiovascular system. Results suggested that as stress increased, African American participants were more vulnerable to the disease than Caucasian participants. The nature of the stress-inducing factors appear to be generalizable to other minority populations that experience persistent life stressors, financial disadvantage, or prejudice. This may be additively or multiplicatively impactful for individuals with multiple minority statuses and similar harmful health effects have been demonstrated across social identities (e.g., income: Vitaliano, Scanlan, Zhang, Savage, Brummett, Barefoot, & Siegler, 2001). Several other studies, reviewed below, highlight the implications of systemic oppression on mental health, particularly for LGB communities (DiPlacido, 1998; Meyer, 2003a; Szymanski & Kashubeck-West, 2008)

Several important concepts assist us in understanding the relationship between environmental stress and mental health or illness. Dohrenwend (2000) distinguishes between *social causation theory*, wherein environment directly shapes outcomes, and

social selection theory, wherein genetic predispositions for mental illness cause individuals to have disadvantaged identity statuses (e.g., low economic status, low education status). The social selection theory, it seems, may perpetuate potentially damaging arguments about identity-based superiority and the notion that mental illness is insurmountable. Environmental stress also exists within ascribed statuses, or immutable identities (e.g., race, gender), as well as achieved statuses (e.g., income, education), those that are earned through a set of behaviors over which individuals have some control. Dohrenwend specified a number of variations in cultural stressors (e.g., valence, predictability, centrality, physical impact), which may contribute to fluctuations in the impact of a given stressor, but are considerably more specific than the current study allows.

In alignment with the social causation theory, Meyer (2003a) reminds us that LGB people are negatively impacted by their experiences of stress caused by social marginalization. Many studies demonstrate poorer mental health and well-being for LGB people than for their heterosexual counterparts (e.g., Dodge & Sandfort, 2007; Herek, Gillis, & Cogan, 1999). There has been an historical shift in our conceptualization of the causes of this type of health disparity across social identity groups, from environmental (placing the blame on external stimuli) to genetic/biological (blaming internal, immutable factors). It is therefore important to recognize how our larger social movements influence the agenda of empirical study and psychological theory (Duckitt, 1992). For example, in the second half of the 20th century, attributions about mental illness changed from primarily environmental etiologies, which were popular explanations in the first half of the 20th century, to genetic or biological attributions. Dohrenwend (2000) describes this

paradigm shift, highlighting historical events chronologically parallel to the shift, such as advances in pharmacological interventions along with compelling conclusions of research comparing twins and adopted siblings. This, again, points to the magnitude of influence that sociopolitical beliefs and movements have on the agenda of scientific study (Duckitt).

Meyer's model. Meyer's conceptual model of minority stress (2003b) was adapted from the work of Dohrenwend (2000), which provided a theoretical model of the impact of life events and circumstances on the mental health of marginalized cultural groups. Meyer wrote that minority stress is a type beyond the general stress expected for any human, continuous and constant, and embedded within society. The theoretical model adapted from Dohrenwend and proposed by Meyer defines minority stress as a multi-faceted reflection of general stress (experienced by all people), proximal stress, and distal stress. This allows researchers to acknowledge and hold constant the general stress experienced by marginalized individuals while also examining their unique proximal and distal stress, which is not experienced by those who do not hold the identity of interest (i.e., multisexuality here).

Grounded in the work of Lazarus and Folkman (1984), two subsets of stress are described in terms of their proximity to the individual; *proximal*, or internally motivated, and *distal*, or externally driven. More specifically, distal stressors are those that exist regardless of a victim's beliefs about their occurrence. Unfortunately, discrimination may go unrecognized as such and therefore unreported. In that objective measurement is dependent on minority individuals' ascriptions, distal stress is often measured by subjective ratings of frequency and intensity of acts of discrimination and prejudice (e.g.,

physical violence, threats of injury, vandalism, name-calling, discriminatory hiring practices).

Meyer excluded some components of the Dohrenwend model, such as biological factors, in favor of situational and intrapersonal processes. Meyer asserted that he used only the components of Dohrenwend's work that were essential in his examination of stress experienced by sexual minorities (i.e., LGB people). Each of the three major components of stress (general, proximal, and distal; Meyer, 2003b) are described below.

General stress. All humans experience a general level of stress as a function of everyday life. As indicated above, general stress is defined here as the process of life events or situations triggering an affective response that exceeds available coping resources *and* is evaluated by the individual as stressful (Cohen, Kamarck, & Mermelstein, 1983). These authors suggest that this definition supports measurement of self-appraised stress rather than objective stress measures due to the importance of affective response and individual interpretation of distress. Psychological stress has been conceptualized as a subset of emotion wherein particular negative emotions are commonly observed (Lazarus, 1993). In accordance with Lazarus, many other studies have used negative affect as a measure of stress (e.g., Bekker, van de Meerendonk, & Mollerus, 2004; Levine & Marcus, 1997).

With respect to the conceptualization of minority stress, Dohrenwend (2000) indicated that general life stress is associated with symptoms of mental illness, emphasizing that these conditions are unequally linked to variations in cultural status, such as social status, income, gender, race and ethnicity. If stress is the condition of environmental stimuli requiring change and adaptation, it is more accurate to connect the

lived experiences of marginalized populations to poor mental health rather than the identity in-and-of itself (e.g., homosexuality as a mental illness; Meyer 2003b).

Distal processes. Distal stress is characterized by overt discrimination or hostile attitudes experienced by individuals based on one's marginalized cultural identity status or the perception of holding a marginalized identity (e.g., being perceived or assumed to be gay; Meyer, 2003b). Herek (2000) distinguished that "homophobia has typically been employed to describe individual antigay attitudes and behaviors, whereas heterosexism has referred to societal-level ideologies and patterns of institutionalized oppression of nonheterosexual people" (p. 19). Herek suggested that the term *sexual prejudice* be used in place of homophobia for several reasons. Speaking of homophobia or biphobia in terms of a sexual prejudice relates this type of oppression to "the broader context of social psychological research on prejudice" and removes the need for "value judgments about such attitudes" (p. 19). More importantly, Herek defines sexual prejudice as "an attitude…directed at a social group and its members [that] is negative, involving hostility or dislike" (p. 20). Though Herek (2000) does not mention it, the term sexual prejudice also allows inclusivity of negative attitudes about bisexuality or bisexual individuals without the use of a separate term (e.g., biphobia) or inappropriate categorization within homophobia. While individual and systemic marginalization, or sexual prejudice, may be perpetuated by negative beliefs and attitudes held by others, the concept is most readily measured by asking victims about hate crimes and discriminatory experiences.

While the main agents of prejudice against bisexual and other queer people appear to be straight people, additional resistance comes from within queer communities or from lesbian and gay individuals. Homophobia and biphobia describe any affect, behavior, or

cognition used to maintain the oppression of sexual minority individuals. Biphobia is an extension of the concept of homophobia (Ochs, 1996). Though society and particular individuals may not necessarily have a "fear" of sexual minority individuals, there certainly are irrational negative beliefs and cognitions at play. These terms describe any affect, behavior, or cognition used to maintain the oppression of sexual minority individuals. In that this does not always imply fear, a relatively new term, homonegativity, has been deemed a more accurate description of this type of prejudice.

Proximal processes. Proximal stress is the phenomenon experienced when an individual internalizes negative stereotypes or generalizations about one's own marginalized cultural identity. Negative self-regard and social devaluation are described further by symbolic interaction theories and social evaluation theory, indicating that judgments and appraisals by others impact the target's feelings about oneself. As summarized by Allport (1954), "One's reputation, whether false or true, cannot be hammered, hammered, hammered, into one's head without doing something to one's character" (p. 142).

The process of being negatively impacted by others' appraisal sets up a dynamic of social power, generally (but not always) characterized by the statistical majority holding more power than a [perceived] statistical minority. This results in a system of marginalization and oppression, constructed to allow the group in power to keep their power (and resulting social privilege) by maintaining a status quo (Sue, 2003; Sue & Sue, 2003). Proximal stressors include internalized homophobia, expectations of rejection, and concealment of minority identity. These are attributed by Meyer to more internal or identity-related development and therefore understood as subjective (2003b). More

specifically, a sense of *incongruence* might be described as a situation in which a person experiences the world in a way that is in conflict with what they've been taught about the world (e.g., girls grow up to fall in love with boys and vice versa), mental, physical, spiritual, or chemical health may be jeopardized for that individual (Meyer, 2003a; Moss, 1973).

As with gay and lesbian individuals, much of the oppression experienced by bisexual people is attributable to same-sex relationships or intimacies. Several other unique prejudices, however, are also associated with bisexuality (Herek, 2002). In contrast to the concept of heterosexism (prejudice based on heterosexuality as a superior identity), discrimination or prejudice against bisexual-identified individuals, or *monosexism*, promotes the idea that attractions or intimacies with only one sex or gender are superior and normative.

Examples of monosexism include assumptions that bisexual people are promiscuous or nonmonogamous, carriers of sexually transmitted infections (particularly HIV), resistant to heterosexual or homosexual identities (Herek, 2002), or just plain confused. This leads to the conclusion that a unique state of fear or disgust exists in response to bisexual behaviors and identities. Biphobia and binegativity are beginning to be discussed in psychological literature in attempts to identify and understand the specific challenges of bisexual people (Eliason, 1997). It should be noted that these forms of prejudice and oppression are or can be held internally by bisexual individuals in addition to the more blatant external attitudes held by others.

Researchers of internalized oppression assume biphobia to be similar to homophobia and therefore understand internalized binegativity as desire to be straight

and that feelings of shame or guilt stem only from the individual's same-sex attractions or behaviors. This unsophisticated definition implies that bisexual people are half-gay and half-straight and that only the gay "parts" of an individual are of concern. Few have written about internalized biphobia as a unique concept that deals more with feelings of extreme differentness from *everyone*, both gay and straight alike. This means that a bisexual person might wish to be gay *or* straight in order to feel like she or he fits into an acceptable category. These individuals may have internalized strong negative feelings about their sexual fluidity or queerness. The term "monosexism: or "internalized monosexism" lends itself more appropriately to understanding and remembering that bisexual women and men have unique concerns.

Model overview. In addition to marginalized identity status and the tri-fold definition of minority stress, several other descriptors of cultural identity are worthy of acknowledgement, though beyond the scope of measurement in the current study (Meyer, 2003b). These include cultural identity salience, valence, and integration of identity. First, salience is the importance or relevance that one identity (e.g., sexual orientation) has over others (e.g., race, ethnicity, gender). Meyer discusses this in terms of prominence, advising that stage models consider that identity salience within an individual's multiple identities might moderate identity development processes. Second, valence is the degree of positive or negative value that is assigned by the individual to an identity they hold. Meyer articulates that negative identity valence is associated with poorer mental health. Finally, integration of identity is a status that is noted by various models of sexual orientation identity development as the extent to which an individual

incorporates a minority identity into multiple other identities or roles. Stage theorists often label integration as an ideal or final phase in developing an identity.

Two important intervening processes are identified by Meyer (2003b) as coping and social support. Support from others is established as a protective factor in the connection between stress and mental health (Frost & Meyer, 2012). For LGBT people this support may come from the traditional sources (e.g., biological relatives, coworkers, friends), and it may manifest in support from a sexual minority community (DiPlacido, 1998). Individuals may have varying degrees of either or both forms of support.

Meyer (2003a) noted three particular challenges to conceptualizing prejudice within a stress and coping framework. Meyer described his efforts at thwarting three challenges: "(1) individual versus structural measures of the impact of prejudice, (2) objective versus subjective assessment of the impact of prejudice, (3) major events versus daily hassles as measures of prejudice" (p. 262). Meyer concluded, however, by discouraging researchers from devising all-purpose solutions to these obstacles, instead favoring a process that considers the research questions or hypotheses of an individual study.

Meyer recognized the importance of stress and coping research for sexual minority groups and the implications for mental health interventions and political advocacy. While Meyer (2003b) reviewed several important psychological studies of sexual minority stress and mental health outcomes, often limited to lesbian and gay men as participants, he referred to their conclusions as generally applicable to "LGB" people and consistently failed to note the importance of lesbian, gay, and bisexual and other multisexual experiences as distinct in important ways. He later briefly acknowledged this

limitation in his work in addition to other assumptions of homogeneity in fusing LGB individuals together (e.g., multiple minority status, gender, generation, and cohort). The current study intends to contribute to increasing research efforts examining the unique experience of bi- and multisexual individuals as a sexual minority category.

Coping and Social Support

The concept of coping can be broadly defined as any method that allows an individual to handle or manage the stressors encountered in their lifetime (Lazarus, 1966; Tennen, Affleck, Armeli, & Carney, 2000). Carver and Connor-Smith (2010) provide a definition of coping as "efforts to prevent or diminish threat, harm, or loss, or to reduce associated distress" (p. 685). An extensive body of literature documents hundreds of different mechanisms of coping (as reviewed by Skinner, Edge, Altman, & Sherwood, 2003). Specific coping mechanisms could be categorized as either effective or ineffective, depending on how successful they are in reducing the individual's level of stress.

Szymanski, Kashubeck-West, and Meyer (2008) support the idea that internalized heterosexism negatively impacts the mental health and well-being of LGB people via poor use of coping and/or decreased access to social support. While the social devaluation of lesbian women and other marginalized groups highlighted by Brooks (1981) manifests in persistent harmful effects for minority individuals, certain protective factors and processes exist to buffer these effects. Two main variables hypothesized to mitigate the effects of minority stress for LGB individuals, according to DiPlacido (1998), are social support and individual resilience factors.

Meyer (2003b) similarly reflects that coping and social support are overarching mitigating factors in the relationship between minority stress and mental health outcomes. Coping strategies are varied in form and effectiveness. Specific to the current study, forgiveness is included as an emotion-focused coping strategy of interest, as reviewed further below. Meyer further distinguishes between group and individual coping resources, as the absence of group resources can imply diminished or ineffective personal coping. In addition to general social support, coping for sexual minority people often includes important contributions by LGBT communities (e.g., bisexual community organizations; Herek & Glunt, 1995). Specifically, Meyer writes, "Group-level resources may therefore define the boundaries of individual coping efforts" (p. 677). Coping mechanisms as measured in the current study (i.e., emotion-focused, active coping, forgiveness, social support, LGBTQ community support) will be reviewed below according to their categorization as individual or group coping.

Individual coping. Individual coping resources include personality characteristics that increase resilience, preventing emotional distress and other symptoms of mental illness. These characteristics include "hardiness" (facing new situations with confidence), high self-esteem, and utilizing negative or harmful situations for the purpose of self-growth (DiPlacido, 1998). Individuals may also choose to think or behave in specific ways that may either exacerbate or mitigate the stress they experience.

Emotion-focused versus active coping. Lazarus and Folkman (1984) initiated research examining distinctions between problem-focused and emotion-focused styles of coping. These styles are defined by actions to remove the stressor versus actions to alleviate psychological distress related to the stressor, respectively (Carver & Connor-

Smith, 2010). Carver and Connor-Smith categorize specific coping styles as: (a) problem focused or emotion focused, (b) engagement or disengagement, (c) accommodative or meaning-focused, and (c) proactive. Problem-focused coping directly addresses the threatening or harmful situation, while emotion-focused coping aims to decrease negative emotions in any number of ways (e.g., "relaxation, seeking emotional support…yelling, crying…rumination…avoidance, denial, wishful thinking" (p. 685)). These authors described problem and emotion-focused coping as complementary rather than competing coping styles, as one may induce or facilitate the other.

Szymanski and Owens (2008) explored problem-solving versus avoidant coping for lesbian and bisexual women. These authors found the relationship between proximal stress (i.e., internalized heterosexism) and mental health to be partially mediated by avoidant coping. Regarding the same association between stress and health, Szymanski and Owens did not find significant results regarding problem-focused coping.

Forgiveness. As an increasingly popular area of study, much work has been done to define, measure, and understand the role of forgiveness and its correlates. Baskin and Enright (2004) define forgiveness as "the willful giving up of resentment in the face of another's (or others') considerable injustice and responding with beneficence to the offender even though that offender has no right to the forgiver's moral goodness" (p. 80). They go on to say, "Forgiveness is an act freely chosen by the forgiver" (p. 80).

In better understanding the specific utility of forgiveness in protecting mental and physical health, researchers have begun to deconstruct the variables involved in the process. One important construct, unforgiveness, plays an important role in understanding how grudge-holding, or intentionally harboring negative emotions, and

vengefulness contribute to the deterioration of cardiovascular and other physical health as well as exacerbation of mental health symptoms. Worthington, Witvliet, Pietrini, and Miller (2007) distinguish between decisional forgiveness, the intentional decision to release negative attitudes and behaviors toward the transgressor, and emotional forgiveness, replacing negative affect with positive affect. Worthington and colleagues go on to note, then, that emotional forgiveness is much more likely to impact health, given the connections between affect and stress processes.

Forgiveness that pertains to a particular person or situation is known as state forgiveness. This type of forgiveness has been defined in many ways and encompasses forgiveness of self, others, and situations. Often, it is considered within religious contexts. As definitions of forgiveness have varied widely, the work of Subkoviak et al. (1995) further develops previous definitions in an attempt to measure state forgiveness by enveloping the affect, behavior, and cognition of individuals toward offenders.

Berry, Worthington, O'Connor, Parrott, and Wade (2005) defined another type of forgiveness as "the replacement of negative unforgiving emotions with positive, other-oriented emotions," or trait forgiveness (p. 183). Some individuals are more likely to release negative emotions by replacing them with positive ones, while others are less likely to do so. Because these individual differences exist, forgivingness, or one's willingness to forgive, has been proposed to be a trait or personality factor. Additionally, this type of forgiveness has been proposed to contribute to outcomes that are beneficial to relationships (Berry et al.).

Lawler-Row and Piferi (2006) define trait forgiveness as "the tendency to forgive across a variety of interpersonal encounters" (p. 1010). These investigators showed that

trait forgiveness was correlated negatively with participant self-ratings of depressive symptoms, stress, and positively with self-rated well-being. They found a relationship between this type of forgiveness and psychological adjustment. However, particular behaviors, spirituality factors, and social support also contributed by mediating this relationship. "Being the sort of person who values forgiveness, who has learned to let go of grudges and who endeavors to be nonjudgmental, seems to foster personal relationships, the feeling of having a purpose in life and the subjective experience of well-being" (p. 1018). Therefore, the concept of trait or personality forgiveness is one that should not be neglected in the study of interpersonal forgiveness.

While a majority of forgiveness research is cross-sectional and correlational in nature, findings imply that forgiveness may play a "protective" role or serve as a buffer against negative outcomes in a variety of situations. For instance, Berry and colleagues (2005) proposed that forgiveness contributes beneficially to interpersonal relationships. Additional evidence by Paleari, Regalia, and Fincham (2003) determined that higher levels of forgiveness by adolescents lowered the probability of parent-child conflict. These investigators found an indirect relationship between willingness to forgive and relationship positivity. They explain that forgiving in interpersonal relationships minimizes harmful reactions to hurt inflicted by the other party and provides healing for these hurts to keep the relationship healthy.

Forgiveness has been shown to be positively correlated with individual health and well-being (Maltby, Macaskill, & Day, 2001; Toussaint, Williams, Musick, & Everson, 2001; Witvliet, Ludwig, & Vander Laan, 2001). With respect to interpersonal relationships, increased life satisfaction and decreased anger, anxiety, and depression

have all been associated with forgiveness (Thompson et al., 2005). This initial evidence suggests that forgiveness may play a role in children's health and well-being, especially with respect to parental and parent-child relationship quality.

It has been proposed that forgiveness is most beneficial to mental health when the relationship between two parties is one of deep commitment versus simple acquaintance (Karremans, Van Lange, Ouwerkerk, & Kluwer, 2003). Without forgiveness, "psychological tension" stemming from a deep hurt between two people in a committed relationship may take a toll on their well-being or life satisfaction (p. 1023). Therefore, forgiveness between parents and children should not be neglected in empirical literature and clinical practice. In addition to state forgiveness, trait forgiveness (a general likelihood that the child will be forgiving) is suspected to protect against maladjustment or mental illness (Lawler-Row & Piferi, 2006).

Group coping. Group solidarity and cohesiveness can be particularly important for marginalized groups, such as LGBTQ people (Meyer, 2003b). Group resources include connection with community (Frost & Meyer, 2012), affirming community space, and positive reframing of stigma (Kertzner, Meyer, Frost, & Stirratt, 2009). Regardless of personal coping skills, a cultural group provides additional support for minority stress. Meyer describes this support of the group as "minority coping," which is most impactful when an individual leans on the group for this type of coping.

Hershberger and D'Augelli (1995) highlighted the protective nature of family support and personal acceptance for the mental health of LGBTQ youth. Along with family of origin and supportive friends, the experience of environments in which one is

not stigmatized, such as LGBTQ and multisexual affirming spaces, can ameliorate the impact of marginalization and discrimination.

Social support. As a protective factor for healthy sexual identity development, the importance of social support for marginalized youth is overwhelmingly stressed in current literature (Coenen, 1998; Eisenberg & Resnick, 2006). Social bonding with parents, peers, and society in general can help gay teens to adjust much more positively to their developing sexuality. This type of bonding can protect youth from negative consequences such as poor grades, drug and alcohol use, emotional struggles, and unsafe sexual behavior (Thompson & Johnston, 2003). These data have been collected primarily, however, from gay and lesbian youth, not bisexual youth.

