Internalized Heteronegativity & Resilience in Relation to the Health of Sexual Minorities of Color

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INTERNALIZED HETERONEGATIVITY & RESILIENCE
IN RELATION TO THE HEALTH OF SEXUAL MINORITIES OF COLOR

BY

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
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Abstract

Internalized oppression and minority/social stress are negatively correlated with various physical and mental health indicators. The research on internalized oppression for sexual minorities is deceptively vast. It appears that extensive literature is available on the subject, but a deeper analysis indicated that the existing literature is limited with respect to the diversity of the populations studied. This study endeavored to explore the relationship between internalized heteronegativity, resilience, physical/general health perceptions and mental health among sexual minorities that also identify with a racial/ethnic minority group. Participants for this study were recruited from New York, New Jersey and Rhode Island, from community centers, health centers, support programs and college/university organizations. Hierarchical multiple regression was utilized to analyze the data obtained from 99 participants. According to the results, as internalized heteronegativity increased, perceptions of physical health decreased. The relationship between internalized heteronegativity and perceptions of general physical health was modified by level of resilience. The moderation revealed that participants who reported higher levels of IHN have poorer perceptions of general health; however, resilience helps attenuate this negative relationship, but only for those who have moderate or high levels of resilience. The results suggest that providers should be encouraged to address heteronegativity and heterosexism in treatment because of its association with general health. Moreover, more research is needed to further understand the experiences of sexual minorities that identify with a racial/ethnic minority group (and other marginalized identities).
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CHAPTER 1

Although sexual minorities comprise about 4% of the population (Gates & Newport, 2012), they are more likely to report psychological distress and endorse symptoms of depression or anxiety than individuals that do not identify as sexual minorities (Berg, Munthe-Kaas & Ross, 2016; Hughes, Matthews, Razzano & Aranda, 2002; Meyer, 2003; Newcomb & Mustanski, 2010; Wong et al., 2013). They are also more likely to smoke, engage in risky sexual behavior, report physical illnesses and contract HIV (Frost, Levahot & Meyer, 2015; Hatzenbuehler, Jun, Corliss & Austin, 2014; Lick, Durso & Johnson, 2013; Rosario, Hunter, Maguen, Gwadz & Smith, 2001; Waldo, 1999). Despite the ample documentation of the negative health outcomes associated with being part of this stigmatized group, few studies have endeavored to explore the experiences of sexual minorities with other marginalized identities (such as race/ethnicity).

Group memberships, including race/ethnicity and sexual orientation, are increasingly viewed as important factors to consider in social and health research. The increased concern is reflected in the growing number of research studies examining issues important to sexual minorities. Unfortunately, few studies focus exclusively on investigating how multiple identities/statuses can affect health (Kertzner, Meyer, Frost, & Stirratt, 2009; Warner & Shields, 2013; Szymanski & Gupta, 2009). Even fewer studies have explored how internalized oppression affects the health of individuals that identify with a sexual minority group and a minoritized racial/ethnic group. Research that addresses multiple minority identities/statuses is important given that social membership can affect different domains of an individual’s life, including
health. Moreover, theories, such as Intersectionality Theory, postulate that certain experiences and their consequences often differ among individuals because of their identities. In the case of sexual minorities, such theories postulate that experiences of discrimination differ among sexual minorities of different racial/ethnic groups (Cole, 2009; Collins, 2008; Crenshaw, 1991; Warner & Shields, 2013). Given the importance of understanding the experiences of individuals with multiple minority identities/statuses, this study aimed to investigate how internalized oppression based on sexual identity related to the physical and mental health of sexual minorities who were also members of racial/ethnic minority groups. A better understanding of the physical and mental health impact at the intersection of multiple marginalized identities has the potential to inform future research and interventions that reflect the unique needs of this understudied and underserved population.