Eisenberg and Resnick (2006) cited four protective factors of negative coming out experiences, including strong family relationships, support of teachers, support of other adults, and safety at school. These factors were found to decrease the likelihood that sexual minority youth will commit suicide, despite the fact that their sexual orientation was not the only factor in suicidality. Most of the other factors were *socially* rather than self-imposed on these teens (e.g., ostracism, family conflict, and victimization). The extreme effects of social isolation, ostracism, stress, and infrequency of positive interactions include substance use and abuse, risky sexual behavior with increased incidence of sexual transmitted diseases, and suicidality (Thompson & Johnston, 2003). Having the support of family, friends – both homosexual and heterosexual - and acquaintances, including co-workers, proved beneficial (Jordan & Deluty, 1998).

LGBTQ community support. Meyer (2003b) defines intraindividual coping processes and the coping processes of a group, such as a cultural identity group, as

separate entities. He extrapolates from this that a minority person could have individual coping responses at one's disposal and still be deficient in ways of coping within the minority group. Even with highly adaptive individual coping, Meyer explains that marginalized individuals are still hindered when coping mechanisms within the group are unavailable. This provided rationale to include LGBTQ community support and general social support as important coping variables for examination in the current study.

Balsam and Mohr (2007) highlighted that feelings about one's sexual minority identity (e.g., sense of queerness or LGB community) may be distinct from feelings about an individual identity status (e.g., lesbian, bisexual). They offered a possibility that a bisexual person may respond differently when reporting positive feelings about being an LGB person versus reporting feelings about being a bisexual person. Divergent responses may subtly imply discrepancies between pride in a sexual minority status versus pride in one's own bisexual orientation.

Mental Health and Well-Being

Mental health is understood as the absence of symptoms that negatively impact social or occupational functioning (APA, 2000). While Kertzner, Meyer, Frost, and Stirratt (2009) measure well-being as the attainment or preservation of mental health, it can also be defined as a sense of happiness or satisfaction with one's life ( ). Together, mental health and well-being provide a complementary view of an individual's symptoms of distress and overall sense of wellness. Measuring both health and illness together is integral to the validity of conclusions. It is true that an individual may have a high or low perception of illness, a high or low perception of wellness, and any combination of these. Though they are not mutually exclusive, illness and wellness are not conceptualized here

as two ends of a linear continuum from absolute health and well-being to absolute illness and lack of well-being.

As highlighted in each of the sections above, mental health and well-being are now more commonly understood to vary for LGB people as a function of minority stress (which also includes general stress) and coping (Herek, Gillis, & Cogan, 1999; Meyer, 2003b; Szymanski, Kashubeck-West, & Meyer, 2008; Thompson & Johnson, 2003). This conceptualization is more widely supported in current psychological research than prior beliefs that observations of poor mental health and well-being in LGB people was caused by some essential pathological features of homosexuality (Hooker, 1957).

Mental health. Symptoms of depression, anxiety, obsessive compulsions, interpersonal sensitivity and well-being variables are examined in the extant literature as common outcomes of general and minority stress. Despite increasing acceptance and forward motion in LGBTQ rights movements, the expression of common symptoms of distress continue to occur for LGB people as evidenced by increasing media coverage of many youth suicides and as measured by research regarding LGB people's use of therapeutic services (Page, 2004). Dodge & Sandfort (2007) reviewed extant literature regarding mental health for bisexual versus heterosexual and lesbian/gay people.

Health and well-being data for LGBTQ people are simply best estimates due to the cultural, relational, and legal stigma associated with being out and able to be identified as LGBTQ. Additionally, differences in how sexual orientation identities are defined (e.g., behavioral, self-determined labeling) may impact the measurement of mental health outcomes for particular identity groups. Regardless of these complexities in sampling technique, research continues to provide evidence that bisexual identified

people experience more depression, anxiety, suicidality, and substance abuse than not only heterosexual counterparts but also lesbian and gay individuals (Dodge & Sandfort, 2007; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). More specifically, in their analysis of five mental health studies including bisexual participants, Dodge and Sandfort (2007) conclude that bisexual individuals are shown to report poorer mental health outcomes than heterosexual and gay/lesbian people regardless of whether they are self-identified as bisexual or behaviorally identified as bisexual.

Many studies combine data from lesbian, gay, and bisexual people into their overall results, regardless of whether each identity group was equally represented in the sample. More often than not, bisexual individuals are underrepresented in such samples. While there are merits to both types of sexual orientation measurement, it appears that mental health outcomes do not differ based on style of identification.

Mental illness or the deterioration of mental health and well-being has been attributed to daily and chronic general stress as well as hardships connected to marginalization of social identities (Dohrenwend, 2000). According to Dohrenwend, a range of ailments manifest for individuals who experience adversity, including PTSD, depression, substance abuse, personality disorders, and overall emotional distress. The etiological study of psychiatric illnesses (e.g., schizophrenia and major depression) historically point to an array of factors, also described via the diathesis-stress model (Holmes & Rahe, 1967), wherein both physiological and environmental variables interact in complex ways to determine causality. Dohrenwend's work, grounded in the literature of epidemiology, social selection, and intense stress experiences, proposes a framework shift toward conceptualizing mental health outcomes as a function of more broadly

defined and persistent identity-based environmental stresses, providing examples including socioeconomic status (SES) and ethnic identity.

Lesbian, gay, and bisexual youth are over-represented in statistics about attempted and completed deaths by suicide (Eisenberg & Resnick, 2006). Young sexual minority people are two to three times more prone to attempt suicide than their heterosexual counterparts and as many as 20-35% of gay youth have contemplated suicide (Thompson & Johnston, 2003). These same authors point out that youth are driven to find their social support in environments with increased availability and exposure to drugs and alcohol with consequent risky sexual behavior. Additionally, "adolescents in general have a higher incidence of sexual transmitted diseases than any other population, as they typically have short-term perspectives of the future and are often impulsive" (p.120). These are the grave dangers that unaccepting and unsupportive parents often face. While suicide, risky sexual and physical health behaviors, and substance abuse extend beyond the scope of the current study, they may be comorbid with symptoms of mental illness (e.g., depression, anxiety).

Less information exists about the psychological impact of marginalization for bi- and multisexual people than for lesbian and gay people. It is more difficult to know how these dynamics have played out for bi- and multisexual populations, perhaps due to the lower likelihood that these individuals might be "out" or identified as sexual minorities. Additionally, as suggested earlier in this review, conclusions are often drawn about bi- and multisexual people as they are lumped together in research that in actuality more accurately portrays the experiences of the higher number of lesbian and gay participants. Dodge and Sandfort (2007) advocate for collecting and understanding specific health and

wellness data for bisexual people, given that previous data has been combined with lesbian and gay participants (often separated by gender) and bisexual people are understood to experience unique stressors that impact mental health and well-being.

Well-being. As a counterweight to the objective measurement of symptoms of mental illness or psychological distress, assessment of well-being provides a framework with a "positive orientation" for understanding subjective experiences of wellness (p. 164, Pavot & Diener, 1993). Well-being is conceptualized in psychological literature as inclusive of positive affect, negative affect, and overall life satisfaction. Pavot and Diener describe this sense of life satisfaction as a cognitive appraisal of one's lived experiences based on that individual's own set of standards for satisfaction. While subjective experiences of positive and negative affect provide important moment-to-moment data, Pavot and Diener highlight the significance of long range perceptions of overall well-being gained by measures of life satisfaction.

Keyes (1998) summarized the multifaceted nature of social well-being, including: social integration, social acceptance, social contribution, social actualization, and social coherence. Due to the social and cultural variability of each person's standards for happiness and well-being, it is important to assess general subjective ratings of overall life satisfaction in addition to specific theoretical domains of well-being (Diener, Emmons, Larson, & Griffin, 1985). The current study focuses on the cognitive appraisal dimension measured by Diener and colleagues, noting that an ideal full assessment of well-being may include an additional specific measure of positive and negative affect.

With respect to LGB populations, Kertzner, Meyer, Frost, and Stirratt (2009) found that bisexual participants indicated lower social well-being than lesbian and gay

participants, while no differences existed between participants of differing gender or racial identities. They further identified that the valence of one's sexual identity and connectedness to the LGB community were associated with social well-being, variables that were shown to mitigate the association between bisexual identity and lower social well-being. That is, these authors noted that bisexual participants identified lower social well-being as a function of lower community connectedness and less positive feelings about their sexual identity.

Statement of the Problem

Diamond (2003a) systematically reviews important gaps in research regarding bisexual and other marginalized or "sexual minority" people. She notes that many researchers are unclear or do not formally assess the sexual orientation identities of their participants. Diamond additionally highlights that many studies assume or imply similarity or sameness within cultural groups (e.g., combining the experiences of lesbian, gay and bisexual people) and do not explore what other variables might account for impacts assumed to be attributable to "sexual minority" identity. This action can unintentionally perpetuate the systemic oppression experienced by the population, blaming negative outcomes on the individual's sexual orientation rather than the influence of marginalization and discrimination (Meyer, 2003b).

Bisexuality has been examined in psychological literature considerably quite less than lesbian and gay identities (Eliason, 1997; Herek, 2002). We know that bisexuals experience unique stressors and stigmas that come from both straight and gay/lesbian communities (Ochs, 1996). For instance, bisexual people may be experienced by lesbian and gay communities as "not gay enough" and by heterosexual communities as "not

straight enough." They may also be seen as a "traitor" to the heterosexual or gay/lesbian community if they begin a relationship with someone of the same or other gender, respectively. These phenomena should be examined thoroughly and understood *separately* from stress related to having other sexual minority identities (e.g., lesbian, gay; Fassinger & Arseneau, 2007). Other multisexual identities (e.g., queer, pansexual) have been studied even less than bisexuality, especially in quantitative psychological research. These identities may have even more and perhaps distinctly different distal and proximal stress processes.

Under circumstances when an individual may have very little control over the stressor, such as negative or harmful attitudes and behaviors of others, Worthington and Scherer (2004) identify and promote the impact of emotion-focused coping (specifically forgiveness) in mitigating harmful mental health outcomes. Other studies provide evidence of specific protective mechanisms of forgiveness for both physical and mental health (e.g., Lawler-Row & Piferi, 2006). This type of coping, conceptualized as a release (rather than holding) of negative affect, is hypothesized in the current study to be a protective factor for mental health and well-being of multisexual individuals. A few studies have begun to examine the impact of forgiveness for marginalized cultural groups (Leach, Baker, & Zeigler-Hill, 2011; McFarland, Smith, Toussaint, & Thomas, 2012; Schoulte, Schultz, & Altmaier, 2011). As U.S. culture continues to perpetuate systemic, group-wise, and individual marginalization and oppression of sexual minority individuals and the dual-oppression of multisexual people, improved understanding of effective coping mechanisms continues to be an important area of research.

Present Study

The methods of the current study are grounded in the work of Meyer (2003b) regarding minority stress with the LGB community, with the general purpose of extending his work toward understanding the unique experiences of multisexual people. This investigation measured minority stress as experienced by self-identified multisexual people, their mechanisms of coping, and mental health and well-being outcomes. More specifically, this study examined the ability of forgiveness and other styles of coping, including individual and community social support, to mitigate the expected negative impact of minority stress on mental health and well-being.

The study addressed several gaps in extant literature regarding sexual orientation identities, forgiveness as a coping strategy, and specificity in measuring sexuality and gender as cultural identities. First, much less is known about bisexual versus lesbian and gay identities. While this body of research is growing, almost none exists about other sexual identities such as pansexual, omnisexual, or queer, collectively termed *multisexual* for the purposes of this study.

Forgiveness is identified as one particular emotion-focused coping strategy with particular protective properties regarding hurts that cannot be directly change by the victim (Worthington & Scherer, 2004), as with active or problem-focused coping. Minimal specific research has been conducted examining the utility of forgiveness for those with multisexual identities. Further, within the scope of interpersonal hurts that are systemic and oppressive in nature (e.g., heterosexism, hate crimes), research regarding forgiveness as a useful coping mechanism is controversial (McKay, Hill, Freedman, & Enright, 2007).

Finally, specificity in measuring gender and other cultural identities is an important strength within the current study. By offering response options that enhance inclusion and all for self-determination, the current study has the potential to better understand this population of multisexual people with a more accurate multicultural and contextual lens. The results of this study may have implications for the intentional coping strategies of multisexual people and mental health professionals providing any such interventions.

Hypotheses

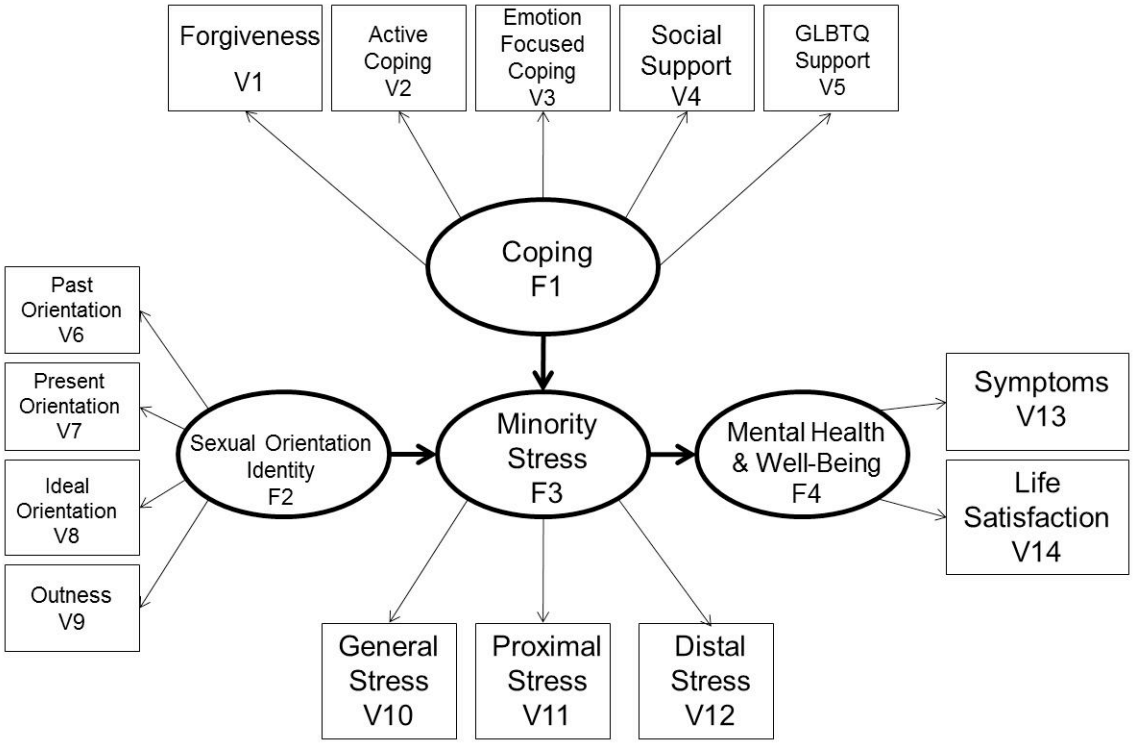
The aim of the current study was to utilize latent path analysis in estimating the fit of self-report data to a model of minority stress adapted from Meyer (2003b). The primary hypothesis of this study was that the adapted model of minority stress would explain the mental health and well-being experiences reported by multisexual individuals. As shown in Figure 1, the current study expected multisexual identity (F2) to be linked to mental health and well-being (F4) *via* minority stress (F3, as delineated by Meyer) and this relationship would be mediated by multifaceted coping (F1). Expanding Meyer's work, the current study measured the latent variable representing minority sexual orientation identity (F2) as self-identified sexual orientation across time (V6-8) *and* outness about this identity (V9). As explained above, outness was included as a manifest variable of sexual identity due to its significance in distal stress, such as targeted attacks, and implications for internalization of stress.

Supplementary hypotheses. Emotion-focused coping (V2), specifically forgiveness (V1), was hypothesized to be an effective coping strategy when interpersonal

hurts are related to systems of oppression, including the unique stresses experienced by LGB individuals and communities (Worthington & Scherer, 2004).

Figure 1

Conceptual Model of Minority Stress



CHAPTER III

METHOD

The current study employed online collection of self-report data from participants recruited via methods discussed below. Data included cultural identity information as well as self-identified dimensions of sexual identity, sexual identity disclosure (i.e., outness), multifaceted aspects of minority stress, coping mechanisms, social support, and perceived mental health and well-being. Quantitative statistical analyses were used to first understand the cultural identities of the sample, second test the fit of the overall model of minority stress, and finally explore smaller sections of rich data points regarding the utility of forgiveness.

Sample and Participant Selection

Participation was open to any individual over age 18 regardless of geographical location; though most recruitment targeted the North American continent, specifically the United States. The primary investigator created an email and similar online call for participants, providing inclusion criteria and a URL to the survey (see Appendices C, D). Special effort was made to recruit lesbian, gay, bisexual, transgender, and queer (LGBTQ) identified participants who may be more likely to identify outside of a binary systems of gender and sexual orientation (i.e., strictly male or female, heterosexual or homosexual). Recruitment of multisexual participants involved forwarding emails to university LGBTQ student groups, queer community websites and listservs (e.g., Bisexual Organizing Project, BiNet USA, University of Minnesota GLBTA Programs), psychology faculty, professional listservs (e.g., Consortium of Higher Education LGBT Resource Professionals), and via snowball sampling among other LGBTQ researchers

and activists in bisexual and transgender communities. Effort was made to utilize recruitment venues including Facebook groups and organizations or events spanning age, race, ethnicity, gender identity, ability status, geographical location and religious/spiritual beliefs (e.g., Color CoordiNATION, Bisexual Empowerment Conference).

The primary investigator collected data from participants who identified with any sexual orientation identity ($N = 527$); though only participants who fit the category of *multisexual* (e.g., bisexual, queer, same gender loving) were utilized for the current set of analyses ($n = 207$). Specifically, data from participants in the full sample who identified as asexual, gay, lesbian, or straight (heterosexual) were not utilized in the current set of statistical analyses.

Descriptive Statistics and Reliabilities

Sexual identity demographics for multisexual participants ($N = 207$) are displayed in Table 1 and other cultural identity characteristics are summarized in Table 2. Most participants in this subset of data identified as bisexual or queer (see below) when asked to respond to a forced-choice demographic question with 12 total sexual identity response options. When given the opportunity to write in their own self-identified label, 85 of the 207 participants provided combined or newly created labels (e.g., Bi-Dyke, bi-curious, Homoflexible, fluid, nonmonosexual, polymorphous perverse, girlfag). The full list of self-identification labels can be found in Appendix A.

When asked a forced choice question about natal sex, 72% of the 207 participants identified as female ($n = 149$), 22.7% as male ($n = 47$), and 4.8% ($n = 10$) selected "Other," describing themselves with labels such as "female born but male identified," "other," or "trans." Interestingly, when asked to report gender identity from this more

Table 1

Forced Choice Sexual Identity Label

Sexual Identity	*N* = 207	%
Bisexual	96	46.4
Queer	74	35.7
Pansexual	17	8.2
No Label for Sexual Orientation	11	5.3
Questioning	4	1.9
Omnisexual	3	1.4
Pomosexual (Post-Modern Sexuality)	2	1.0

inclusive list of gender identity labels, only 55.6% of these same participants identified as female and 16.4% as male. The remaining 28% identified as FTM (female to male), genderqueer, gender non-conforming, MTF (male to female), Two Spirit, or Other (See Table 2). Self-reported identities (n = 18) under the category of "other" included "Femme," "Tranny Girl," "gender-elastic female," "transmasculine transguy," and "multigendered" (see Appendix B).

Participants (N = 207) ranged in age from 18 to 67 years (M = 30.92, SD = 11), with a modal age of 22 years. Though the sample represented a large range of ages, the modal age is reported here to emphasize a larger percentage of younger rather than older participants. This group was largely comprised of European American/White (85.0%) and "Other, including biracial or multiracial" identities (8.7%), with smaller percentages representing African American, Native American, Asian American, Latino/a, and individuals of Arab descent. About one-third of participants reported being single (33.3%), with others reporting being in a long-term committed relationship (not legally recognized; 15.5%), romantic or sexual dating relationship (21.3%), married/legal union

(14.5%), multiple types of current relationships/polyamorous (11.1%), or divorced (4.3%).

With respect to spiritual and religious identity, 22.2% of participants self-identified as Agnostic, 16.4% as Christian, 15% as Pagan, and 13.5% as Atheist. Several other participants identified with a diverse array of identities (e.g., Jewish, Pagan, Buddhist, Wiccan). Those who indicated "Other" (24.8%) were characterized by several participants who endorsed (a) "None" (7.7%), (b) uncertainty in some form, (c) multiple religious or spiritual identities, or (d) an identity not listed above (e.g., Native American/Tribal, Unitarian Universalist, Quaker, Mysticism).

Most of the participants in the current sample had a great deal of formal education, including 26.6% who completed a graduate degree, 39.6% with a college degree, 32.9% who completed some college at time of survey, and 1.0% who completed education up to a high school diploma. Most participants identified their annual personal income in the lower brackets, including $0 – 10,000 (32.4%) and $10,001 – 30,000 (27.5%).

At the end of the online survey, participants were given the opportunity to reflect on items that were difficult to answer due to the individual's particular identities. Of this multisexual sample, 53 participants provided qualitative responses to this optional item. While specific qualitative analysis methods were not utilized in the current study, a discussion of general impressions and patterns will be presented in Chapter V.

Table 2

Demographic Characteristics

Identity	N=207	%
Natal Sex		
Female	149	72.0
Male	47	22.7
Other	10	4.8
Missing	1	0.5
Gender Identity		
Female	115	55.6
Male	34	16.4
MTF (Male to Female Transgender)	3	1.4
FTM (Female to Male Transgender)	11	5.3
Gender Nonconforming	6	2.9
Genderqueer	19	9.2
Other	19	9.2
Racial Identity		
African American/ Black/ Caribbean/ African descent	4	1.9
Arab Descent	1	0.5
Asian American/Asian/South Asian/Pacific Islander descent	2	1.0
European American/Caucasian/White	176	85.0
Hispanic or Latina/o	3	1.4
Native American/Indigenous	3	1.4
Native Hawaiian or Other Pacific Islander	0	0.0
Other, including biracial or multiracial	18	8.7
Relationship Status		
Divorced	9	0.0
Long-term Committed	32	0.2
Married/Legal Union	30	0.1
None/Single	69	0.3
Polyamorous/Multiple Types of Current Relationships	23	0.1
Romantic or Sexual Dating Relationship	44	0

Table 2 (cont.)

Demographic Characteristics

Identity	N=207	%
Religious & Spiritual Beliefs		
Agnostic	46	22.2
Atheist	28	13.5
Ba'hai	1	0.5
Buddhist	9	4.3
Catholic	0	0.0
Christian	34	16.4
Hindu	1	0.5
Islam	0	0.0
Jewish	16	7.7
Mysticism	1	0.5
Pagan	15	7.2
Protestant	0	0.0
Wiccan	5	2.4
Other	51	24.8
Highest Education Completed		
No High School	0	0.0
Some High School	0	0.0
High School Graduate	2	1.0
Some College	68	32.9
College Degree	82	39.6
Master's Degree	39	18.8
Doctoral Degree	16	7.7
Current Income		
$0 to $10,000	67	32.4
$10,001 to $30,000	57	27.5
$30,001 to $60,000	44	21.3
$60,001 to $90,000	19	9.2
$90,001 or more	5	2.4
No Response	15	7.2

Participants were also given space to express any experiences or identities not conveyed in the answer choices I provided. Of this sample, 42 participants chose to expand upon some of the unique stressors they experienced as bi- and multi-sexual individuals. These included the summarized examples below:

- Having a history of relationships with both women and men
- Not necessarily always being attracted to both men and women across time
- Married bisexuals feeling alienated from queer community
- Having attraction to transgender, gender nonconforming, or genderqueer partners
- Passing or not passing as a particular sexual orientation (e.g., straight or gay)
- Wanting or not wanting to pass as straight, gay, or bisexual
- Being culturally or politically queer

Measures

The following section describes the general use, psychometric properties, and procedures (or revised procedures) for administration for each measure utilized in the current study. Each measure represents a manifest variable in service of measuring the four main latent variables show in Figure 1.

Demographic information. A demographic questionnaire written by the primary investigator (see Appendix F) asked participants to report natal sex, gender identity, age, racial identity, religious or spiritual beliefs, sexual orientation identity, other sexual orientation labels used, current relationship status, education level, current country of residence, U.S. geographic region, and current personal income. Other optional items included past or current participation in counseling or therapy and the nature of this counseling. Participants were further given open space to describe identities or life experiences not conveyed in answer choices above.

Minority identity. Many theories attempt to explain the development of sexual minority identity and change in these identities over time, as outlined in the previous

chapter. Sexual orientation identity has been conceptualized and is still frequently measured as unidimensional and stable across time (Stein, 1999), but current research practices acknowledge and advocate for measuring multidimensionality and the capacity for change in sexual identity across time (Chung & Katayama, 1996; Diamond, 2008b).

Given the frequently "invisible" nature of sexual orientation as a cultural identity, it is important to further account for outness as a variable that may inform an understanding of environmental differences (e.g., stress, coping and social support, and mental health and well-being) between monosexual and multisexual individuals. Internalized and externalized oppression (labeled distal and proximal processes in the model of minority stress) depend on self and others identifying real or perceived sexual minority identity, whether intentionally or unintentionally disclosed. For instance, a bisexual male who is perceived to be straight likely experiences the external world (and is experienced *by* the external world) differently than a bisexual male who is "out" or recognized by others as bisexual. A measure of sexual orientation and a measure of outness will be reviewed below, as utilize in the current study to reflect the latent variable of minority identity.

Sexual orientation. The Klein Sexual Orientation Grid (KSOG; Klein, Sepekoff, & Wolf, 1985) is a 21-item response grid (7 categories by 3 time classifications; see Appendix G). In order to understand a multidimensional perspective of sexual orientation, participants rate their sexual attraction, sexual behavior, sexual fantasies, emotional preferences, and social preferences on a Thurstone scale from "Other Gender Only" (0) to "Same Gender Only" (6). Lifestyle preference and self-identification are rated from "Heterosexual Only" (0) to "Homosexual Only" (6). Participants are given

descriptors such as “to whom are you sexually attracted” and “with whom do you like to socialize” in order to understand these dimensions.

Each of the seven dimensions of sexual identity was given a rating for the present year, the past (before this year), and an ideal or future identity. The ratings from zero to six align with the Kinsey Heterosexual-Homosexual Scale (Kinsey, Pomeroy, & Martin, 1948) wherein higher scores denote more affiliation with homosexuality or a preference for same-sex sexual behaviors. The KSOG responses may therefore be averaged across the 21 items to create a score that translates to one’s position on the Kinsey Scale (see Chapter II) *and* may be used to understand individual identity dimensions separately.

Klein, Sepekoff, and Wolf (1985) proposed a multidimensional construction of sexual orientation. This framework serves as a means to correct over-simplified and inconsistent previous definitions. They distinguish sexual attractions from sexual behaviors, emotional attraction (feelings of love) from social inclinations (preference of social interaction), and personal identity from community identity. Their conceptualization also allows for distinctions between these categories across time. The original study by Klein and colleagues offered a Thurstone scale from one to seven rather than zero to six (hetero- to homosexual). Alpha reliabilities were not specified, but rather described as “generally excellent” (p. 43). It was also hypothesized by the scale’s developers that the results of these Kuder-Richardson 20 calculations for test-retest reliability were not as consistently high across time category (e.g., past, present, ideal) as within because sexual orientation identity has the capacity for change between these time periods.

Interitem correlations suggested that social preference might represent a unique component of sexual orientation (Klein, Sepekoff, & Wolf, 1985). As an indication of the capacity for change over time, Klein and colleagues found significant overall change (specifically between past and present, though not between present and ideal sexual orientation). This general finding remained consistent across heterosexual, homosexual, and bisexual identified participants, though not across the same time periods. The Klein scale is reported to be useful for demonstrating fluidity in sexual identity and in accounting for more dimensionality than is allowed by measures of sexual behavior only. As measures of sexual orientation continue to be revised to embrace current understandings of the fluidity of sexuality and multisexual identities, the KSOG serves as an imperfect but useful measure of these orientation identities.

Outness. The Outness Inventory (OI; Mohr & Fassinger, 2000) is an 11-item measure of the degree to which family, religious community members, and other individuals are aware of participants' sexual orientation status (see Appendix H). Participants were asked to indicate the awareness of each individual or group from "Definitely does NOT know about your sexual orientation status" (1) to "Definitely knows about your sexual orientation status, and it is OPENLY talked about" (9). Participants are also allowed to indicate that this item is "not applicable" (0). Subscales include Out to Family, Out to World, and Out to Religion and scores are determined by calculating the mean of subscale items. The three subscale scores can be averaged to describe Overall Outness. Higher scores indicate a greater degree of outness and openness with others about one's sexual orientation identity.

Results of principal components factor analysis and examination of scree plots determined a three-factor solution to be most fitting for both lesbians and gay men (Mohr & Fassinger, 2000). The three factor model was also compared to a one factor model and determined to be more appropriate according to fit indices (*CFI* = .95; *NNFI* = .94; *GFI* = .91) and significant Chi-square analysis $\chi^2(3, N = 103) = 164.97, p < .001$. It should be noted that results from all items, including two items that address religious community, were calculated using a partial sample, given that not all participants completed these items.

Normative data were collected from a non-random sample of same-sex partnered community members, with special efforts directed toward recruitment of people of color (Mohr & Fassinger, 2000). Initial results of psychometric testing also provided data revealing adequate internal consistency for each subscale: Out to World (α = .79), Out to Family (α = .74), and Out to Religion (α = .97). Mohr & Fassinger used measures of self-esteem, same- and other-group orientation (level or preference for involvement with either gay/lesbian or straight individuals and groups), phase of sexual orientation identity development, age at development milestones, and affiliation with affirming religious organizations to provide supporting evidence of satisfactory convergent and appropriate divergent validity.

Stress. In alignment with Meyer's model of minority stress (2003b), measures of stress were summarized according to their representation of (a) general stressors, (b) proximal processes, and (c) distal processes. While each of these is a complex construct, as reviewed above, one measure was used in the current study to estimate levels of each domain of stress.

General stress. The Perceived Stress Scale (PSS; Cohen & Williamson, 1988) is a 10-item self-report measure wherein participants' deem the stressfulness of their life events (see Appendix I). Items such as, "In the last month, how often have you felt that things were going your way" and "In the last month, how often have you felt that you were unable to control the important things in your life" were rated from "Never" (0) to "Very Often" (4). Reverse coding was performed on positively worded items and all items were then summed to create a total score. Higher scores indicated greater levels of distress.

Regarding physical symptoms and mood disturbances, Cohen, Karmarck, and Mermelstein (1983) noted the original 14-item PSS to be a better gauge of health than life event checklists. This original study also found perceived stress, as measured by the PSS, to be positively correlated with social anxiety. Coefficient alphas were between .84 and .86 with test-retest reliability at .85 after two days and .55 after six weeks.

As expected by Cohen and colleagues (1983), the 14-item measure of perceived stress showed significant correlations with measures of stressful life events, symptoms of depression, somatization, and social anxiety. These authors suggested this measure to be most valid in assessing processes involved with "nonspecific appraised stress" or the degree to which other variables might mitigate the effects or perceptions of stress (p. 385). The PSS, in a 12-item version, was used by Diamond and Lucas (2004) to investigate relationships and differences in perceived stress and other variables in a sample of young people. They found no significant differences between heterosexual and sexual minority youth in this measure of perceived general stress. This lends evidence to

the validity of this instrument as a measure of general stress that is separate from the unique distal or proximal stressors experienced by minority individuals.

Diamond and Lucas (2004) demonstrated convergent validity of the PSS as it correlated negatively with a measure of control in relationships. This was an expected association according to Cohen and Williamson's characterization of the PSS as a measure of "how unpredictable, uncontrollable, and overloaded" the participants' lives are perceived to be (1988, p. 34). Scores on the PSS were also correlated with negative affect, as expected (Diamond & Lucas).

Proximal stress. The Lesbian Internalized Homophobia Scale, adapted (LIHSa, Hoang, 2006; LIHS, Szymanski & Chung, 2001) is 55-item measure adapted from the original version targeting Lesbian-identified participants. The scale used in the current study was revised based on a modified version used with ambisexual women to measure internalized monosexism (Hoang). The current study further adapted Hoang's work, using the word "queer" to allow for relevance to participants of any gender identity and to encompass all multisexual identities. While not all individuals embrace the word "queer" as a positive identity term or one that they claim for themselves, the term was used in the current study as the most recognizable and closest approximate umbrella term for the intended sample. Appendix J provides adapted instructions and items of the LIHSa.

The original scale, Lesbian Internalized Homophobia Scale, consisted of 52 items measuring internalized stigma (Szymanski & Chung, 2001). Participants are asked to rate their agreement with each item from "Strongly Disagree" (1) to "Strongly Agree" (7). Examples of revised such items include, "As a queer person, I am loveable and deserving

of respect." and "I live in fear that someone will find out I am a queer person." After reverse scoring 11 items, subscale scores are calculated by summing item responses. Higher scores indicate greater internalized stigma.

Original items (Szymanski & Chung, 2001) were designed to reflect five dimensions of internalized stigma, specifically: connection to the lesbian community (13 items; $\alpha = .87$), public identification as a lesbian (16 items; $\alpha = .92$), personal feelings about being lesbian (8 items; $\alpha = .79$), moral and religious attitudes towards lesbianism (7 items; $\alpha = .74$), and attitudes toward other lesbians (8 items; $\alpha = .77$). Total scores ($\alpha = . 94$) were moderately correlated with subscale scores (*r*s = .60 - . 87). As noted, internal consistency was found to be adequate or superior for all subscales.

Normative data were collected using a sample of 303 women between 18 and 65 years old (Szymanski & Chung, 2001). Some of these women identified their sexual orientation label as "bisexual but primarily lesbian," "bisexual but primarily heterosexual" or "other." This totaled 25.9% of the sample that did not identify as strictly lesbian or strictly heterosexual. Additionally, Hoang (2006) utilized an adapted version of this scale with women who identified as bisexual or as having both male and female partners. This lends some support for use of the measure in the current study of bisexual identified people, though no males were included in normative data or other studies (e.g., Hoang, Holloway, & Mendoza, 2011)

While a similar measure specifically created for bi- or multisexual internalized stigma does not exist, the LIHSa is one of the most comprehensive and well-researched tests of this concept for lesbian identified people. Results should be analyzed carefully,

with the understanding that separate and unique factors may explain internalized stigma as experienced by multisexual people.

Distal stress. Crimes Against You (Herek, Gillis, & Cogan, 1999) is a portion of the paper and pencil measure used in the Northern California Men's Health Study as well as a separate study of 2,259 LGB persons from the Sacramento, CA area (Appendix K). Herek and colleagues measured the experience of hate crimes (14 items) and harassment (9 items) motivated by sexual orientation. This scale also includes measurement of other crimes not related to sexual orientation, or non-bias crimes (14 items). These items address frequency of incidents, description of the most recent and other past crimes or harassment events, reporting to police, anticipation of future crimes, and likelihood of being a victim relative to others in the local area. Crimes of interest here include physical attack, sexual assault, robbery, and vandalism due to perceived minority sexual orientation. Other types of harassment include threats, verbal insults and abuse, being spit on, being chased, and discrimination in housing, employment, or other services.

Herek, Gillis, and Cogan (1999) did not report psychometric data in their use of these items with a sample of men and women in the Sacramento, CA area. They did, however, review potential problems with the scale's use. Their critique included self-report bias, no doubt exaggerated due to the sensitive nature of the topic and the participant's perceptions of bias (those related to sexual orientation) versus non-bias (those unrelated to sexual orientation) crimes against them. In summarizing their findings, Herek and colleagues note that men endorsed more experiences of hate crimes than women and gay/lesbian individuals endorsed more experiences of bias crimes than bisexual individuals. This study by Herek and colleagues found no differences in

psychological distress of bisexual participants across victim groups, hypothesized as due to the smaller sample size of bisexual participants (about 17% of the LGB sample).

Though it is most desirable to utilize scales with firm psychometric data, the current study utilized the Crimes Against You items as written in straightforward behavioral terms by a well-respected researcher (Herek). In the study conducted by Herek, Gillis, and Cogan (1999) the guiding principles for use of the items were grounded in past research documenting psychological responses to victimization (e.g., recent versus past crime, personal versus property crimes, bias versus nonbias motivations).

While Herek and colleagues (1999) did not provide specific scoring instructions, they did describe their means of categorizing victims into hierarchical categories based on their perceptions of psychological impact. These authors combined participants who endorsed only property crimes (less highly correlated with emotional distress) with participants who did not endorse any crime victimization. Participants who experienced only attempted crimes were excluded from analyses due to their low number. Other categories were created based on number of direct victimizations and time period of the crimes, with those experienced in the past two years indicating greater current distress. A scoring system was constructed for the current study by the primary investigator with faculty consultation. Based on the core assumptions set forth by Herek and colleagues, the current study did not categorize victims, but rather created a quantitative value for each item, with higher values assigned to direct (versus indirect) and completed (versus attempted) crimes.

Analyses within the current study included only the first 16 items regarding hate crimes and harassment based on sexual orientation (bias crimes), though participants completed the other 14 items related to non-bias crimes. The items were first marked as endorsed versus not endorsed, and later were given numerical values based on the severity of the crime. For instance, personal attacks (e.g., hit, beaten, or physically attacked) were given a score of four, property crimes (e.g., burglary or theft) were given a score of three, attempted crimes (e.g., robbery, sexual assault) were assigned a score of two, and other unknown crimes were assigned a score of one. Forms of harassment, such as verbal insult or being threatened with violence, were scored with numerical values according to the number of reported instances. Scoring of these items was assigned as follows: never (0), once (1), twice (2), and three or more times (3). The maximum score on this scale was 67, with higher scores indicating more experience of hate crimes and harassment.

Coping and social support. Mechanisms of coping with stress can be measured across various personal types or styles. The current study measured coping across several types of styles, general social and queer community support, and forgiveness, specifically as an emotion-focused coping strategy.

General coping. The Brief COPE (Carver, 1997) is a 28-item measure of tendencies toward particular styles of coping with stressful situations (see Appendix L). It consists of 14 scales with two items each. These scales are Active Coping, Planning, Positive Reframing, Acceptance, Humor, Religion, Using Emotional Support, Using Instrumental Support, Self-Distraction, Denial, Venting, Substance Use, Behavioral Disengagement, and Self-Blame. Items include statements such as "I've been turning to

work or other activities to take my mind off things" and "I've been using alcohol or other drugs to help me get through it." These items are rated from "I usually don't do this at all" (1) to "I usually do this a lot" (4). Means are calculated to create subscale scores. Higher subscale scores indicate a greater affinity for each particular coping style.

The Brief COPE was constructed as an abbreviated version of the original COPE inventory of 60 items (Carver, Scheier, & Weintraub, 1989) to reduce participant fatigue and increase full participation, of great benefit in the current study's battery. Carver (1997) described psychometric data from the Brief COPE using a sample of U.S. hurricane survivors, with the noted advantage of using a nonstudent sample. Scales were reduced from the original COPE measure based on high factor loadings and readability for a general population (Carver). The sample obtained by Carver was quite racially diverse (reported as: 40% White, 34% African American, 17% Latino/a, and 5% Asian) and produced acceptable alpha reliabilities for each of the 14 scales (α = .50 - .90). Carver described exploratory factor analysis with oblique rotation using the Brief COPE to have a factor structure "generally consistent" with that of the original COPE (p. 98).

The current study utilized only two subscales of the Brief COPE (e.g., Active Coping, Using Emotional Support) in order to simplify analyses and focus on specific coping styles of interest. This study limited its scope to these two styles of coping in order to compare and contrast styles of coping and their effectiveness in relation to minority stress. These selections are supported by Carver and Connor-Smith (2010), as reviewed in Chapter II.

Forgiveness. The Heartland Forgiveness Scale (HFS; Thompson et al., 2005) is an 18-item measure of forgiveness of self, others and situations (see Appendix M). For

each item, participants indicated that the statement is "Almost Always False of Me" (1) to "Almost Always True of Me" (7). Sample items included, "I don't stop criticizing myself for negative things I've felt, thought, said, or done" and "If others mistreat me, I continue to think badly of them." Scores were calculated by summing the items associated with each subscale. Higher scores indicated a greater degree of forgiveness. The test-retest reliability for the each of the subscales, HFS total (α = .83), Self (α = .72), Other (α = .73), and Situation (α = .77), was adequate after three weeks. Correlations between the scales ranged from .31 - .60, all significant at $p < .001$ (Thompson et al.).

The HFS was chosen over other measures of forgiveness due to its conceptualization of forgiveness as multidimensional (i.e., forgiveness of self, others, situation). Further, it was desirable to measure trait forgiveness as a coping variable within the model of minority stress versus state or transgression-specific measures of forgiveness due to not identifying only one particular instance of hurt, but rather ongoing hurts related to sexual orientation identity.

General social support. The Inventory of Social Support Behaviors (ISSB; Barrera, 1981) is a 40-item measure of supportive behaviors experienced by participants (see Appendix N). These behaviors were categorized as guidance (12 items), emotional (13 items), tangible (6 items), and nonspecific support behaviors (9 items). Examples of items included, "Gave you some information to understand a situation," "Was right there with you in a stressful situation," "Loaned you under $25" and "Looked after a family member when you were away." Participants indicated the frequency of their experience of these supports on a 5-point Likert scale from "Not at All" (1) through "About Every Day" (5). Higher scores indicated more received support.

In attempt to produce high content validity (Barrera & Ainlay, 1983), items were crafted by reviewing pertinent behaviors identified in social support literature, particularly Gottlieb's data from single mothers (1978). The author desired objective and action-oriented support behaviors to be used with any population and to avoid inferences of mental health or well-being. Caldwell and Reinhart, in an unpublished study, found a three-factor solution that is closely associated with the subscales of Guidance, Emotional Support, Tangible Support, and Nonspecific Support. Other examinations of factor analysis agree fairly closely with a four-factor solution that is represented by the current four subscales or support behavior categories (Barrera & Ainlay; Stokes & Wilson, 1984).