**Guiding Theories**

The research on the relationship between social stress and health among sexual minorities is saturated with White sexual minority participants. According to the literature, internalized oppression is associated with both poorer physical and mental health, but this relationship has been understudied among sexual minorities of racial/ethnic minority groups. Relevant guiding theories that help contextualize previous research in this area are presented below followed by a review of the literature (Chapter 2), which provides the foundation for the proposed study on the experiences of sexual minorities that also identify with a racial/ethnic minority group.

This study drew upon various models and theories to guide inquiry and help contextualize the findings. The theories underpinning this research include

**Ecological model of human development**

The psychological research literature stresses the importance of considering the environment/context of sexual minorities when considering health and wellness which aligns with Bronfenbrenner’s Ecological Model (1994). The model states that social systems directly and indirectly affect the development of an individual. The model emphasizes the effects of environmental factors on one’s life trajectory. The environment within which sexual minorities exist is important to consider because of its direct and indirect effects, which can manifest as negative health outcomes. There are five main components/systems in the Ecological Model: Microsystem, Mesosystem, Exosystem, Macrosystem and Chronosystem (Bronfenbrenner, 1994) (see Appendix C). The Ecological Model is useful when seeking to understand the potential factors that influence many phenomena and has broad application because of its general domains. Although this study did not directly test the Ecological Model, the model was used to emphasize the importance of environmental factors (not just biological factors), such as discrimination and oppression, when assessing health. More specifically, this study used the Ecological Model to highlight the interaction between sexual minorities of color and their typically oppressive environment.

**Minority Stress Model**

The Minority Stress Model (Meyer, 2003) is helpful when seeking to understand the complex factors that affect individuals with multiple minority statuses; it expands traditional models of stress and considers stressors that are prevalent and
uniquely relevant to individuals with a minority status. According to the Minority Stress Model (Meyer, 2003), individuals that identify as Lesbian, Gay or Bisexual (LGB) encounter a myriad of psychosocial stressors that individuals who are not sexual minorities may not face. The model describes the intricate relationship between LGB identity and environmental circumstances, minority status, minority identity, general stressors, distal minority stress processes (i.e., prejudice events), proximal minority stress processes (e.g., expectations of rejection, concealment, and internalized homophobia), characteristics of minority identity, coping/social support and mental health outcomes (Meyer, 2003).

An important consideration of the Minority Stress Model is that in addition to personal events, the sociopolitical environment within which the individual is immersed also contributes to stress. Based on the Minority Stress Model and other stress theories, such as Lazarus and Folkman’s Theory of Cognitive Appraisal (1984), stress, particularly chronic stress, takes a tolling role on an individual. It is important to consider the stressors experienced by minorities because they are “likely to be subject to such conflicts because dominant culture, social structures, and norms do not typically reflect those of the minority group” (Meyer, 2003, p. 675). In other words, society itself is a stressor because the dominant culture often conflicts, negates, and invalidates minority cultures. Such impositions may occur at an institutional level (macro-level) or individual level (micro-level).

The Minority Stress Model has three main underlying assumptions. The first assumption is that “minority stress is additive to general stressors that are experienced by all people” (Meyer, 2003, p. 676). The second assumption is that minority stress is
chronic, “it is relatively stable [and stems from] underlying social and cultural structures” (Meyer, 2003, p. 676). Third, minority stress is “socially based—that is, it stems from social processes, institutions, and structures…rather than individual events or conditions that characterize general stressors or biological, genetic, or other nonsocial characteristics of the person or the group” (Meyer, 2003, p. 676).

According to Meyer (2003), LGB individuals are likely to be “vigilant in interactions with others (expectations of rejection), hide their identity for fear of harm (concealment), or internalize stigma” (p. 677). Moreover, the Minority Stress Model postulates that an individual with a minority identity or status will encounter an increased number of stressors – these stressors are distinct from the stressors experienced by members of the majority/dominant group. Unfortunately, the chronic exposure to these distinct stressors relates to adverse health effects – both physically and mentally.
CHAPTER 2

Internalized Heterosexism (IH) and Internalized Heteronegativity (IHN)

Herek (1990) defined heterosexism as an “ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community” (316). Heterosexism extends beyond attitudes and focuses on social, political and economic systems that discriminate against “nonheterosexual attractions, behaviors, and identities” (Feinstein, Goldfried & Davila, 2012, p. 917). Heterosexism also implies that all “nonheterosexual attractions, behaviors, and identities” are invalid or inferior.