Original and supplementary psychometric data for this scale include high internal consistency, frequently above .90 (Barrera, 1981; Barrera, Sandler, & Ramsay, 1981; Stokes & Wilson, 1984). Test-retest reliability after two days was .88 (Barrera et al.). Test-retest reliability was found by Barrera and Ainlay (1984) to be .80 for an undergraduate sample after one month, but .63 for a sample of female graduate students as studied by Valdenegro and Barrera (1983). Finch and colleagues (1997) found expected negative correlations between the ISSB and a measure of depression, as well as positive correlations with the Satisfaction with Life Scale. Finch and colleagues also provided further evidence in support of four stable dimensions within the ISSB, where others described a three-factor structure (e.g., Walkey, Siegert, McCormick, & Taylor, 1987).

Using meta-analytic techniques, Haber, Cohen, Lucas, and Baltes (2007) reviewed studies using the ISSB (received social support) along with measures of

perceived social support. These authors selected the ISSB for study as a frequently utilized, reliable and valid measure of social support with rigorous validation procedures. While original validation studies were conducted in the 1980s, many studies continue to utilize the ISSB as a psychometrically sound measure of social support (Haber et al.). The measure has also been used with a sample of lesbian woman (Leavy & Adams, 1986) and one dissertation study using gay male participants (Matchett-Morris, 2004).

LGBTQ community support. The nine items of the GLBT/Queer Community Support scale (Herek & Glunt, 1995; Appendix O) were created to measure the support that individuals feel from communities of gay, lesbian, bisexual, transgender and other queer-identified people. Sample items included "I regularly attend GLBT events and meetings in my area" and "I feel at home in my area GLBT community." Participants were asked to indicate their agreement with each statement from "Strongly Disagree" (1) to "Strongly Agree" (5). Total scores were calculated by summing item scores. Higher scores indicated a greater degree of support and resource availability.

While this set of items was used informally in research (Herek & Glunt, 1999), no data has been published regarding its psychometric properties. Using items from Herek and Glunt and other researchers, Frost and Meyer (2012) created an eight-item modified scale (Connectedness to the LGBT Community Scale) that produced strong internal consistency ($\alpha = .81$), demonstrated convergent validity (i.e., correlated with collective self-esteem, strength of group identity, internalized homphobia, and behavioral connectedness to LGBT community), and showed discriminant validity between connectedness scores and the size of participants' support networks. Some predictive validity existed between scores on the connectedness scale and positive mental health and

well-being, though significance was not demonstrated between connectedness and a measure of depression. Regarding within group differences, Frost and Meyer found that bisexual participants felt less connected to the LGBT community than gay and lesbian participants.

Health and well-being. The current study chose to measure both mental health and well-being, as two indicators of adjustment. Symptoms of mental illness are interpreted here as overall indications of emotional distress, and their absence is interpreted as a signal of health. Measurement of life satisfaction contributes to understanding the cognitive component of overall well-being. The two measures reviewed below were chosen to provide a multifaceted view of participant psychological adjustment and wellness.

Mental health. The Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) consists of 58 symptom indicators of 5 factors (somatization, obsessive-compulsive, interpersonal sensitivity, depression, and anxiety). Outpatient respondents rated a list of health symptoms (e.g., headaches, itching, feeling lonely) on a scale from "Not at all Distressed" (0) to "Extremely Distressed" (3) according to how much distress this problem caused them in the past week (see Appendix P). Total scores (summed) indicated more overall symptom distress. Scores were reversed in the current study so that higher scores indicated more mental health (rather than more symptoms of mental illness). Results of statistical analyses should be read so that scores or correlations indicate more or less mental *health*.

According to Derogatis and colleagues (1974), somatization refers to an individual's perceived physical ailments and is measured on the checklist by items such

as headaches, faintness or dizziness, and pain in the chest. Depression was characterized by lack of positive affect and motivation or presence of negative affect and is represented on the checklist by items such as poor appetite, crying easily, and feeling trapped or caught. Anxiety was measured by the HSCL as apprehension or nervousness, with checklist items including trembling, being suddenly scared for no reason, and avoidance of places or activities.

Derogatis and others (1974) found internal reliability at coefficient alphas between .84 and .87 along with test-retest reliability between .75 - .84. Although criterion validity for the HSCL was demonstrated with treated outpatients with low levels of depression and anxiety, it was found to be acceptable. Criterion validity was found to be strong in comparisons between the HSCL and clinician symptom ranking or other clinical standards.

Well-being. The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen & Griffin, 1985) is a brief measure of overall life contentment that is practical for use with all ages (see Appendix Q). Life satisfaction is a measurement of the judgmental rather than the emotional dimension of subjective well-being (Pavot, Diener, Colvin, & Sandvik, 1991). This judgment results from a comparison of one's current state with a criterion for well-being that one has created and enforced. Satisfaction with life can also be viewed as an assessment of an individual's adjustment (Weiner, Harlow, Adams, & Grebstein, 1995). The SWLS attempts to accomplish this with five self-report statements, including, "The conditions of my life are excellent," and "So far I have gotten the important things I want in life." These items were rated on a 7-point scale from "Strongly

Disagree" (1) to "Strongly Agree" (7). Scores were calculated by summing items responses, with higher scores indicating greater personal well-being or life satisfaction.

Principal axis factor analysis revealed one factor explaining 66% of the variance (Diener et al., 1985). The work of Diener and colleagues was validated by Pavot and colleagues (1991) who found that one factor accounted for 74% of the variability in scores and only this factor neared an eigenvalue of 1. This unidimensional structure is an improvement over other measures of satisfaction and well-being (e.g., Philadelphia Geriatric Center Morale Scale).

The SWLS, according to Diener and colleagues (1985), has high internal consistency ($\alpha = .87$) and test-retest reliability over two months ($r = .82$). Adequate convergent validity was demonstrated in moderate correlations between the SWLS and other measures of well-being, such as the Affect Balance Scale ($|r\text{s}| = .37 - .75$). This was confirmed via significant correlations between self and peer reports along with self and family reports of participants' life satisfaction ($r\text{s} = .54 - .57$, $p < .001$; p. 158). Studies by Diener and colleagues and Pavot and colleagues contend that true measurement of life satisfaction with this scale is not impacted by current mood or situational factors. According to the authors of the measure, the SWLS provides a sound alternative to psychometrically compromised single-item measures of life satisfaction.

Procedure

The measures described above were completed by participants via online testing site Survey Gizmo. Participants first acknowledged they were at least 18 years old and their own legal guardian as they viewed an informed consent page (See Appendix E). They were instructed to indicate their agreement or disagreement with consent by

checking the appropriate option, and written consent was waived by the Institutional Review Board (IRB). Within the consent form, participants were informed that they could quit the study at any time.

Protocol change. In the first few days of data collection, one participant notified this investigator and one participant notified the IRB that some items did not fit their lived experience, either as a bisexual person or a transgender person. This lack of fit stemmed from an imperfect attempt to be inclusive when describing a broad array of sexual orientations and gender identities (e.g., asking participants to identify gender-based attractions for past and present without opportunity to reflect a change in participant's gender identity; not adapting response choices to reflect polyamorous relationships). An IRB protocol change was submitted, covering three domains: (a) to clarify the difficulty in being as inclusive as possible in such a study, and that the terms used in the study might evoke strong feelings in participants if they do not fit participants' experience. (b) to clarify that participants' own identity label for their sexual orientation and/or gender identity may be substituted for the labels provided, and (c) offer opportunities for participants to provide feedback and suggestions for future surveys.

The protocol change included the following additions and revisions. First, a descriptive paragraph was added to the Informed Consent page:

> The nature of this research is limited by the existing methods of data collection. The primary investigator has made significant effort to highlight the complexity and diversity of gender and sexual identities by offering many response choices and areas for you to write in additional responses. In doing so, this research is still not fully able to account for all lived experiences; you may find that suggested identity categories and labels do not fit your experience and you may find this lack of fit to be discouraging or frustrating. To improve future data collection methods, you are invited to provide feedback in the allotted spaces within the

survey or email the investigator.

Second, the following item was added to allow for qualitative reflections on the demographic survey items.

> Item 16. Use the space below to describe identities or life experiences not conveyed in answer choices above. These descriptors will be considered in analysis of this data.

Third, the instructions for the Klein Sexual Orientation Grid were revised to assist transgender and gender non-conforming persons in making appropriate response selections.

> Item 17. Please respond to each item according to your experience in the past, present, and a future ideal. This scale asks you to indicate your attraction for same and other gender partners, friends, and community members.
>
> **It is acceptable to respond in terms of your preferred gender identity rather than sex, even if that identity has changed at some point during your life.**
>
> The terms "same sex" and "other sex" may be complex for people of some gender identities. "Same sex" is meant to refer to anyone with the same gender identity as yours. "Other sex" is meant to refer to anyone with a gender identity that does not match your own. For individuals whose gender identity has changed over time, it may be difficult to answer items in terms of past, present and future status. Your feedback below on how well these items fit your experience is welcome.

Fourth, the instructions for the Lesbian Internalized Homophobia Scale, adapted were revised to provide clarity about use of the word *queer* as an umbrella term for non-heterosexual participants.

> Item 20. Please indicate your agreement or disagreement with each of the following statements. There are no right or wrong answers; however, you must answer each statement given below as honestly as possible. Please do not leave any statement unmarked.
>
> For each of the following items, the term "queer" is used to mean having sexual and/or emotional attractions to people across more than one gender identity (Female, Male, Trans, Genderqueer, etc) or people of your same sex or gender identity, regardless of how you label your sexual orientation. Though many individuals do not use the word "queer" to describe their identity, it is used here to

encompass several identities within LGBTQ communities.) **You may replace "queer" with the label of your choice (e.g., Bisexual)** if that helps.

Some items ask about specific same- or other-gender attractions or relationships. Please answer these items in a way that makes the most sense to you or select "Not Applicable."

Example: 1. Many of my friends are bisexual.

Fifth, the following item was added to provide an open-ended response space to capture the qualitative experiences of participants.

Item 57. Were there items that were difficult to answer because they didn't seem to fit your identity or life experiences? If so, please describe here. Feel free to offer suggestions for improvement.

Each consenting participant completed the same set of online questionnaires in randomized order. Participants were allowed as much time as needed to complete the measures, though and were able to complete them in multiple sittings as a function of the online computer program. Given the magnitude of the battery of measures, the procedures required up to 45-60 minutes to self-administer. Participants were notified that they should reserve plenty of time to complete the measures.

Upon completion of the questionnaires, the screen displayed debriefing information. This information included contact information for the principal investigator, Institutional Review Board, and resources for counseling and other services appropriate to alleviate any emotional discomfort caused by participation in this study. A listing of national and regional resources (e.g., websites, hotline numbers) was provided. Participants were allowed to enter their email address to enter a drawing for one of eight $25 gift cards.

Statistical Analyses

Initial analyses included missing data removal and replacement, data cleaning procedures, followed by descriptive statistics and bivariate correlations calculated using the SPSS Statistical Package. Hypothesis testing was conducted by utilizing the SAS Program to conduct path analysis. Supplementary multiple regression analyses were also conducted using SPSS.

Subsample. Missing data procedures resulted in a new sample of $n = 207$ participants who were classified as multisexual for the purposes of hypothesis testing. All participants identifying their sexual identity as asexual, gay, lesbian, or straight (heterosexual) were removed from further analysis for the current manuscript. The current study made hypotheses only about individuals classified by the primary investigator as multisexual. Within a forced choice format these individuals selected one of the following identities: bisexual, pansexual, queer, no label for sexual orientation, questioning, omnisexual, and pomosexual. Participants were also provided the opportunity to list any other words they use to describe their sexual identity (see Appendix A for a full list).

Individuals who identified as having "no label for sexual orientation" ($n = 11$) were included as multisexual participants based on support from the literature regarding trends in sexual fluidity and rejection of labeling (Diamond, 2008b; Entrup & Firestein, 2007; Savin-Williams, 2005). In a longitudinal study of female sexual fluidity, Diamond wrote that many unlabeled women "have a more nuanced perspective on sexuality than those who unquestioningly treat "lesbian," "bisexual," and "heterosexual" as fixed and essential sexual types" (p. 82). Additionally, it could be that those who intentionally

endorse “no label” are questioning a culturally assumed heterosexual identity or rejecting labels for sexual orientation in some form. That is, it seems unlikely that individuals who feel comfortable with a heterosexual or gay/lesbian identity would select “no label” within a forced choice item. While this inference is not grounded in direct statements from the participant, individuals without a sexual identity label may experience similar forms of minority stress as others who reject a binary identity option, particularly social invisibility.

Latent path analysis. Latent path analysis was conducted using the SAS System’s CALIS procedure to first understand the convergent validity of manifest variables to the latent variables. Significant results indicate that indicator variables appropriately contribute to measurement of the latent variable. An appropriate contribution is indicated by moderate to strong correlations with one another (Hatcher, 1994). Additionally, it is important to note that indicators do not also measure another latent variable.

The procedure in the current study began with confirmatory factor analysis (CFA), using the maximum-likelihood method. Chi-square values and Bentler fit indices to test the null hypothesis that the data does not fit the model (Hatcher, 1994). Exploratory factor analysis was then utilized to more closely examine the location and reason for model success or failure.

Multiple regression. In order to examine important dynamics within specific areas of the overall conceptual model of minority stress, multiple regression techniques were utilized to further understand the prediction capacities. Multiple regression is best conducted with predictors from each latent construct that are highly correlated with the

criterion but not highly intercorrelated with one another, avoiding multicollineaity (Brace, Kemp, & Snelgar, 2009). Multiple regression allows the prediction of criterion or dependent variables from any combination of predictor or independent variables. Given a lack of specific theoretical grounding for the individual variables chosen, the simultaneous method rather than hierarchical method was utilized here. Additionally, tolerance variables were examined in order to indicate the strength of relationship between predictor variables, looking for high tolerance values (i.e., closer to 1). Brace, Kemp, and Snelgar suggest excluding tolerance values less than 0.01 (2009).

CHAPTER IV

RESULTS

Descriptive analyses using SPSS provide frequency data, means and standard deviations for each scale, internal consistency values for measurement techniques, and a list of open-ended qualitative responses. A summary of latent path analysis using SAS describes results using factor reliabilities, confirmatory factor analysis (CFA), and exploratory factor analysis (EFA, including rotated factor pattern). Supplementary multiple regression analyses demonstrate the predictive power of sexual orientation identity, proximal stress, and forgiveness in estimating mental health and well-being.

Missing Data

A total sample of 628 original participants was analyzed for missing data. Participants with 75% completed data or ten of the 14 measured variables complete were identified. First, 101 participants were removed due to having large amounts of missing data. For example, some participants began the survey but ended participation early in the process or failed to respond to entire questionnaires within the full survey procedure. Of the remaining 527 participants, 295 were categorized by the primary investigator as *multisexual*, and were included in this group if they self-identified on the demographic measure as Bisexual, No Label for Sexual Orientation, Omnisexual, Pansexual, PoMoSexual, Queer, Questioning, or Same Gender Loving.

The data set was determined to have two required variables for participants to be include in data analysis: (a) sexual orientation identity (i.e., KSOG scores) and (b) overall

outcome measures (i.e., HSCL and SWLS scores). A total of 96 (32.5%) multisexual participants were observed to have incomplete data. Based on the first criteria, 69 of these participants with incomplete data were removed for an excess of missing scores on the KSOG. Little's MCAR test was conducted to evaluate patterns of missing data and the non-significant result ($\chi^2 = 361.2$, $df = 394$, $p = .881$) suggested that these data were missing completely at random (MCAR; Schlomer, Bauman, & Card, 2010). With this new sample ($n = 226$), 19 of 27 remaining participants with incomplete data were removed due to excess missing data on outcome measures. Again, Little's MCAR test was conducted with non-significant results ($\chi^2 = 157.4$, $df = 195$, $p = .978$) suggesting that data were missing completely at random. Using multiple imputation methods (Schlomer, Bauman, & Card), missing data were replaced for the remaining 207 participants.

Descriptive Statistics and Reliability Analyses

Descriptive statistics and reliability analyses are displayed in Table 3 for each measure, including mean scores and standard deviations. Cronbach's alpha describes internal consistency for each measure. Most measures demonstrated acceptable reliability using Nunnally's (1978) recommendation of $\alpha \geq .70$, though Outness, Active Coping, Emotion-Focused Coping produced lower reliability scores. The three measures with lower reliability were also those with a small number of items per scale.

Model Testing and Parameter Estimation

Figure 2 below displays the results of the model tested in the current study using standardized loadings first, and standard error values, listed in parentheses. The first

factor, labeled as F1, is conceptualized as the coping construct and is measured using five latent variables**:** Forgiveness (V1); Active Coping (V2); Emotion-Focused Coping (V3); Social Support (V4); and GLBTQ Community Support (V5). The Cronbach Coefficient Alpha for F1 is $\alpha = 0.49$. This alpha is somewhat low or weak, though F1 seems to be an acceptable factor. The sexual orientation identity construct, labeled F2, is measured using four latent variables: Past Sexual Orientation (V6); Present Sexual Orientation (V7); Ideal Sexual Orientation (V8); and Overall Outness (V9). The Cronbach Coefficient Alpha for F2 is $\alpha = .71$, suggesting a strong latent factor. The set of variables measuring sexual orientation identity seems to have substantial commonality, suggesting a unified construct.

Table 3

Descriptive Statistics and Reliabilities

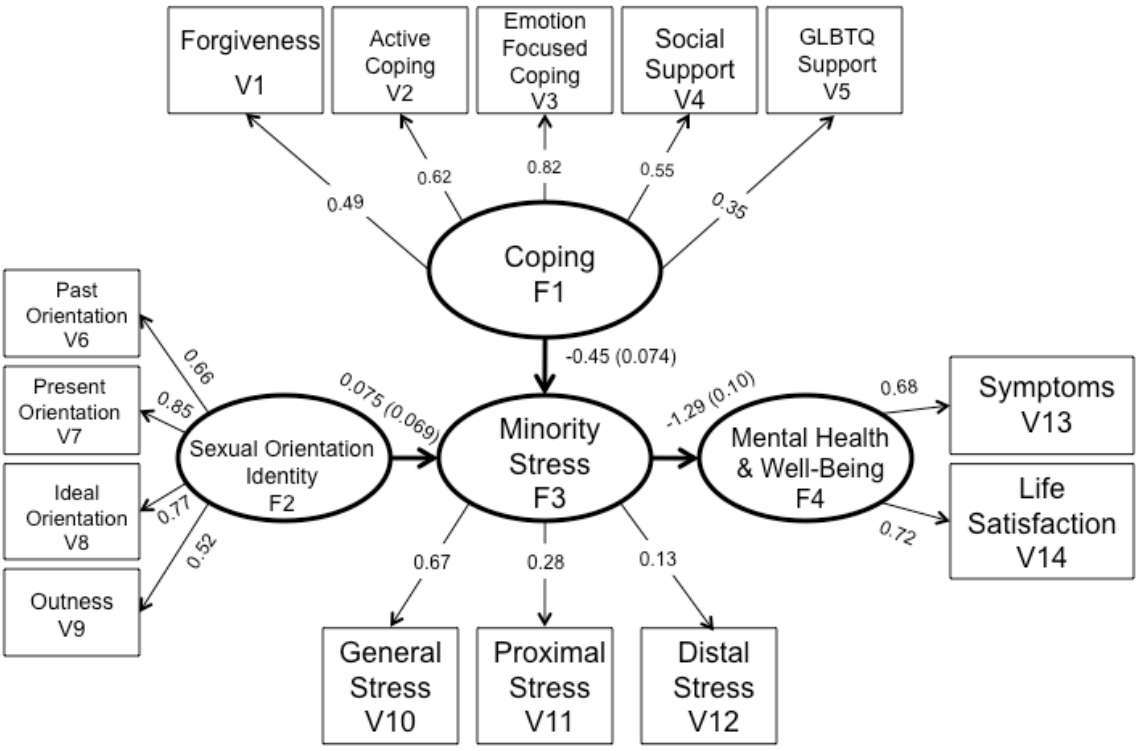
	Scale	Mean	SD	Cronbach Alpha
V6	Past Orientation (KSOG)	20.4	7.6	0.81
V7	Present Orientation (KSOG)	22.7	7.4	0.80
V8	Ideal Orientation (KSOG)	22.9	6.3	0.86
V9	Outness	34.3	15.1	0.60
V10	General Stress (PSS)	20.1	5.4	0.78
V11	Proximal Stress (LIHSa)	113.4	42.1	0.95
V12	Distal Stress (CAY)	4.7	7.9	0.87
V1	Forgiveness	52.8	8.4	0.89
V2	Active Coping	18.8	3.3	0.63
V3	Emotion-Focused Coping	18.3	3.4	0.55
V4	Social Support (ISSB)	78.5	21.0	0.95
V5	GLBTQ Support	32.6	9.0	0.86
V13	Mental Health (HSCL)	129.8	31.5	0.97
V14	Well-Being (SWLS)	23.7	7.4	0.92

Note. V = Variable with numbers aligning with labels for Figure 1 and 2.

The stress construct, labeled F3, is measured using three latent variables: General Stress (V10); Proximal Stress (V11); and Distal Stress (V12). The Cronbach Coefficient Alpha for F3 is α = -.033 (Standardized α = 0.097). This negative alpha is theoretically

Figure 2

Latent Path Model of Minority Stress



Note. Values above are standardized loadings followed by standard error values in parentheses.

impossible, suggesting a failed latent factor in the model and poor convergent validity. To be further discussed in Chapter 5, the measurement of the stress construct was problematic in testing the current model.

The measure of general stress (Perceived Stress Scale; V10) in the model is not well correlated with V11 and V12 (see Table 4 below). The overall F3 (stress) alpha could be improved by removing V11 or V12, though reliability would still be below 0.30.

Table 4

Cronbach Coefficient Alpha with Deleted Variable

Deleted Variable	Correlation with Total	Alpha	Correlation with Total	Alpha
V10 (General Stress)	0.157	-0.128	0.208	-0.395
V11 (Proximal Stress)	-0.06	0.231	-0.024	0.246
V12 (Distal Stress)	-0.144	0.062	-0.016	0.228

The mental health & well-being factor, labeled F4, is measured by Mental Health (V13) and Life Satisfaction (V14). The Cronbach Coefficient Alpha for F4 is $\alpha = 0.36$. The standardized alpha value ($\alpha = 0.65$) is somewhat better than the raw alpha, but still somewhat low. Overall, however, F4 seems to be an acceptable factor. Both raw and standardized Coefficient Alpha reliabilities for all four factors are summarized in Table 5 below.

Table 5

Standardized Factor Reliabilities (Alpha)

Factor	Raw	Standardized
Factor 1 (V1-V5)	0.49	0.69
Factor 2 (V6-V9)	0.71	0.79
Factor 3 (V10-V12)	-0.03	0.10
Factor 4 (V13-V14)	0.36	0.65

Latent Path Analysis. Latent path analysis resulted in a negative Error Variance for F4 (Mental Health & Well-Being), an indication of the failure of the overall model. More specifically, the coefficient for the path from F2 (Sexual Orientation Identity) to F3 (Minority Stress) is not significant, though other paths do demonstrate statistical

significance. It appears that the stress factor (F3) is not functioning as a good latent factor, given that its manifest variables (V10-V12) are not covarying well together. Due to poor covariance, it is difficult to estimate the latent stress construct. The poor functioning of F3 (stress) prevents the accurate prediction of mental health and well-being in that other variable paths (e.g., Sexual Orientation → Mental Health/Well-Being) must include stress (See Figure 2).

Confirmatory factor analysis. CFA was used to assess general model fit. Confirmatory chi-square analyses with a significant result for the current study indicated poor fit between the model and observed data $\chi 2$ (72, $N = 199$) = 403.87, $p < .0001$. A large chi-square, with a consequently a small p value, indicates a poor fit of the model to the observed data (Hatcher, 1994). Indication of good fit would be noted as a large p value. Subsequent assessment of the Latent Path Model, with a Bentler Comparative Fit index of 0.6617, was conducted using Confirmatory SEM. The model of interest was estimated using the maximum likelihood method. The chi-square value was $\chi 2$ (73, $N = 207$) = 405.85, $p < .0001$, which was rejected. A degrees of freedom (*df*) ratio near 2 would indicate a good fit of the model (Hatcher, 1994). The observed *df* ratio for both chi-square analyses is 5.6, indicating poor fit of the theoretical model. Results of Maximum Likelihood Estimation analyses demonstrate that Bentler Comparative Fit Index (0.66) and Bentler-Bonett Non-normed Index (0.57) are less than the desired 0.9 (Hatcher). These results generally suggest problems with the original model.

Exploratory factor analysis. The model was predicted to hold together well, but it does not. The critical reason for poor model fit seems to be the failure of the latent stress factor (F3). Exploratory Factor Analysis allows for an examination of specifically

where and why Factor 3 (stress) failed the model. The factor loadings, also called component loadings in Principal Components Analysis (PCA), are the correlation coefficients between the variables (rows) and factors (columns; Brown, 2006). Analogous to Pearson's *r*, the squared factor loading is the percent of variance in that indicator variable explained by the factor (Kline, 2005).

As shown in Table 6, latent variables V10, V11, and V12 for F3 (stress) are not well correlated. As mentioned above, it is essential that a group of indicators chosen to measure the same latent construct show a high level of convergent validity (Hatcher, 1994). It is important for all indicators to clearly be measuring the same underlying construct, evidenced by moderate or strong intercorrelations (i.e., variables correlated with one another). Additionally, each set of indicators intended to assess one latent variable should not at the same time be measuring a different latent variable. In the current model it seems that the general stress, proximal stress (internalized oppression), and distal stress (overt discrimination) variables are not cohesively measuring the latent construct of "minority stress." Individually, each of these variables or scales may be contributing useful data about the population, but together they are not loading strongly onto the same factor.

Supplementary Analyses

Given that few broad conclusions can be drawn from the lack of statistical fit found for this version of the minority stress model with this particular sample of the multisexual population, it seemed important to examine the possibility that some portions of the data may still provide useful knowledge about connections between variables and

Table 6

Rotated Factor Pattern

Variable	Factor 1		Factor 2		Factor 3		Factor 4	
V1	0.436	*	0.006		0.012		0.068	
V2	0.004		0.006		0.004		0.436	*
V3	0.053		0.006		0.014		0.518	*
V4	0.008		0.001		0.044		0.292	*
V5	0.036		0.026		0.360	*	0.026	
V6	0.001		0.372	*	0.078		0.012	
V7	0.005		0.624	*	0.010		0.000	
V8	0.000		0.578	*	0.012		0.000	
V9	0.002		0.168		0.384	*	0.053	
V10	0.640	*	0.000		0.001		0.000	
V11	0.044		0.109		0.462	*	0.040	
V12	0.032		0.000		0.116		0.000	
V13	0.548	*	0.000		0.005		0.001	
V14	0.449	*	0.000		0.048		0.090	

Note: Values above indicate squared factor loadings. Variables with original factor loadings greater than 0.5 are indicated with *.

between factors. Due to significant intercorrelations existing between many of the measured variables (Table 10), one variable from each predictive factor was selected for supplemental analyses based on both statistical *and* theoretical rationales. Outness, proximal stress, and forgiveness were chosen as indicators of the criteria, given that each was significantly and fairly highly correlated with both mental health and well-being (*r*s = - .34 - .57, $p < .05$). Some of the indicators were also intercorrelated and thus estimations of multicollinearity (i.e., two or more predictors being highly intercorrelated) were also conducted.

Several pertinent themes from extant literature support the statistical rationale for selecting these particular indicators of mental health and well-being. Within the latent concept of Sexual Orientation Identity, outness appears to be the best choice in aiding our understanding of the significance such "visibility" of a multisexual orientation. Given historically mixed findings about the implications of being "out" as a sexual minority (e.g., resiliency versus risk; D'Augelli, 2006; Jordan & Deluty, 1998; Legate, Ryan & Weinstein, 2012; Waldner & Magruder, 1999), it seems prudent to further examine the connections among outness, minority stress, coping and their combined impacts on mental health and well-being in the current study. In addition to avoiding the further pathologization of marginalized people, choosing outness rather than sexual orientation identity scores (KSOG) seems prudent due to the limitations of the Klein Sexual Orientation Grid in accurately portraying complex and variable sexual orientations.

While general stress was more highly negatively correlated with mental health and well-being, proximal stress was chosen to be included in supplemental analyses due to the potential for greater impact on literature regarding multisexual populations. The impacts of outness and proximal stress on mental health and well-being appear to be connected to the reaction of others to an individual's sexual orientation rather than an inherent or essential aspect of that sexual orientation itself. Further, forgiveness as an emotion-focused coping strategy based on an *interpersonal* hurt, is a style of coping that has not been studied with this particular population (i.e., multisexual people) and has only begun to be understood in relation to internalized oppression and subtle cultural oppression (Schoulte, Schultz, & Altmaier, 2011).

Based on the statistical and theoretical rationale above, multiple regression analyses were conducted for the prediction of mental health and well-being, separately. Results of multiple regression yielded an Adjusted R square = .241; $F_{3, 197} = 22.17$, $p < 0.001$ (using the simultaneous method) in the prediction of mental health. Tolerance values ranged between .58 and - .96. Results indicate that 24% of the variance in mental health is predicted by this particular combination of variables (i.e., outness, proximal stress, forgiveness).

As noted in Table 7, both outness and proximal stress were associated with lower mental health. That is, being more out and having more proximal stress predicted the presence of less mental health. Importantly, forgiveness was much more strongly associated with positive mental health, indicating a significant ability to predict mental health by understanding one's ability and willingness to forgive.

Table 7

Results of Multiple Regression for the Prediction of Mental Health

Predictor Variable	Standardized Coefficients Beta	*t*	*p* Value
Outness	-.20	-2.49	.01
LIHStotal	-.19	-2.32	.02
ForgTOTAL	.47	7.41	<.001

Multiple regression analyses conducted for the prediction of well-being, yielded an Adjusted R square = .376; $F_{3, 196} = 40.99$, $p < 0.001$ (using the simultaneous method). Tolerance values ranged between .56 and - .96. These results indicate that nearly 38% of the variance in well-being were predicted by outness, proximal stress, and forgiveness.

As demonstrated in Table 8, forgiveness has a significant positive association with well-being. The negative Beta values between proximal stress and well-being

indicate a significant negative relationship. Regarding outness, no evidence of impact on well-being is found here. In this regression analysis we see forgiveness affecting well-being the most (i.e., highest standardized coefficient), indicating that it is a strong predictor.

Table 8

Results of Multiple Regression for the Prediction of Well-Being

Predictor Variable	Standardized Coefficients Beta	*t*	p Value
Outness	.03	.33	.74
LIHStotal	-.23	-3.03	< .01
ForgTOTAL	.53	9.21	<.001

Intercorrelations

Pearson's correlations were calculated for all variables in the current study (see Table 9). Due to difficulty in interpreting sexual orientation identity (i.e., KSOG values) as it correlates with stress, coping, mental health, and well-being, these values are listed in Table 9, but not described in detail here. This difficulty can be summarized as a conceptual/theoretical discrepancy between measuring sexuality as a continuous variable (as with the Kinsey Scale) versus a multidimensional construct, with the KSOG. Limitations and complexities related to interpreting quantitative analyses of sexual orientation and its stability across time will be further explored in Chapter V. Additionally, intercorrelations reviewed below were selected in order to distinguish important similarities and unique differences between proximal and distal stress. Correlations between forgiveness and other stress and coping variables were also examined in service of further exploring this unique variable of interest.

Outness. A significant correlation does exist between both proximal ($r = -0.66$, $p < .001$) and distal stress ($r = 0.25$, $p < .001$) and outness, suggesting that level of outness is an important variable in understanding the connection between sexual orientation identity and minority stress. Importantly, the correlation between outness and proximal stress is negative, suggesting that being more out is related to having lower internalized monosexism; in contrast, the correlation between outness and distal stress is positive, suggesting that being more out is related to a greater number of experiences of overt discrimination. Additionally, a positive correlation existed between forgiveness and outness ($r = 0.14$, $p < .05$).

Stress and coping. General Stress (PSS) was negatively correlated with forgiveness and emotion-focused coping (rs = -.56 and - .21, $p < .05$), but not with active coping, general social support, or GLBTQ community support. Proximal stress (LIHSa) was consistently negatively correlated with all coping strategies measured in the current study (rs = - .59 and - .20, $p < .05$). Generally, distal stress (CAY) was not correlated with coping strategies except for one. A positive correlation between distal stress and GLBTQ Community Support contrasted the *negative* correlation between proximal stress and GLBTQ Community Support ($r = -.59$, $p < .001$). That is, individuals who experience higher internalized monosexism experience lower GLBTQ Community Support. Given that proximal stress was also negatively correlated with all five coping variables measured (active coping, emotion-focused coping, social support, GLBTQ community support; See Table 9), this pattern might also suggest that internalized monosexism is damaging to mental health and well-being, and resistant to the usually positive benefits of these types of coping (see Chapter V).

Forgiveness. A negative correlation existed between general stress and forgiveness (r = *-0.56*, $p < .001$) and between proximal stress and forgiveness (r = *-.201*, $p < 01$). Forgiveness was not significantly correlated with distal stress (e.g., being hit, beaten, physically assaulted, being raped or sexually assault, being robbed). Forgiveness was positively intercorrelated with all other coping variables (active coping, emotion-focused coping, social support, GLBTQ community support; See Table 9).

Mental health and well-being. Forgiveness, emotion-focused coping, and active coping were all positively correlated with mental health (r = *.48,* $p < .001$) and well-being (r = *.568*, $p < .001$). General social support and GLBTQ community support were both correlated positively with well-being (rs = .29 - .32, $p < .05$) but not with mental health. Proximal stress was negatively correlated with both mental health and well-being (rs = -.34 and - .16, $p < .05$). Distal stress was only correlated (also negatively) with mental health (r = -.22, $p = .001$). This suggests that internalized stress is more pervasive in its impact, while experiencing overt discrimination is not necessarily related to overall well-being or life satisfaction, to be further discussed in Chapter V.

Table 9

Intercorrelations

Scale	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Forgiveness (HFS)	1.0												
2. Active Coping	.194 *												
3. Emotion-Focused Coping	.400 *	.586 *											
4. Social Support (ISSB)	.219 *	.357 *	.453 *										
5. GLBTQ Community Support	.229 *	.137 *	.274 *	.263 *									
6. Past Sexual Orientation (PastKSOG)	.054	.194 *	.170 *	.047	.313 *								
7. Current Sexual Orientation (PresentKSOG)	-.061	.087	.097	-.013	.178 *	.552 *							
8. Ideal Sexual Orientation (IdealKSOG)	-.080	.027	.050	.040	.187 *	.470 *	.682 *						
9. Outness (OutOverall)	.142 *	.219 *	.287 *	.233 *	.458 *	.465 *	.384 *	.349 *					
10. General Stress (PSS)	-.560 *	-.074	-.211 *	-.019	-.089	.039	.089	.042	-.016				
11. Proximal Stress (LIHStotal)	-.201 *	-.222 *	-.316 *	-.227 *	-.591 *	-.389 *	-.282 *	-.339 *	-.658 *	.128			
12. Distal Stress (CAYTotal)	-.023	.059	-.042	.067	.140 *	.124	.080	.016	.249 *	.140 *	-.165 *		
13. Mental Health (HSCL)	.476 *	.142 *	.166 *	.061	.117	-.044	-.093	-.008	-.018	-.652 *	-.156 *	-.220 *	
14. Well-Being (SWLS)	.568 *	.239 *	.376 *	.317 *	.288 *	.070	-.007	.035	.229 *	-.569 *	-.342 *	-.037	.484 *

Note. Statistical significance of $p < .05$ is denoted with '*'.

CHAPTER V

DISCUSSION

Interpretations of quantitative data, summaries of qualitative responses, and conceptual/theoretical conclusions about the study's research questions are presented in the following pages. Further, the impact of the current study on the population of interest and existing psychological research will be elucidated. The first section will provide a picture of the participant population, highlighting aspects of the current sample that add unique data to extant literature and elicit a call for specificity in assessing cultural identities. The next sections will provide interpretations for statistically significant results, hypotheses about non-significant results, and further exploration of supplementary qualitative data. The remaining sections will highlight conceptual and methodological limitations of the current study, suggest implications for psychologists as agents for change, and pose recommendations for future research.

Understanding the Population

The current study analyzed data from a sample that was extremely diverse with respect to the cultural identities of biological sex, gender identity, sexual orientation and identity, spirituality and religion, and relationship status. The sample also identified as highly educated, with all but one percent completing at least "some" college. This likely reflects bias within the sampling method of sending emails to listservs targeting community activists, university students, and other people who have ready access to the

Internet and available resources (including literacy) to complete the study's measures. The social class privilege inherent in online samples may help understand underrepresentation of communities with identities that intersect with lower social class and economic status, such as People of Color, people with disabilities, youth, and elders.

The statistical analyses presented in Chapter IV are important data points for cultural groups that are often underrepresented in scientific research, specifically transgender and gender nonconforming people, people of many faith orientations, and multisexual people. This study contributes quantitative data that can be used to explore social constructionist and other postmodern theoretical conceptualizations of gender identity, and the utility of minority stress models with multiple marginalized and complex cultural identities.

Socioeconomic identity. The 2010 U.S. Census reports a national average per capita income of $27,334 for the past 12 months (U.S. Census Bureau, 2012).[2] The demographic survey of the current study asked participants to endorse large general categories of personal annual income (e.g., "$10,000-30,000"). While 27.5% of the sample reported personal income between $10,001-30,000, there is no way to know the *distribution* of income within this category. Additionally, personal income as measured by the current study can only be roughly compared to U.S. Census calculations of per capita income. Additionally, 32.4% of the sample endorsed an annual personal income below $10,000, reflecting approximately one third of multisexual people living below

[2] U.S. Census data should be utilized and interpreted with caution with respect to LGB samples (Meyer & Wilson, 2009). Given that sexual orientation is not yet clearly measured by the U.S. Census, it is not known whether the LGBTQ community reflects a parallel distribution of other cultural identities (e.g., race, income), a detrimental assumption made by researchers in the past.

U.S. poverty levels. Despite this sample having much more formal education than the general U.S. population, they still appear to earn less income than the national average.[3] This reflects that many participants (a) may be currently attending college (32.9% endorsing "some college" as their education status); (b) are young (*Mdn* = 27.0 years, *M* = 30.67 years); and (c) the possibility that participants were targets of discrimination in employment, and therefore a barrier to adequate income, based on sexual orientation, gender identity, or other marginalized cultural identities.

Sex and gender identity. Participants in the current sample were provided the opportunity to identify sex as well as gender identities and given multiple options outside of a standard male-female binary (including open-ended write-in options). Research regarding transgender and non-binary gender identities, often connected or combined with LGB identity research, suggests that a significant number of individuals identify their gender either privately and/or publicly as something other than male or female (Harrison, Grant & Herman, 2012). Those who identify within a gender binary and feel a sense of congruence between their sex and gender are believed to have a "natural" or "normal" gender orientation and receive social privilege in this way. Examples of this type of privilege include using public gendered restrooms without conflict or question, being associated with appropriate pronouns (e.g., he/him, she/her, ze/hir, they) and preferred names, and the ability to obtain legal documentation that fits with their congruent identity (e.g., driver's license, passport). Transgender and other gender non-conforming individuals are therefore often restricted in their movement in public spaces (e.g., Denny & Green, 1996; Harrison, Grant & Herman). Stigmatized individuals may

[3] Personal income as measured by the current study can only be roughly compared to U.S. Census calculations of per capita income.

begin to believe the negative information that constantly bombards them and reinforces their sense of abnormality, "wrongness," and/or worthlessness. A binary view of sexual orientation (i.e., heterosexual – homosexual) becomes problematic when considering the potential for more than two sexes and gender identities (Intersex Society of North America, 1993).

Within the current sample, a significant number of individuals who identified with a binary sex identity (male or female), identified outside of binary *gender* options. While 72% of participants identified their natal or birth sex as female, only 55.6% of participants endorsed their current *gender identity* as female when given the opportunity to identify as something other than a gender congruent with their natal sex. For example, an individual may identify their natal (birth) sex as female, but embrace a genderqueer or other fluid gender identity. In other words, sex and gender do not always hold the same label for individuals and this applies in a significant way to the current sample and other queer communities.

While it is first important to note that many female-sexed people have female gender identities, it is also significant to note that some of the 55.6% of participants who identify their gender identity as female may not have been a part of the original 72% of female-sexed participants. Therefore it is not possible to simply conclude that 55.6% participants are female-sexed with a congruent female gender identity. Some of these participants may be male-sexed individuals or intersex individuals who identify their gender as female, for instance.

While 22.7% of participants identified their natal sex as "male," there were 16.4% who identified their gender as male. Once again, it is not possible to conclude simply that

the 16.4% male-identified participants were all from the male-sexed subset. Most research does not allow the opportunity to identify outside of a male-female binary (Harrison, et al., 2012). Demographic measures and subsequently reported results rarely indicate whether biological sex or self-determined gender identity (as defined in Chapter II) was sought and/or clearly measured. Participants in the current study were provided the opportunity to identify a natal sex other than male or female, offering them the opportunity to identify as intersex or some other sex identity. Importantly, 4.8% of participants in the current study chose this "other" sex identity, indicating the significance of providing a diverse range of response options and/or opportunities to write in cultural and biological identities not often measured.

Socially, female-bodied people are provided with much more latitude than male-bodied people to move outside of their gender role and gender expression expectations (Kilmartin, 2009). If sexism represents a valuing of masculinity as superior to femininity, then it becomes more socially acceptable for women to move toward increasingly masculine identities but less acceptable (and even repulsive) for men to move away from a masculine identity toward femininity. Sexism, therefore, contributes to discrimination and bullying that are often labeled as homophobia and heterosexism (Kilmartin). That is, if we value masculinity over femininity and recognize the power inherent in male identity, there is a devaluing of men who present their gender identity as less masculine and outrage about women who want to be more like men – a fear that they will be able to gain power that women are not "supposed" to have. We see then that deviation from expected gender roles and presentations is often the underlying explanation for

discriminatory or violent behaviors that are labeled as homophobic – or as targeting an individual's sexual orientation.