Internalized Heterosexism (IH) refers to the internalization of “negative societal attitudes about nonheterosexual attractions, behaviors, and identities” (Feinstein, Goldfried & Davila, 2012, p. 917). Shildo (1994) stated that IH originates from stereotypes and myths about nonheterosexual individuals; it also stems from embedded social and institutional discrimination, which permeates the social sphere. According to Szymanski and Kashubeck-West (2008), heterosexism is similar to racism because it is a form of discrimination by the dominant/majority group aimed towards the minority group (or oneself). Heterosexism, as racism, shows that the dominant group holds a set of privileges and power in society that the minority group lacks (Szymanski & Kashubeck-West, 2008).

Some researchers use other terms interchangeably with internalized heterosexism (see Appendix A). The term internalized heteronegativity (IHN) will be used in this study, except when referring to previous research. The terms used in this literature review will correspond to the terms utilized by the respective
author(s)/researcher(s). Similarly, for the purpose of this study, the term sexual minority will be used to refer to individuals that identify as lesbian, gay, bisexual, pansexual or queer (see Appendix B).

Research studies have found various associations between IHN and other factors, particularly health related factors. For example, utilizing a structural model, Waldo (1999) found that IH was associated with psychological distress, adverse health, and job dissatisfaction among LGB adults in a workplace setting. More specifically, Waldo (1999) found that LGB adults who perceived their company as tolerant of heterosexism typically reported higher levels of IH. Furthermore, LGB individuals who “experienced heterosexism exhibited higher levels of psychological distress and health-related problems” (Waldo, 1999, p. 229).

Similarly, Gold, Feinstein, Skidmore, and Marx (2011) found adverse relationships between IH and psychological symptoms in a study with a sample of 122 adult lesbian women and 115 adult gay men. In their study, Gold and colleagues (2011) treated IH and experiential avoidance as mediators for lesbian and gay individuals with a history of childhood physical abuse and psychological symptoms. The results revealed that IH fully mediated the relationship between childhood physical abuse and symptoms of Major Depressive Disorder and partially mediated the relationship between childhood physical abuse symptoms of Post-Traumatic Stress Disorder for gay men only. Childhood physical abuse and depression, as well as childhood physical abuse and Post-Traumatic Stress Disorder were not mediated by IH for lesbian women. The results of the study suggest that IH may play an important role in the mental health of individuals that identify as gay.
Feinstein, Goldfried and Davila (2012) also reported findings that support the relationship between IH and mental health. The study of 218 women that identified as lesbian and 249 men that identified as gay, was mainly composed of white sexual minorities (76%). Feinstein et al. (2012) conducted a path analysis to assess model fit. The results of the study indicated that IH served as a partial mediator for the relationship between discrimination and mental health among individuals that identified as lesbian and gay (Feinstein, Goldfried, Davila, 2012). According to the researchers, higher levels of reported discrimination related to higher reports of IH (Feinstein, Goldfried & Davila, 2012). In turn, higher levels of IH related to an increased expectancy of future discrimination, this higher expectancy related to increased endorsement of “symptoms of depression and social anxiety” (Feinstein, Goldfried & Davila, 2012, p. 922).


The early research on the physical health of sexual minorities focused on HIV/AIDS (Boehmer, 2002; Mink, Lindley & Weinstein, 2014). The focus was associated with the HIV/AIDS crisis of the late 20th century. These early studies
mainly assessed the experiences of men that identified as gay and did not consider the experiences of other sexual minorities.