Based on demographic data highlighting (a) that sex and gender are not congruent for all people in this sample and (b) important cultural distinctions between sex and gender identity, it is important for researchers to know which identity they hope to best understand in any particular study and use accurate and thorough measures. Most researchers, however, dismiss the complexity of such identities and provide one brief item asking about either sex or gender, often only providing two options (i.e., female or male). This calls into question, then, results of scientific studies that claim to have demonstrated "gender differences" but have not given participants the opportunity to identify outside of male or female options and may have asked participants to label their sex (versus gender) identity. Broad conclusions drawn from binary sex and/or gender identity options from the current study would provide a skewed image of stress, coping, and social support for this population. It is further important for researchers to make explicit their understanding of whether and why sex or gender is the best choice of identity for study in relation to the other variables of interest. For instance, the current study recognizes self-determination of gender identity and the significance of socially constructed marginalization in understanding the experiences of identity-related stress, coping, and mental health.

Regarding public perception and subsequent internal and external stress, another important concept is that of *passing*, or being assumed to be one's preferred gender (e.g., a transgender man being perceived as male rather than female or questioned by others). The current study did not collect data about passing as one's desired gender identity,

which might provide additional information about the experience of minority stress due to (a) the additional distal and proximal stress related to not being perceived as one's preferred gender identity, and (b) that sexual orientation is predominantly defined by one's own gender and [potential] partner's gender. While acknowledging the importance of biological sex, it seems most likely for individuals to experience internalized stress and overt discrimination based on their internal sense and public expression of gender identity rather than their sex. Biological sex is unlikely to be known *for certain* by others, given the intimate nature and limitations of determining sex only via genital presentation. Other than sexual partners, doctors, and parents, most people infer another individual's sex identity based on their gender expression (Intersex Society of North America, 1993).

Racial identity. Regarding race, the current study exhibited the common occurrence of over-representing White individuals (85%), though this demonstrates some improvement in racial diversity from many samples in behavioral sciences. The 2010 U.S. Census reports 78.1% of the population identifying as White, with 63.4% identifying as White Non-Hispanic (U.S. Census Bureau, 2012). Given that the second largest group in the current study identified as bi/multi-racial or another race not listed (8.7%) it is interesting to note this statistic as much higher than that reported in the 2010 U.S. Census (2.3%). The experiences of bisexual, biracial individuals have begun to be explored (Collins, 2000; King, 2011). Both groups exist as "border" identities, or those that have overlap with two or more communities and share some forms of oppression (e.g., marginalized by two or more communities for not fully fitting in one or another, being pathologized, asked to choose a side).

In conceptualizing an overall understanding of the current sample, it appears that recruiting LGB and specifically multisexual people from a range of community organizations and networks resulted in a representation of many other understudied cultural identities. While the demographics of the current sample imply that multisexual people also hold very diverse religious/spiritual, racial, socioeconomic, and gender identities, they also highlight the current study's method of providing both more forced-choice demographic options *and* open-ended response blanks for cultural identity information. Across data collection strategies, when participants are offered fewer response options, they may attempt to fit themselves within a specific response set in order to comply with researcher instructions of choosing the best-fit group membership descriptor. Additionally, participants who feel included in the demographic survey may be more likely to continue in their participation, allowing for better exploration of the lived experiences of these groups.

Hypothesis Testing

The current study set out to test the fit of observed data to an adaptation of Meyer's (2003b) model of minority stress. The primary investigator constructed a latent path analysis based on a simplified version of the conceptual model put forth by Meyer, which in turn was based on his own adaptation of Dohrenwend's (2000) model of minority stress. In the current study latent variables included (a) sexual orientation identity, (b) minority stress, (c) coping, and (d) mental health and well-being. For each of these, at least two manifest variables provided data to measure the larger construct. Sexual orientation was measured via (a) present, past, and ideal scores of multidimensional facets of sexual identity along with (b) outness, a measure of disclosure

and openness of sexual identity with others. Minority stress was measured in accordance with Meyer's model (2003b) via (a) perceived general stress, (b) internalized monosexism or proximal stress, and (c) overt discrimination or distal stress. Coping variables included emotion-focused coping, active coping, forgiveness, overall social support, and LGBTQ community support. Finally, mental health and well-being were measured via symptom checklist and a brief measure of life satisfaction.

Results of latent path analysis demonstrated that the model was unable to function properly. While non-significant results may suggest fault within the conceptual or structural model, it is also possible and arguably more likely that improved methods of measurement may facilitate a positive outcome using the current model. Specifically, the measurement of stress appeared to create the most problems related to model fit.

Testing this model using latent path analysis resulted in several variables that did not load appropriately onto the four hypothesized factors or latent constructs (e.g., Sexual Orientation, Stress, Coping, Mental Health/Well-Being). Given that the distal and proximal stress variables did not co-vary well, the overall model was not supported. Future revisions of this work may do well to restructure the current model. It will be important, however, to conceptualize and better understand the validity of the stress factor and ideal mechanisms for measuring stress in this population. Meyer's conceptual model (2003b) described the three components of stress (general, distal, and proximal) as discrete variables, though overlapping. In translating this conceptual model to a structural model and conducting path analysis, the variables were lumped together as manifest variables of one overall latent variable of stress. Whereas in some respects it is intuitive

to combine these stress variables, they are indeed measuring quite distinct concepts and therefore unlikely to load well together in factor analysis.

Perceived stress and internalized minority stress were not significantly correlated in this study, perhaps indicating that our external indicators of stress are not good predictors of our internal emotional stress. Perceived stress and Crimes Against You, however, were significantly correlated – which makes sense given that overt discrimination and hate crimes may directly impact perceived stress in life. This suggests that there is something significant about the ability to directly perceive one's stress. This may imply that internalized stress is not well understood or well addressed by individuals (i.e., if you don't directly feel or understand your stress then you are not taking care of it).

Measurement issues. Rather than true sexual orientation behaviors or other forms of assessment criteria, manifestations of minority stress, particularly distal stress, are more frequently based on assumptions of identification in social situations (e.g., hate crimes based on perpetrator's perception that an individual is LGB). The addition of questions regarding "passing" or being perceived accurately as one's intended identity would lend further validity to dynamics underlying both internal and external monosexism.

While the KSOG provided a multifaceted measure of sexual orientation identity, other factors, such as outness, were hypothesized to contribute to proximal and distal stress processes. Knowing how an individual understands their sexual identity may not fully explain why they experience internalized prejudice or why they were targeted in a hate crime. This seems particularly salient for multisexual individuals who may express

their sexuality and gender identity in ways that are less common among gay men and lesbians.

Given that minority stress is a social process (Dohrenwend, 2000; Meyer, 2003b), it is important to construct a holistic picture that portrays its multiple levels. A combination of self-identification *and* outness provide improved measurement of sexual orientation over strictly behavioral measures. This is not to say that behavioral measures are not useful, but rather that measures of sexual orientation should be chosen based on theory and accurate conceptualization of the research questions (e.g., behaviorally driven questions about sexual orientation versus social identity questions).

Supplemental Analyses

In addition to the primary hypothesis about model testing, a number of other useful and unique data were collected in this study. This study makes a significant contribution to scant literature about multisexual people as well as understanding the complexities involved in measurement of individuals with multiple marginalized identities, more fully described below. It should be reiterated that the current study examines a subset of all data collected (which included participants of all sexual orientation identities, including heterosexual, lesbian, gay, and asexual). The sample in the current study, along with the full data set, offers rich opportunities for understanding the experience of minority stress and mental health outcomes across sexual orientation and other cultural identities.

While statistical support was not shown for the overall model of minority stress, supplementary analyses provided important information about components of the model. It is possible that general, proximal, and distal stress, as three unique types of stress, are

not best measured as the manifest variables of one overarching latent stress variable. Statistically, proximal and distal stress do appear to function differently. In general, the coping variables measured (e.g., forgiveness, social support, active coping) were more highly and consistently correlated to internalized oppression versus overt discrimination. Szymanski and Balsam (2011) propose that there are insidious effects of trauma that result from the more covert and seemingly innocuous daily slights that, when taken cumulatively, cause what Meyer (2003) conceptualizes as proximal stress.

Both outness and proximal stress had a negative relationship with mental health. Specifically, being more out and having more proximal stress predicted lower mental health. Importantly, forgiveness had a much greater positive relationship with mental health, indicating a significant ability to predict mental health by understanding one's ability and willingness to forgive. Regarding results for outness, this variable may predict only a small proportion of variance in mental health because people may be out to some important and supportive individuals but not everyone in their life, given that others may be non-affirming (Legate, Ryan, & Weinstein, 2012).

Regression analyses indicated that forgiveness was most predictive of well-being. Proximal stress predicted lower scores on well-being, while no predictive relationship was found between outness and well-being. It is important to note that many people identify outness as a positive influence on an individual's sense of well-being or happiness in their life. While outness may increase access to community resources, Waldner and Magruder (1999) remind us that coming out is only one marker of the developmental task of identity formation. For the current sample of multisexual people, the inverse relationship between proximal stress and well-being makes sense when

considering that higher levels of internalized monosexism seem likely to decrease one's overall life satisfaction. It is also true that being visibly out may increase exposure to experiences of bias and discrimination.

In the current study, outness appeared to impact mental health (negatively), but not overall well-being. While the absence of a relationship between outness and well-being should not be over-interpreted, it is important to consider the difference between mental health and well-being in their relationship with outness as an important aspect of marginalized sexual identities. Again, research provides mixed results regarding the impact of outness on mental health and well-being.

Szymanski and Balsam (2011) address a gap in current literature and diagnostic criteria regarding microaggressions and other heterosexist experiences that do not qualify as a "traumatic event" in diagnosing post-traumatic stress disorder. They posit, however, that many instances of heterosexist events (e.g., rejection based on sexual orientation, unfair treatment) contribute to similar symptom presentations or mental health outcomes resulting from overt trauma or victimization (e.g., physical or sexual assault). Using self-reported quantitative data, they found that both overt and covert (or insidious) discrimination experiences "were unique and positive predictors" of PTSD symptoms for lesbian identified participants (p. 4). In relation to Meyer's model of minority stress, DSM-IV TR diagnostic Criterion A1 for PTSD is similar to the concept of Distal Stress in that it requires an individual the traumatic event to involve "actual or threatened death or physical injury or pose a threat to one's own or others' physical integrity" (p. 467; APA, 2000).

One significant association existed between distal stress and GLBTQ Community support, suggesting that GLBTQ communities provide more consistent or direct support for overt discrimination occurring in the community. Given that proximal stress was also negatively correlated with every other type of coping measured, this trend might also suggest that internalized monosexism is harmful and resistant to the historically positive benefits of these types of coping.

Scores on the Crimes Against You scale (CAY; distal stress) indicate the number of overt discriminatory events experienced by participants. The scores therefore depend on the participants' interpretation of such events as being related to their sexual orientation. The types of overt discrimination and hate crimes measured by the CAY are more likely to be experienced as externally validated by others. That is, individuals may more readily experience agency in coping actively with such events rather than the more nebulous experiences of internalized oppression or proximal stress.

Regarding specific coping strategies of interest, forgiveness was associated with internal perceptions of both general and proximal minority stress rather than the number of countable, overt acts of discrimination experienced. This suggests that people who forgive more experience less general stress and internalized monosexism. While this finding is correlational in nature, it provides initial indications in alignment with previous research substantiating the protective nature of forgiveness (Maltby, Macaskill, & Day, 2001; Toussaint, Williams, Musick, & Everson, 2001; Worthington, Witvliet, Pietrini, & Miller, 2007). In that interpersonal hurts related to negative affect and stress, Worthington and Scherer (2004) provide five evidence-guided hypotheses about how specifically forgiveness works to protect health, including reduction of anger and

hostility, reduction of cellular immune dysregulation caused by stress and negative affect, reduction of cortisol production, release of antibodies, and positive impact on the central nervous system. Implications for forgiveness-related clinical interventions to reduce or prevent physical and mental health and well-being will be discussed below.

Multisexuality. Much of the current literature about sexual minorities examines the experiences of lesbian- and gay-identified individuals. The literature that does explore beyond this simplified examination of sexual minorities might include lesbian and bisexual women together (Balsam, 2003; Diamond, 2003b) or gay and bisexual men (Herek & Glunt, 1995; Meyer, 2003a). The current study was designed to facilitate a new understanding of sexuality that embraces the fluidity of gender and sexual identities across time and extends between and beyond discrete binary categories and labels for sexual orientation, such as *straight*, *gay*, and *lesbian*. An increasing number of studies have examined the experiences of bisexual participants (Beaber, 2008; Diamond, 2008a; Dworkin, 2001; Hoang, 2006; Potoczniak, 2007), though few of them extend beyond those participants who identify their sexual orientation specifically as "bisexual." In the current examination of an expanded category, described here as "multisexual" participants, it becomes important to shift not only the conceptualization of sexual orientation but of the type and nature minority stress, such as shifting from examining homophobia or heterosexism to an analysis of biphobia and monosexism.

Internalized biphobia (proximal stress) was correlated negatively to sexual orientation across time (past, present, ideal KSOG scores), while hate crimes (distal stress) was not correlated to sexual orientation scores. The lack of correlation between sexual orientation and distal stress may indicate that participants in this sample

experience general stress and overt discrimination similarly, though individuals experience internalized biphobia differently depending on their sexual orientation (KSOG). Given that higher scores on the KSOG indicate great same-sex/gender attraction, it appears that people with more same sex attraction experience less internalized biphobia. The inverse, people with less same-sex attraction experiencing more internalized biphobia, speaks to the experience of biphobia often described as feeling or being labeled "not gay enough."

The relationship between more same-sex attraction and less internalized oppression may also indicate a greater acceptance (social acceptance leading to greater internalized acceptance) of same-sex relationships, though not necessarily multisexual experiences or multisexual people with greater levels of other-sex/gender attraction. These dynamics also provide quantitative support for ethnographic data (e.g., Ochs, 2007) suggesting that bisexual (and multisexual) people do experience oppression from both straight communities implying that they are "not straight enough" *as well as* lesbian and gay communities saying that they are "not gay enough." As the experience of same-sex attraction and same-sex relationships becomes more socially legitimate, there may be subsequent decreases in internalized heterosexism, though not necessarily analogous decreases in internalized monosexism. That is, while same-sex relationships are becoming more acceptable and even valued, the expression of attraction to partners of many genders is still largely marginalized and pathologized across both straight and lesbian/gay communities.

In contrast to correlations with sexual orientation, *both* proximal and distal stress are correlated to outness. While sexual orientation is only correlated to proximal stress,

outness appears to be a key variable in understanding the connection between sexual orientation and both types of minority stress (proximal and distal). Given that sexual orientation can be an "invisible" identity (i.e., one must "come out" as bisexual), individuals are likely to experience more stress related to their marginalized identity as the number of people who *know* or clearly see that identity increases.

The positive correlation between distal stress and GLBTQ Community Support was in stark contrast with this *negative* correlation between proximal stress and GLBTQ Community Support ($r = -.59$, $p < .001$). Individuals who experience higher internalized monosexism experience lower GLBTQ Community Support. This suggests, perhaps, that GLBTQ communities provide more consistent or direct support for individuals who are the targets of overt discrimination occurring in the community.

Limitations

The structure of the current study involved a lengthy online survey, taking up to an hour to complete and including 12 questionnaires, as necessary to measure a complex model. The length and depth of this survey was likely to produce participant fatigue, which is evidenced by many incomplete or abandoned surveys as noted by the online survey mechanism. While efforts were made to ethically interpret missing data, several participants were removed from the total sample for too much incomplete data. Additionally, participants who began to feel fatigue may have completed the survey while completing later items more quickly and less thoughtfully. Future studies should incorporate randomized questionnaire order to avoid potential fatigue bias.

In many ways, the current study is not representative of the United States nor is the participant sample random. Participants were self-selected and a large proportion

likely came from recruitment on LGBTQ-activism listservs and websites. They over-represent higher formal education statuses, ages 20-30, and White identified individuals. In comparison to attempts to quantify the number of lesbian, gay, bisexual, transgender and other gender nonconforming individuals in this country, the current sample appears to over-represent this group. Accurate measurement becomes more difficult, however, because self-identification with a marginalized identity can be impacted by fear of prejudice and discrimination as well as internalized heterosexism and genderism. In some ways, then, studying internalized isms can be self-defeating if a researcher cannot get the most vulnerable populations to even participate or to be fully truthful in their responses.

The racial/ethnic identities of the current sample over-represented White and bi- or multi-racial individuals when compared to U.S. census data (U.S. Census Bureau, 2012). While this may reflect the non-representative nature of the current sample, there are known cultural differences related to identifying as bisexual or in general as anything but heterosexual (e.g., being on the "down low," cultural expectations of machismo; Diamond, 2008b). Future research may benefit from further exploration of the greater propensity for bi- and multi-racial individuals to also identify with a bi- or multisexual sexual identity.

The use of quantitative methodology to describe incredibly complex identity processes and lived experiences (e.g., gender identity, sexual identity across time) bears many limitations. First, several participants voiced frustration in open-ended comment space, noting that the concepts, identity terms, and definitions did not match their lived experience, despite the investigator's attempts to be as inclusive as possible and allow for

write-in options. Specifically, the Klein Sexual Orientation Grid (KSOG) was very difficult for transgender and gender non-conforming individuals to complete, given its reliance on same and other-sex relationship dynamics. This was likely also true for those with intersex conditions or who do not identify their natal sex/current gender as male or female, though there were no qualitative comments that described this scenario. Given that sexual orientation is defined by the combination of one's own gender identity and potential partners' sex/gender identities, the oversimplification of gender identity and multiple and fluid attractions is not easily quantified. Those who are sexually/emotionally attracted to persons with non-binary sex and/or gender identities also indicated difficulty in completing this measure. While the KSOG provides space for more detail than the Kinsey Scale (measuring only sexual behaviors), there is much complexity that remains uncaptured in the use of numerical scales and matrices in the implied sense of linearity.

Implications for Clinical Practice

Szymanski & Owens (2008) examine the relationship between internalized heterosexism and psychological distress. They highlight a distinction by minority stress theorists between research that suggests that individual coping and social support moderate the relationship between minority stress and health, while feminist and other sexual identity theorists suggest that coping styles mediate this same relationship. More specifically, minority stress theorists believe that coping and social support "exist independently from the experience of a stressor" and can minimize the negative impact of minority stress on mental health (p. 96). This suggests that interventions to increase individuals' coping strategies and social support networks would reduce negative impact on mental health. Szymanski and Owens describe the belief of feminist researchers that

individuals with higher levels of minority stress (e.g., internalized heterosexism), for example, are more likely to utilize less effective coping mechanisms (e.g., avoidant coping). Szymanski and Owens therefore suggest reduction of internalized heterosexism as the most effective initial intervention, prior to increasing direct coping and social support. This is one potential direction for clinicians to consider in therapeutic work with multisexual people and other marginalized individuals, including attempts to destigmatize and reduce individual negative beliefs about multisexual identities.

The use of forgiveness in therapeutic interventions is another specific strategy that clinicians may consider, based on the outcome of the current study. Individuals who have higher levels of forgiveness or the ability to apply forgiveness to specific interpersonal hurts are less likely to experience a negative impact on their mental health and well-being. In the context of therapy, a clinician might utilize bibliotherapy techniques with insight-oriented clients (Enright, 2001), or may follow structures set forth by forgiveness researchers (Enright & Fitzgibbons, 2000; Malcolm, Warwar, & Greenberg, 2005). Many of the current models for applying forgiveness theory to therapy include stage models or step-wise processes for understanding what forgiveness is and is not, exploring anger, increasing empathy, increasing positive affect, and releasing negative affect (Enright; Freedman, Enright, & Knutson, 2005), which facilitates individual treatment planning or group therapy interventions (Wade, Worthington, & Meyer, 2005).

Future Research

The current study would best be replicated using a random and nationally representative sample of individuals. There are many variables of interest in sex/gender difference research that would be best re-examined using carefully clarified and inclusive

cultural identity options, particularly regarding gender. This includes scale development to better define gender identity, a complex and often avoided endeavor. Such development is likely to require newly constructed quantitative measures inclusive of non-binary gender and sexual experiences, non-monogamous experiences, married-queer experiences, and use of neutral pronouns language within items. These revisions of quantitative measures may be facilitated by first examining qualitative studies of diverse gender experiences. In the meantime, as we continue to use our current measures, an analysis and consideration of the instrument's instructions and definitions is necessary. The current study, for example, revised instructions and gender pronouns for several items with approval from the instrument's author (e.g., Lesbian Internalized Homophobia Scale).

Endeavors to understand the current model of minority stress require improved measurement of the latent stress variable. This process also necessitates a better *understanding* of the multidimensional stress factor and how stress corresponds to mental health. Regarding measurement of sexual orientation, a future study of interest might compare outcomes within the minority stress model between (a) self-identification/self-report of sexual identity label and (b) utilization of KSOG statistical clustering techniques (as described in Weinrich & Klein, 2002). Research specific to multisexual people with less formal education, as well as more in-depth examinations of the experience of poverty, would aid in more fully exploring the cultural stress experiences of people with multiple marginalized identities.

By focusing on forgiveness and emotion-focused interventions, we offer clinicians new directions in intervening with the mental health ramifications of sexual

prejudice (Baskin & Enright, 2004; Karremans, Van Lange, Ouwerkerk, & Kluwer, 2003; Lawler-Row & Piferi, 2006). As noted above, key ingredients in successful adaptation for LGB people are the ability to maintain resilience and to garner adequate social support. Forgiveness can potentially play significant roles in fostering both of these aspects of successful coping as it has been shown to protect mental health, and facilitate both happiness and social support (Maltby, Macaskill, & Day, 2001; Toussaint, Williams, Musick, & Everson, 2001; Witvliet, Ludwig, & Vander Laan, 2001). To the extent that counselors can encourage and educate clients in ways of becoming more forgiving, clients may reap the resilience and support benefits that are critical to their successful coping.

In addition to specific quantitative findings from the current study, rich qualitative data from this sample will allow for deeper exploration of the current sample in forthcoming manuscripts, including specific experiences of discrimination and ways in which the current quantitative methodology did not fully reflect their identities and experiences. Given the complex nature of the multisexuality (and the limitations of quantitative measurement), the experiences of minority stress, and multiple intersecting cultural identities, qualitative and mixed-methods designs are well suited for continued research with this population. Specifically, the construct of proximal stress is less well understood than overt discrimination (distal stress), and future research would do well to more rigorously explore its internal mechanisms in the relationships among stress, coping, and health. It is recommended that follow-up studies separate the measurement and examination of proximal and distal stress in order to highlight the potential for

unique impacts on health and which coping mechanisms work best in each case respectively.

Summary and Conclusions

In order to address gaps in current literature, the current study sampled an understudied population of individuals who identify under an umbrella of multisexual identities (e.g., bisexual, omnisexual, pansexual, queer, questioning). Psychological research examining the experiences of bisexual people lags behind that for lesbian and gay individuals, and is nearly non-existent suggests for multisexual people who identify outside of those labels. This paucity of research regarding multisexual people further perpetuates the invisibility of this community. The body of research that does exist identifies unique oppression-related stress toward bisexual individuals from both heterosexual and lesbian/gay communities. These unique stressors and potential coping strategies were the areas of primary interest in the current study.

This study endeavored to explore the fit between data from a community sample of multisexual individuals and a model of LGB minority stress (Meyer, 2003b). While the observed data did not provide a strong statistical fit with the hypothesized model, supplementary analyses suggested a unique contribution of forgiveness in preventing the detrimental relationship between oppression-related stress and mental health and well-being. As forgiveness research grows, there is an increased understanding of the specific mechanisms by which forgiveness protects mental health and wellness from the harmful impact of emotional stress. It is possible that this particular model is not well suited to a multisexual population, though data also suggest that improved measurement of the stress variable could facilitate a better statistical fit.

A recommendation based on the findings of this study is that clinicians inform themselves about LGB populations, including the unique experiences of multisexual individuals. Increasing self-awareness of cultural biases as a clinician contributes to enhanced cultural competence and engagement in culturally sensitive therapeutic practices, such as LGB-affirming therapy, reducing subtle and unintended bias comments (Shelton & Delgado-Romero, 2011), culturally sensitive trauma treatment (Brown, 2008), and a general awareness that sexual orientation may not be centrally related to a client's presenting concerns. Clinicians are also advised to attend to practice guidelines published by professional organizations, including the report by Division 44/Committee on Lesbian, Gay, Bisexual, and Transgender Concerns Guidelines Revision Joint Task Force (2011).

It is further suggested that theorists and researchers increase specificity in measuring sexual, gender, and other cultural identities. It is important to be clear about the intended scope of study and provide a strong rationale for inclusion/exclusion criteria, measurement or lack of measurement of identities, and rigorous in methods intended to demonstrate causal connections between cultural identities and other variables (Diamond, 2003a). Results of this study call researchers, clinicians, and other psychologists to action in effort to adhere to ethical and professional standards of multicultural competence in service of our constituents.

APPENDICES

Appendix A

Self-Identified Sexual Identity Labels

1. attracted to feminine people who usually happen to be female
2. Bisexual (N = 3)
3. Bisexual in terms of attraction with a greater preference towards women, asexual in practice
4. bisexual lesbian
5. bisexual, but questioning whether I am actually a lesbian
6. bisexual, celibate
7. Bisexual, Open, Fluid
8. Bisexual, Pan/biromantic
9. bisexual, queer, gay
10. bisexual, try-sexual, open
11. "Bisexual" is the closest word I've got, though not entirely accurate.
12. Confused
13. Dyke (N = 2)
14. dyke, homosexual, lesbian, bisexual
15. Equal Opportunity Romantic
16. fabulous, gay, dyke, homo
17. faerie, faggot, sissy but mostly just queer
18. fag, gay
19. femme trannyboy twinkfagdyke
20. Fluid (N = 4)
21. free, open, interested, experimentive
22. Gay (N = 3)
23. 80/20 gay/str8
24. gay, lesbian
25. guydyke, tomboy, girlfag, lesbian identifying male, homosexual male identifying female
26. homoflexible: I'm gay, but shit happens
27. Homoromantic Bisexual
28. Inclusive
29. "labels are for cans!" :)
30. Leaning towards straight
31. Lesbian
32. lesbian-identified bisexual
33. lesbian, bi
34. Lesbian, Gay
35. Lesbian, Hasbian
36. 3/4 lesbian, complexual
37. liberating
38. Non-discriminatory
39. none
40. Not straight (N = 2)

41. Open to falling for people, regardless of genetalia and/or gender
42. open-minded lesbian
43. pansexual (N = 2)
44. Pansexual, Fluid
45. Pansexual, lesbian, bisexual, straight
46. polyamorous
47. Pomosexual
48. Private, complicated, not body based
49. prosexual
50. queer (N = 5)
51. Queer, Bi-Dyke, Gay, Lesbian
52. queer, bisexual, superqueer, awesomesexual, ?sexual
53. Queer, Gay
54. queer, gay, bisexual
55. queer, lesbian, bisexual, gay
56. queer, omnisexual
57. queer, pansexual
58. Queer, queer-identified bisexual
59. Queer/Bisexual
60. radical queer
61. submissive (BDSM), attracted to masculine/androgynous gender expression
62. Transitionally bisexual; fluid

Others gave a more detailed response to this same prompt:

- gay or lesbian if I'm talking to people I perceive as straight, lesbiana or lesbienne if I'm speaking Spanish or French since I don't know the appropriate translation for 'queer'
- I always say my heart/love doesn't discriminate based on genitals. :)
- I am orally bisexual for pleasure only. I only relate emotionally to females.
- I do use words like queer & polymorphous perverse. I suppose pansexual might work, too
- I like Gore Vidal's Stance, and the Pomosexual term is interesting, but since I heard and researched it now Im not goin to count myself as such
- I typicly identify as bisexual due its being relatively well understood
- I usually say queer but sometimes use the word bisexual.
- Sometimes I also use bi, especially when I'm in places where people don't understand what queer means.
- Thank you for including bisexual...

Appendix B

Self-Identified "Other" Gender Identity Labels (Alphabetical Order)

1. both FTM and genderqueer
2. butch
3. Female Assigned, Boy Identified
4. Female/Genderqueer
5. Femme (N = 2)
6. femme trans-masculine gender-fucker
7. FTM genderqueer
8. FTM/Transmasculine/Genderqueer
9. gender-elastic female
10. Genderqueer Femme
11. genderqueer woman
12. multi-gendered
13. Queer
14. Tranny Girl
15. transmasculine
16. transmasculine transguy
17. Woman

Appendix C

Email Recruitment Materials

Hello!

My name is Kim Jorgensen and I am a doctoral candidate in Counseling Psychology at the University of North Dakota. I hope you will consider participating in my dissertation research examining how stressful experiences are affected by social and cultural identities and coping strategies. Your participation in this study will contribute to greater knowledge and understanding of effective coping and improved well-being in instances of daily and situational stress.

I am seeking participants over the age of 18 who are willing to complete an online survey that will require up to 30-60 minutes of your time. You will also have the opportunity to enter a drawing for one of eight $25 Target gift cards. This study is completely voluntary and you may end your participation at any time. Questions or concerns about this study should be directed to kimberly.jorgensen@und.nodak.edu.

You may begin participation by clicking on the link below and will find additional information about your participation there. Please contact Kimberly.jorgensen@und.nodak.edu for disability or other reasonable accessibility accommodations. This includes alternate survey formats (i.e., electronic file or paper copy) and re-formatted online text but not language translation.

Link to Study: http://www.surveygizmo.com/s/154317/iajqo

The Institutional Review Board at the University of North Dakota has approved the procedures of this study. Further questions can be directed to office of Research Development and Compliance at the University of North Dakota, at 701-777-4279.

Thank you very much.

Sincerely,

Kimberly Jorgensen, MA
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Appendix D

Web Recruitment Materials

Looking for Research Participants [Who Identify as Bisexual, Pansexual, Omnisexual Queer, Same Gender Loving, Questioning, Unlabeled or any other sexual identity label that is not straight or lesbian/gay]

Note: Some advertisements will target specific populations in the title and description.

Please consider participating in a research study examining how stressful experiences are affected by social and cultural identities and coping strategies. Your participation in this study will contribute to greater knowledge and understanding of effective coping and improved well-being in instances of daily and situational stress.

I am seeking participants over the age of 18 who are willing to complete an online survey that will require approximately 30-60 minutes of your time. You will also have the opportunity to enter a drawing for one of eight $25 Target gift cards. This study is completely voluntary and you may end your participation at any time. Questions or concerns about this study should be directed to kimberly.jorgensen@und.nodak.edu.

You may begin participation by clicking on the link below and will find additional information about your participation there. Please contact Kimberly.jorgensen@und.nodak.edu for disability or other reasonable accessibility accommodations. This includes alternate survey formats (i.e., electronic file or paper copy) and re-formatted online text but not language translation.

Link to Study: http://www.surveygizmo.com/s/154317/iajqo

Thank You!

Appendix E

Informed Consent

Informed Consent Statement

You are being asked to participate in a study examining identities, stressors, and ways that stressful experiences are impacted by sexual identities and coping strategies. If you are under 18 years of age, please do not continue with the rest of this study.

The study is being conducted by Kimberly Jorgensen, MA under the supervision of Dr. David Whitcomb from the Department of Counseling Psychology and Community Services at the University of North Dakota. Any questions about the study may be directed to kimberly.jorgensen@und.edu. If you have any other questions or concerns, please call the Institutional Review Board at the University of North Dakota, at 701-777-4279.

As a participant, you will be asked to complete a series of questionnaires that may take 30-45 minutes to complete. All collected data will be securely stored electronically for a period of three years, after which time the data will be deleted. Only the primary investigator, supervisor, and persons who audit the Institutional Review Board procedures will have access to the data.

The procedures of this study do not require you to release your name. Further, information from the surveys will be coded, analyzed, and summarized in such a way that you cannot be identified based on your answers. Results will be reported in aggregate form only, meaning that there will be no way to connect your answers to your individual identity. Participation in this study is completely voluntary. You may withdraw from the study without consequences at any time by discontinuing the survey.

NOTE: The nature of this research is limited by the existing methods of data collection. The primary investigator has made significant effort to highlight the complexity and diversity of gender and sexual identities by offering many response choices and areas for you to write in additional responses. In doing so, this research is still not fully able to account for all lived experiences; you may find that suggested identity categories and labels do not fit your experience and you may find this lack of fit to be discouraging or frustrating. To improve future data collection methods, you are invited to provide feedback in the allotted spaces within the survey or email the investigator.

By participating in this study, you will contribute to an improved understanding well-being as impacted by sexual identity, stress, and coping processes. As a

participant in this study, you will have the opportunity to participate in a confidential drawing in which you may enter to win one of eight $25 gift certificates to Target stores or Target.com. If you choose to participate in this drawing, you will submit your contact information (email address) at the end of the survey. Your identifying and contact information will not be linked in any way to your answers in the survey.

Few risks are expected to result from participation in this study. The nature of some of the questions may require you to recall emotionally painful memories regarding past stressors. You may also experience strong feelings if you feel that your life has not been accurately reflected in the limited response options offered. If you find that completing this survey results in distress or discomfort for you, you are encouraged to take advantage of counseling or support services. Contact information for national support services is provided at the end of the survey. Neither the researchers nor the University of North Dakota can be responsible for the expense of those services.

Please feel free to print this Informed Consent Statement for your records.

I am fully aware of the nature and extent of my participation in this project as stated above and the possible risks arising from it. I am 18 years of age or older. By clicking the appropriate response below, I hereby agree to participate in this project.

1. I understand the risks and benefits of my participation in this study. I wish to participate by completing the following questionnaires. *

- ○ I agree.
- ○ I do not agree.

Appendix F

Demographic Information

Check the answer that most closely reflects your identity. When longer responses are called for, please enter information in the appropriate space.

Sex
- o Female
- o Male

Gender Identity
- o Female
- o Male
- o MTF
- o FTM
- o Gender Non Conforming
- o Genderqueer
- o Other:_____

My age today: ____ years ____ months

Racial Identity:
- o African American/Black/Caribbean/African descent
- o Arab Descent
- o Asian American/Asian/South Asian/Pacific Islander descent
- o European American/Caucasian/White
- o Hispanic or Latina/o
- o Native American/Indigenous
- o Native Hawaiian or Other Pacific Islander
- o Other, including biracial or multiracial (Please specify: _____)

Current spiritual or religious beliefs:
- o Agnostic (believe that it is unknowable whether God exists)
- o Atheist (do not believe in the existence of a higher power/God)
- o Ba'hai
- o Buddhist
- o Catholic
- o Christian
- o Hindu
- o Islam
- o Jewish
- o Mysticism
- o Pagan
- o Protestant
- o Wiccan

- Other, please specify: _____

Of the following, the sexual orientation label that most closely reflects my current identity is: (Please choose the label that you most frequently tell other people when you come out.)

- Ambisexual/Bisexual
- Asexual
- Bisexual Identified _____ (specify)
- No Label for Sexual Orientation
- Omnisexual
- Pansexual
- Pomosexual (Post-Modern Sexuality)
- Queer
- Questioning
- Same-Gender Loving

Please list any other word(s) that you use to describe your sexual orientation.

_____

Current sexual or romantic relationship status:

- None/Single
- Romantic or Sexual Dating Relationship (regardless of label)
- Long-term Committed Relationship (Non-legal)
- Married/Legal Union

Highest level of education completed:

- no high school
- some high school
- high school graduate
- some college
- college degree
- master's degree
- doctoral degree

Current residential location:

- Urban (Population ____
- Suburban (Population ____
- Rural (Population less than _____
- Other_____

Current country of residence

- United States
- Canada
- Mexico
- Other Country _____

Current U.S. geographic location:

- **West** (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming)
- **Northeast** (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Vermont, Rhode Island)
- **Midwest** (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)
- **South** (Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Tennessee, Texas, South Carolina, Virginia, West Virginia)
- **Not Applicable**

Approximate current *personal* income: (Estimate)

- $0 to $10,000
- $10,001 to $30,000
- $30,001 to $60,000
- $60,001 to $90,000
- $90,001 or more

Approximate current *household* income: (Estimate if you do not know)

- $0 to $10,000
- $10,001 to $30,000
- $30,001 to $60,000
- $60,001 to $90,000
- $90,001 or more

I have participated in counseling or therapy.
___ Yes
___ No

If yes, my counseling/therapy:
___ was related to stress regarding my sexual orientation or gender identity or expression
___ was *not* related to stress regarding my sexual orientation or gender identity or expression

I was ___ years old when I first started this counseling/therapy.
This counseling or therapy:
___ is still occurring.
___was in the past.
It lasted / has been going on for:
___ months. (indicate number)
___ years. (indicate number)

Optional: I have received a psychiatric diagnosis by a medical doctor or psychologist.
___ Yes. Specify (optional) _____
___ No.

Appendix G

Klein Sexual Orientation Grid

Please respond to each item according to your experience in the past, present, and a future ideal. For items A-E and F-G, use the corresponding scale below. This scale asks you to indicate your affinity for same and other gender partners, friends, and community members.

Scale for A-E
0 other gender only
1 other gender mostly
2 other gender somewhat more
3 both genders equally
4 same gender somewhat more
5 same gender mostly
6 same gender only

Scale for F-G
0 heterosexual only
1 heterosexual mostly
2 heterosexual somewhat more
3 equally heterosexual and homosexual
4 homosexual somewhat more
5 homosexual mostly
6 homosexual only

	Past (Your entire life up until a year ago)	**Present** (The last 12 months)	**Ideal** (If you could order your life any way you wanted, what would it be like?)
A. Sexual Attraction (To whom are you sexually attracted?)			
B. Sexual Behavior (With whom do you actually have sex?)			
C. Sexual Fantasies (Who do you fantasize about?)			
D. Emotional Preference (Who do you feel more drawn to or close to emotionally?)			
E. Social Preference (With whom do you like to socialize?)			
F. Lifestyle Preference (In which community do you prefer to spend your time? In which do you feel most comfortable?)			
G. Self-Identification (How do you label or identify yourself?)			

Appendix H

Outness Inventory

Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you.

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

1. mother
2. father
3. siblings (sisters, brothers)
4. extended family/relatives
5. my new straight friends
6. my work peers
7. my work supervisor(s)
8. members of my religious community (e.g., church, temple)
9. leaders of my religious community (e.g., church, temple)
10. strangers, new acquaintances
11. my old heterosexual friends

Appendix I

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during *the last month*. In each case, please indicate by writing a number in the space of *how often* you felt or thought a certain way.

0	1	2	3	4
Never	Almost Never	Sometimes	Fairly Often	Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt you were able to control the important things in your life?
3. In the last month, how often have you felt nervous and "stressed"?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. In the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that were outside of your control?
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Appendix J

Lesbian Internalized Homophobia Scale, adapted

"Please indicate your agreement or disagreement with each of the following statements by clicking the appropriate number from the scale below. There are no right or wrong answers; however, for the data to be meaningful, you must answer each statement given below as honestly as possible. Please do not leave any statement unmarked. Some statements may depict situations that you are have experience please imagine yourself in those situations when answering those statements."

For each of the following items, the term "multisexual/queer" means having underlying sexual and/or emotional attractions to people of any gender identity (Female, Male, Trans, Genderqueer, etc), regardless of sexual behavior and sexual identity.

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

1. Many of my friends are multisexual/queer.
2. I try not to give signs than I am multisexual/queer. I am careful about the way I dress, the jewelry I wear, the places, people and events I talk about.
3. Just as in other species, multisexuality/queerness is a natural expression of sexuality in humans.
4. Attending multisexual/queer events and organizations is important to me.
5. I hate myself for being attracted to same-gender people.
6. I hate myself for being attracted to other-gender people.
7. I believe multisexuality/queerness is a sin.
8. I am comfortable being an "out" multisexual/queer person. I want others to know and see me as multisexual/queer.
9. I feel comfortable with the diversity of people who make up the bisexual community.
10. I have respect and admiration for other multisexual/queer people.
11. I feel isolated and separate from other multisexual/queer people.
12. I wouldn't mind if my boss knew that I was a multisexual/queer person.
13. If some multisexual/queer people would change and be more acceptable to the larger society, bisexual people as a group would not have to deal with so much negativity and discrimination.
14. I am proud to be a multisexual/queer person.
15. I am not worried about anyone finding out that I am a multisexual/queer person.
16. When interacting with members of the multisexual/queer community, I often feel different and alone, like I don't fit in.
17. Multisexuality/queerness is an acceptable lifestyle.
18. I feel bad for acting on my multisexual/queer desires.

19. I feel comfortable talking to my heterosexual [straight] friends about my everyday home life with my same-gender partner/lover or my everyday activities with my gay/lesbian friends.
20. I feel comfortable talking to my heterosexual [straight] friends about my everyday home life with my other-gender partner/lover or my everyday activities with my gay/lesbian friends.
21. Having multisexual/queer friends is important to me.
22. I am familiar with multisexual/queer books and/or magazines.
23. Being a part of the multisexual/queer community is important to me.
24. As a multisexual/queer person, I am loveable and deserving of respect.
25. It is important for me to conceal the fact that I am multisexual/queer from my family.
26. I feel comfortable talking about multisexuality/queerness in public.
27. I live in fear that someone will find out I am a multisexual/queer person.
28. If I could change my sexual orientation and become heterosexual [straight], I would.
29. If I could change my sexual orientation and become gay/lesbian, I would.
30. I do not feel the need to be on guard, lie, or hide my multisexuality/queerness to others.
31. I feel comfortable joining a multisexual/queer social group, queer sports team, or queer organization.
32. When speaking of my same-gender lover/partner to a straight person, I change pronouns so that others will think I'm involved with an other-gender person.
33. Being a multisexual/queer person makes my future look bleak and hopeless.
34. Children should be taught that being multisexual/queer is a normal and healthy way for people to be.
35. My feelings toward other multisexual/queer people are often negative.
36. If my peers knew of my multisexuality/queerness, I am afraid that many would not want to be friends with me.
37. I feel comfortable being a multisexual/queer person.
38. Social situations with other multisexual/queer people make me feel uncomfortable.
39. I wish some people wouldn't "flaunt" their multisexuality/queerness. They only do it for shock value and it doesn't accomplish anything positive.
40. I don't feel disappointment in myself for being a multisexual/queer person.
41. I am familiar with multisexual/queer movies and/or music.
42. I am aware of the history concerning the development of multisexual/queer communities and/or the bisexual/queer rights movement.
43. I act as if my same-gender lovers are merely friends.
44. I act as if my other-gender loves are merely friends.
45. Multisexual/queer lifestyles are a viable and legitimate way of life for people.
46. I feel comfortable discussing my multisexuality/queerness with my family.
47. I could *not* confront a friend or acquaintance if they made a biphobic, heterosexist, or "homosexist" statement to me.
48. I am familiar with bisexual/queer music festivals and conferences.
49. When speaking of my same-gender lover/partner to a straight person, I often use neutral pronouns so the gender of the person is vague.
50. When speaking of my other-gender lover/partner to a straight person, I often use neutral pronouns so the gender of the person is vague.