Recent studies have expanded their focus to assess health promotive behaviors, such as substance use, dietary habits and physical activity (Aaron, Markovic, Danielson, Honnold, Janosky & Schmidt, 2001; Paul Cabaj, 2000). For example, Aaron and colleagues (2001) focused on individuals that identified as lesbian and assessed their engagement in cigarette smoking, alcohol use, exercise and eating habits. According to the researchers, individuals that identified as lesbian were more likely to report cigarette and alcohol consumption, being overweight and less likely to get pap smear tests than heterosexual women (Aaron et al., 2001).

Similarly, Amadio and Chung (2004) found that individuals that identified as gay or lesbian were more likely to report alcohol, cigarette and marijuana consumption and proposed that the increased rates may be due to internalized homophobia.

Discrimination, social stress and oppression has also been associated with cigarette consumption among sexual minority youth (Hatzenbuehler, Jun, Corliss & Austin, 2014). Although the majority of the research on sexual minorities suggests that sexual minorities are more likely to engage in substance use, there are studies that report little to no differences in prevalence when compared to non-sexual minorities (Sandfort, Bakker, Schellevis & Vanwesenbeeck, 2006). When considering other minoritized identities, Hughes, Matthews, Razzano and Aranda (2002) found that African American women who identified as lesbian were more likely than heterosexual African American women to report alcohol and drug consumption, which suggests differences associated with racial/ethnicity identity.
Other indicators of physical health, such as weight, obesity and exercise engagement have also been studied with sexual minorities (Boehmer, Bowen & Bauer, 2007; Calzo et al., 2014). In their study of women who identified as lesbian, bisexual and heterosexual, Boehmer, Bowen and Bauer (2007) found that women that identified as lesbian had higher overweight and obesity prevalence than women who identified as bisexual or heterosexual. In a qualitative study that assessed the barriers to engaging in physical activity, Roberts, Stuart-Shor and Oppenheimer (2010) found that women who identified as lesbian were likely to report minority stress, mood disorders (e.g., anxiety, depression) and homophobia as barriers to engaging in healthy behaviors.

In regards to general physical health, Diamant and Wold (2003) reported that individuals who identified as lesbian were likely to report more ‘poor’ physical health days. By the same token, Frost, Levahot and Meyer (2015) and Lick, Durso and Johnson (2013) found that physical health is related to experiences of discrimination, minority/social stress and oppression. Interestingly, in their longitudinal study, Frost, Levahot and Meyer (2015) found that a year after having experienced a prejudicial event, sexual minorities were more likely to report physical health problems, even after accounting for factors such as age, gender and lifetime health history.

Most studies on IH and IHN have focused mainly on individuals who identify as gay or lesbian, with only a limited number of studies focusing on bisexual individuals. Moreover, the “typical participant in research is a White, well-educated” person and of middle class background (Croteau, 2008; Szymanski, Kashubeck-West, 2008, p. 656). According to Croteua (2008), there is a need to understand the
experiences of sexual minorities who are also members of racial/ethnic minority groups because (in accordance to intersectionality theory) people have multiple social identities/statuses and each identity has its own implications (Crenshaw, 1991). Some speculate that individuals with multiple minority identities are expected to have an increased number of stressors and to have a lower mental health status; therefore, it is important to assess this (speculated) relationship among sexual minorities who are also members of racial/ethnic minority groups.

After an extensive literature review of PsycARTICLES, PsycINFO, PubMed, and Taylor and Francis, a limited number of peer-reviewed research articles that investigate IHN among racial/ethnic minorities emerged. One of the articles where IH among racial/ethnic minorities was examined includes Szymanski and Gupta’s (2009) research on multiple internalized oppressions among African American lesbian, gay, bisexual, and questioning individuals. Szymanski and Gupta (2009) examined the relationship between multiple minority statuses, self-esteem, and psychological distress in a sample of 106 African Americans. In the sample, 70% identified as lesbian or gay, 26% as bisexual, and 4% as unsure [age, M=31.17(SD= 10.95)]. The hierarchical multiple regressions and path analysis rendered significant: self-esteem significantly (negatively) correlated with IH and internalized racism and that psychological distress significantly (positively) correlated with internalized racism and IH (Szymanski & Gupta, 2009). The research results suggest that IH is a “unique predictor of psychological distress” (Szymanski & Gupta, 2009). This is an important finding because it suggests that IH has a negative effect on sexual minorities of a racial/ethnic minority group.
Resilience