51. Same-gender couples should be allowed to adopt children the same as other-gender couples.
52. I frequently make negative comments about other multisexual/queer people.
53. Growing up in a multisexual/queer family is detrimental for children.
54. I am familiar with community resources for multisexual/queer people (i.e., bookstores, support groups, bars, etc.).

Appendix K

Crimes Against You

Please respond to the following items honestly. Follow instructions in each item about moving forward to the next item or skipping to a later item. The terms "queer/multisexual" are used to indicate any self-label for sexual orientation that is NOT heterosexual or homosexual. This may include queer, bisexual, pan or omnisexual, same-gender loving or other labels. The combined terms (queer/multisexual) are used as terms to abbreviate this category of minority sexual orientation.

1. Have you ever been the victim of any sort of crime or attempted crime — such as a physical attack, sexual assault, robbery, or vandalism — because someone thought you were queer/multisexual?

- o NO [SKIP TO #7]
- o YES [GO TO NEXT QUESTION]
- o NOT SURE [GO TO NEXT QUESTION]

2. How many times have you ever been the victim of any sort of crime or attempted crime because someone thought you were queer/multisexual?

- o ONCE
- o TWICE
- o THREE OR MORE TIMES
- o NEVER (Go to #8)

If you were the victim of more than one anti-queer crime, first tell us just about the most recent one.

ANTI-GAY/BISEXUAL CRIME #1 (MOST RECENT)

3. When was the most recent time you were a victim of a crime or attempted crime because someone thought you were queer/multisexual? (CHECK ONE)

- o 2009
- o 2008
- o 2007
- o 2006
- o BETWEEN 2000-2005
- o BETWEEN 1990-1999
- o BETWEEN 1981-1989
- o BETWEEN 1970-1980
- o BEFORE 1970

4. What happened to you that time? (Check as many as apply)
   - o You were hit, beaten, or physically attacked.
   - o You were raped or sexually assaulted.
   - o You were robbed, as in a holdup or mugging.
   - o Your property was stolen, as in a break-in, burglary or theft.
   - o Your property was purposely damaged or vandalized.
   - o You saw a friend or relative deliberately killed or murdered.
   - o Someone tried to hit you or attack you physically, but they were stopped or you got away?
   - o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
   - o Someone tried to steal or damage your property, but they were stopped?

5. Did they use a gun, knife, or other weapon?
   - o NO
   - o YES
   - o NOT APPLICABLE

6. Did you report this event to the police, sheriff or other law official?
   - o NO
   - o YES

7. Other than the above, have you been the victim of other crimes because of your sexual orientation?
   - o NO [SKIP TO #15]
   - o YES [GO TO NEXT QUESTION]

ANTI-GAY/BISEXUAL CRIME #2

8. Other than the crime you already described, when was the next most recent time that you were a victim of a crime or attempted crime because someone thought you were queer/multisexual? (CHECK ONE)
   - o 2009
   - o 2008
   - o 2007
   - o 2006
   - o BETWEEN 2000-2005
   - o BETWEEN 1990-1999
   - o BETWEEN 1981-1989
   - o BETWEEN 1970-1980
   - o BEFORE 1970

9. What happened to you that time? (Check as many as apply)
   - o You were hit, beaten, or physically attacked.
   - o You were raped or sexually assaulted.
   - o You were robbed, as in a holdup or mugging.
   - o Your property was stolen, as in a break-in, burglary or theft.
   - o Your property was purposely damaged or vandalized.
   - o You saw a friend or relative deliberately killed or murdered.
   - o Someone tried to hit you or attack you physically, but they were stopped or you got away?
   - o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
   - o Someone tried to steal or damage your property, but they were stopped ?
   - o Something else? (please tell us what happened in a few words on the back of this page)

10. Did they use a gun, knife, or other weapon?
   - o NO
   - o YES
   - o NOT APPLICABLE

11. Did you report this event to the police, sheriff or other law official?
   - o NO
   - o YES
   - o Something else? (please tell us what happened in a few words on the back of this page)

12. Other than the anti-queer crimes you described on the last page, have you been the victim of other crimes because of your sexual orientation?
   - o NO [SKIP TO #15]
   - o YES [GO TO NEXT QUESTION]

13. Other than the crimes you described on the last page, which of the following have you ever had happen to you because of your sexual orientation? (Check as many as apply)
   - o You were hit, beaten, or physically attacked.
   - o You were raped or sexually assaulted.
   - o You were robbed, as in a holdup or mugging.
   - o Your property was stolen, as in a break-in, burglary or theft.
   - o Your property was purposely damaged or vandalized.
   - o You saw a friend or relative deliberately killed or murdered.
   - o Someone tried to hit you or attack you physically, but they were stopped or you got away?
   - o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
   - o Someone tried to steal or damage your property, but they were stopped?
   - o Something else? (please tell us what happened in a few words on the back of this page)

14. Did they ever use a gun, knife, or other weapon?
    - o NO
    - o YES
    - o NOT APPLICABLE

OTHER KINDS OF HARASSMENT BECAUSE YOU ARE QUEER OR MULTISEXUAL

OTHER THAN THE EVENTS YOU ALREADY DESCRIBED, how often have any of the following things happened to you in the last year because someone perceived you to be queer/multisexual?

15. Someone threatened you with violence?
    - o NEVER
    - o ONCE
    - o TWICE
    - o THREE OR MORE TIMES

16. Someone verbally insulted or abused you?
    - o NEVER
    - o ONCE
    - o TWICE
    - o THREE OR MORE TIMES

17. Someone spit on you?
    - o NEVER
    - o ONCE
    - o TWICE
    - o THREE OR MORE TIMES

18. Someone threw an object at you?
    - o NEVER
    - o ONCE
    - o TWICE
    - o THREE OR MORE TIMES

19. Someone chased or followed you?
    - o NEVER
    - o ONCE
    - o TWICE
    - o THREE OR MORE TIMES

20. You were discriminated against in a job, housing, or services? (CHECK ALL THAT APPLY)

- o NO, NONE OF THESE
- o HOUSING
- o JOB
- o SERVICES

21. Have you had any other incidents that happened because you were perceived to be queer/multisexual?

- o NO
- o YES (On the back of this page, please tell us what happened in a few words.)

22. How likely do you think it is that you will be the victim of an anti-queer crime during the next 12 months? (Please circle one number.)

0	1	2	3	4	5	6	7	8	9
Not at all Likely									Very Likely

23. Compared to other queer/multisexual people in your area, what would you say are your own chances of ever being the victim of a crime? (Please circle one number.)

0	1	2	3	4	5	6	7	8	9
Very Low									Very High

The next page has questions about your experiences with other crimes, not because of your sexual orientation.

Please read the directions carefully and answer all of the questions.

CRIMES AGAINST YOU FOR OTHER REASONS
NOT BECAUSE OF YOUR SEXUAL ORIENTATION

These questions are about other crimes -- not the one(s) you reported on earlier pages of this survey.

24. Have you ever been the victim of any other sort of crime or attempted crime — such as a physical attack, sexual assault, robbery, or vandalism.

- o NO [SKIP TO #30]
- o YES [GO TO NEXT QUESTION]
- o NOT SURE [GO TO NEXT QUESTION]

25. How many times have you ever been the victim of any sort of crime or attempted crime? (Remember: These are not crimes because someone thought you were queer/multisexual.)

- o ONCE
- o TWICE
- o THREE OR MORE TIMES
- o NEVER (Go to next page)

If you were the victim of more than one crime, first tell us just about the most recent one.

OTHER CRIME #1 (MOST RECENT)

26. When was the most recent time you were a victim of such a crime or attempted crime? (CHECK ONE)

- o 2009
- o 2008
- o 2007
- o 2006
- o BETWEEN 2000-2005
- o BETWEEN 1990-1999
- o BETWEEN 1981-1989
- o BETWEEN 1970-1980
- o BEFORE 1970

27. What happened to you that time? (Check as many as apply)

- o You were hit, beaten, or physically attacked.
- o You were raped or sexually assaulted.
- o You were robbed, as in a holdup or mugging.
- o Your property was stolen, as in a break-in, burglary or theft.
- o Your property was purposely damaged or vandalized.
- o You saw a friend or relative deliberately killed or murdered.
- o Someone tried to hit you or attack you physically, but they were stopped or you got away?
- o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
- o Someone tried to steal or damage your property, but they were stopped?
- o Something else? (please tell us what happened in a few words on the back of this page)

28. Did they use a gun, knife, or other weapon?

- o NO
- o YES
- o NOT APPLICABLE

29. Did you report this event to the police, sheriff or other law official?
    - o NO
    - o YES

30. Other than the above, have you been the victim of other crimes not because of your sexual orientation?
    - o NO [SKIP TO NEXT PAGE/SURVEY]
    - o YES [GO TO NEXT QUESTION]

OTHER CRIME #2

31. Other than the crime you already described, when was the next most recent time that you were a victim of a crime or attempted crime? (CHECK ONE)
    - o 2009
    - o 2008
    - o 2007
    - o 2006
    - o BETWEEN 2000-2005
    - o BETWEEN 1990-1999
    - o BETWEEN 1981-1989
    - o BETWEEN 1970-1980
    - o BEFORE 1970

32. What happened to you that time? (Check as many as apply)
    - o You were hit, beaten, or physically attacked.
    - o You were raped or sexually assaulted.
    - o You were robbed, as in a holdup or mugging.
    - o Your property was stolen, as in a break-in, burglary or theft.
    - o Your property was purposely damaged or vandalized.
    - o You saw a friend or relative deliberately killed or murdered.
    - o Someone tried to hit you or attack you physically, but they were stopped or you got away?
    - o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
    - o Someone tried to steal or damage your property, but they were stopped?
    - o Something else? (please tell us what happened in a few words on the back of this page)

33. Did they use a gun, knife, or other weapon?
    - o NO
    - o YES
    - o NOT APPLICABLE

34. Did you report this event to the police, sheriff or other law official?
    - o NO

o YES

35. Other than the anti-queer crimes you described on the last page, have you been the victim of other crimes because of your sexual orientation?
o NO [SKIP TO NEXT PAGE/SURVEY]
o YES [GO TO NEXT QUESTION]

36. Other than the crimes you described on the last page, which of the following have you ever had happen to you because of your sexual orientation? (Check as many as apply)
o You were hit, beaten, or physically attacked.
o You were raped or sexually assaulted.
o You were robbed, as in a holdup or mugging.
o Your property was stolen, as in a break-in, burglary or theft.
o Your property was purposely damaged or vandalized.
o You saw a friend or relative deliberately killed or murdered.
o Someone tried to hit you or attack you physically, but they were stopped or you got away?
o Someone tried to rape you or sexually assault you, but they were stopped or you got away?
o Someone tried to steal or damage your property, but they were stopped?
o Something else? (please tell us what happened in a few words on the back of this page)

37. Did they ever use a gun, knife, or other weapon?
o NO
o YES
o NOT APPLICABLE

Appendix L

Brief COPE

This questionnaire asks you to indicate what you generally do and feel, when *you* experience stressful events. Obviously, different events bring out somewhat different responses, but check the response choice that most closely reflects what you *usually* do. Please try to respond to each item *separately in your mind from each other item*. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer *every* item. There are no "right" or "wrong" answers, so choose the most accurate answer for YOU-- not what you think "most people" would say or do. Indicate what YOU usually do when YOU experience a stressful event.

1	2	3	4
I usually don't do this at all	I usually do this a little bit	I usually do this a medium amount	I usually do this a lot

1. I've been concentrating my efforts on doing something about the situation I'm in.
2. I've been trying to come up with a strategy about what to do.
3. I've been trying to see it in a different light, to make it seem more positive.
4. I've been accepting the reality of the fact that it has happened.
5. I've been making jokes about it.
6. I've been trying to find comfort in my religion or spiritual beliefs.
7. I've been getting emotional support from others.
8. I've been trying to get advice or help from other people about what to do.
9. I've been turning to work or other activities to take my mind off things.
10. I've been saying to myself "this isn't real."
11. I've been saying things to let my unpleasant feelings escape.
12. I've been using alcohol or other drugs to make myself feel better.
13. I've been giving up trying to deal with it.
14. I've been criticizing myself.
15. I've been learning to live with it.
16. I've been taking action to try to make the situation better.
17. I've been thinking hard about what steps to take.
18. I've been looking for something good in what is happening.
19. I've been making fun of the situation.
20. I've been praying or meditating.
21. I've been getting comfort and understanding from someone.
22. I've been getting help and advice from other people.
23. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
24. I've been refusing to believe that it has happened.
25. I've been expressing my negative feelings.
26. I've been using alcohol or other drugs to help me get through it.
27. I've been giving up the attempt to cope.
28. I've been blaming myself for things that happened.

Appendix M

Heartland Forgiveness Scale

In the course of our lives negative things may occur because of our own actions, the actions of others, or circumstances beyond our control. For some time after these events, we may have negative thoughts of feelings about ourselves, others, or the situation. Think about how you typically respond to such negative events. Next to each of the following items write the number (from the 7-point scale below) that best describes how you typically respond to the type of negative situations described. There are no right or wrong answers. Please be as open as possible in your answers.

1	2	3	4	5	6	7
Almost Always False of Me		More Often False of Me	Always Me	More Often True of Me		Almost Always True of Me

1. Although I feel bad at first when I mess up, over time I can give myself some slack.
2. I hold grudges against myself for negative things I've done.
3. Learning from bad things that I've done helps me get over them.
4. It is really hard for me to accept myself once I've messed up.
5. With time I am understanding of myself for mistakes I've made.
6. I don't stop criticizing myself for negative things I've felt, thought, said, or done.
7. I continue to punish a person who has done something that I think is wrong.
8. With time I am understanding of others for the mistakes they have made.
9. I continue to be hard on others who have hurt me.
10. Although others have hurt me in the past, I have eventually been able to see them as good people.
11. If others mistreat me, I continue to think badly of them.
12. When someone disappoints me, I can eventually move past it.
13. When things go wrong for reasons that can't be controlled, I get stuck in negative thoughts about it.
14. With time I can be understanding of bad circumstances in my life.
15. If I am disappointed by uncontrollable circumstances in my life, I continue to think negatively about them.
16. I eventually make peace with bad situations in my life.
17. It's really hard for me to accept negative situations that aren't anybody's fault.
18. Eventually I let go of negative thoughts about bad circumstances that are beyond anyone's control.

Appendix N

Inventory of Socially Supportive Behaviors

Below are some statements about ways in which others may have helped you. Respond to each item using the scale below to indicate how often you receive this type of support.

1	2	3	4	5
Not at All	1 or 2 Times	About Once/Week	Several Times/Week	About Every Day

GUIDANCE

1. Gave you some information on how to do something
2. Helped you understand why you didn't do something well
3. Suggested some action you should take
4. Gave you feedback on how you were doing
5. Made it clear what was expected of you
6. Gave you some information to help you understand a situation*
7. Checked back with you to see if you followed advice
8. Taught you how to do something
9. Told you who you should see for assistance
10. Told you what to expect in a future situation*
11. Told you what he/she did in a similar situation*
12. Told you how he/she felt in a similar situation

EMOTIONAL

13. Told you that she/he feels very close to you
14. Let you know that he/she will always be around help if needed*
15. Told you that you are OK just the way you are
16. Expressed interest and concern in your well-being
17. Comforted you by showing you some physical affection
18. Told you that she/he would keep conversations confidential*
19. Expressed esteem or respect for a competency of yours*
20. Was right there with you in a stressful situation
21. Listened to you talk about your private feelings
22. Let you know that you did something well
23. Did some activity together to help divert your thoughts*
24. Talked with you about some interests of yours
25. Provided you with a place where you could get away for awhile

TANGIBLE

26. Gave you over $25
27. Gave you under $25
28. Loaned you over $25
29. Loaned you under $25
30. Provided you with a place to stay

31. Gave you transportation*

NONSPECIFIC

32. Loaned or gave you something that you needed*
33. Pitched in to help you do something that you that needed to be done
34. Went with you to someone who could take action
35. Looked after a family member when you were away
36. Watched after your possessions when you were away
37. Said things that made your situation clearer*
38. Assisted you in setting a goal for yourself
39. Agreed that what you wanted to do was right
40. Joked and kidded to try to cheer you up

Appendix O

GLBTQ Community Support

Indicate your level of agreement with each statement.

1	2	3	4	5
Strongly Disagree				Strongly Agree

1. I feel that I am a member of my area GLBTQ community.
2. I plan to stay in my area for a long time.
3. I have many gay/bisexual/queer male friends in my area.
4. I have many lesbian/bisexual/queer women friends in my area.
5. I have many transgender-identified friends in my area.
6. I wish that I could live someplace with a stronger GLBTQ community than my current community.
7. I regularly attend GLBTQ events and meetings in my area.
8. My area where I live is a bad place for me to live as a queer/multisexual person.
9. I feel at home in my area GLBTQ community.
10. As a queer/multisexual person, I enjoy living in my area.

Appendix P

Hopkins Symptom Checklist

Below is a list of symptoms and complaints that people sometimes have. Read each question carefully, then, using the scale shown below, select one of the numbered descriptors that best describes how much discomfort that problem has caused you during the past week including today. Do not skip any items.

0	1	2	3
Not at All Distressed	A Little Distressed	Quite a Bit Distressed	Extremely Distressed

1. Headaches
2. Nervousness or shakiness inside
3. Being unable to get rid of bad thoughts or ideas
4. Faintness or dizziness
5. Loss of sexual interests or pleasure
6. Feeling critical of others
7. Bad dreams
8. Difficulty in speaking when you are excited
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in the heart or chest
13. Itching
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Sweating
17. Trembling
18. Feeling confused
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. A feeling of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Constipation
26. Blaming yourself for things
27. Pains in the lower part of your back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying or stewing about things
32. Feeling no interest in things
33. Feeling fearful

34. Your feelings being easily hurt
35. Having to ask others what you should do
36. Feeling others do not understand you or are unsympathetic
37. Feeling that people are unfriendly or dislike you
38. Having to do things very slowly in order to insure you were doing them right
39. Heart pounding or racing
40. Nausea or upset stomach
41. Feeling inferior to others
42. Soreness of your muscles
43. Loose bowel movements
44. Difficulty in falling asleep or staying asleep
45. Having to check and double check what you do
46. Difficulty making decisions
47. Wanting to be alone
48. Trouble getting your breath
49. Hot or cold spells
50. Having to avoid certain things, places, or activities because they frighten you
51. Your mind going blank
52. Numbness or tingling in parts of your body
53. A lump in your throat
54. Feeling hopeless about the future
55. Trouble concentrating
56. Weakness in parts of your body
57. Feeling tense or keyed up
58. Heavy feelings in your arms or legs

Appendix Q

Satisfaction with Life Scale

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by selecting the appropriate number.

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

1. In most ways my life is close to my ideal.
2. The conditions of my life are excellent.
3. I am satisfied with life.
4. So far I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Appendix R

Debriefing Page

Thank you for your participation in this study. Your time and effort are greatly appreciated in gathering data for thesis research. This data will be examined in the near future. The information obtained from this research will help us to investigate personal well-being as impacted by sexual identity, stress, and coping processes. Anyone wishing to know the results should feel free to contact the investigator via email. Any emotional discomfort stirred by completing this survey should be addressed immediately. Please contact any of the national hotlines or services below for support. If you have any other questions regarding your survey or participation in this study, please email Kim Jorgensen (Kimberly.jorgensen@und.nodak.edu) or faculty advisor David Whitcomb (david_whitcomb@und.nodak.edu).

National Resources

GLBT National Help Center – Providing free and confidential telephone and internet peer-counseling, information and local resources for gay, lesbian, bisexual, transgender and questioning callers throughout the United States. (http://www.glnh.org/)

Toll Free Number: 1-888-843-4564

- Monday thru Friday from 1pm to 9pm, *Pacific Time*
- Saturday from 9am to 2pm, *Pacific Time*

The Trevor Helpline – A free and confidential service that offers hope and someone to talk to, 24/7. The Trevor Helpline's trained counselors will listen and understand without judgment. If you or someone you know would like to talk to one of our highly trained counselors,
dial **866-4-U-TREVOR.** (http://www.thetrevorproject.org)

Fenway Health

Gay, Lesbian, Bisexual and Transgender Helpline
Toll Free Number: 1-888-340-4528

Peer Listening Line
Toll Free Number: 1-800-399-PEER

You can receive help, information, referrals, and support for a range of issues without being judged or rushed into any decision you are not prepared to make. Across the country, Fenway's HelpLines are a source of support. Talk to our trained volunteers about safer sex, coming out, where to find gay-friendly establishments, HIV and AIDS, depression, suicide, and anti-gay/lesbian harassment and violence. No matter what is on your mind, we are here to encourage and ensure you that you are not alone.

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