Resilience is an important factor to consider when assessing psychological health. According to Luthar and Cicchetti (2000), “resilience is a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma” (p. 858). Masten, Best, and Garmezy (1990), Earvolino and Ramirez (2007) and Ahern (2006) also describe resilience as a process. Resilience is also important to consider because it relates to decreased severity of psychopathology (Garmezy, 1970; Masten, Best & Garmezy, 1990). Additionally, it can “protect against risky health behaviors such as suicide ideation or attempts” (Azlina & Jamaluddin, 2010, p. 3) and can “buffer the negative psychological effects of social and structural injustice” (Walker & Longmire-Avital, 2013, p. 2). Moreover, resilience is one of the concepts that helps us to illuminate why people react differently to life disruptions (Dyer & McGuinness (1996) (see Appendix D).

In their landmark study, Werner and Smith (1977, 1982) followed 505 individuals on the Island of Kauai from their birth until they turned 40– all of the participants were born on 1955. Werner and Smith (1977, 1982) used a natural history method to comprehend the lives of the individuals on the island. The study found that approximately two-thirds of the participants developed “serious problems as adults,” but the other third “developed into competent, caring adults” – this is significant because all of the participants experienced adverse conditions (such as poverty, parental divorce, alcoholism, or mental illness) (Earvolino & Ramirez, 2007, p. 74-75). Werner and Smith (1977, 1982) inspired future resilience research because people
were interested in what contributed to the differential development of the population under study.

Research conducted by Garmezy (1970) on individuals with schizophrenia (indirectly) promoted resilience research as well. Garmezy (1970) found that individuals with schizophrenia with the “least severe courses” all shared common factors. These factors were “premorbid history of relative competence at work, social relations, marriage, and capacity to fulfill responsibility” (Luthar, Cicchetti & Becker, 2000, p. 2; Garmezy, 1970). Although Garmezy did not describe these individuals as resilient, they “might be viewed today as prognostic of relatively resilient trajectories” (Luthar, Cicchetti & Becker, 2000, p. 2).

Resilience has also been studied in regards to physical health. Gattuso (2003) studied resilient aging among older women. The results revealed that resilient women were more likely to “describe themselves as well in spite of being objectively in poor health” (Gattuso, 2013, p.171). Similarly, in a systematic review of the research literature (published from June 1993 to June 2013) on chronic diseases and resilience, Call, Ribeiro de Sá, Glustak and Barreto Santiago (2015) found that resilience is “an important factor in health promotion” (p. 1). More specifically, their results revealed that resilience was inversely correlated with illness progression and positively correlated with quality of life and health promotive behaviors (Call, Ribeiro de Sá, Glustak & Barreto Santiago, 2015). Ma and colleagues (2013) found analogous results with patients with varying stages of chronic kidney disease and DeNisco (2011) with African-American women with type II diabetes.
Most studies on resilience focus on children, adolescents and young adults (Ahern, 2006; Garmezy, 1985; Garmezy, 1970; Masten, Best & Garmezy, 1990; Werner & Smith, 1977, 1982; Zolkoski & Bullock, 2012). However, resilience is also an important factor to consider in adulthood (Luthans, Vogelgesang & Lester, 2006; Teti, et al., 2012). Teti and colleagues (2012) conducted semistructured interviews to explore resilience among urban Black men with low incomes. In their study, Teti and colleagues (2012) found evidence that resilience can be studied in adults. Bronfenbrenner’s Ecological Model (1994) also supports the study of resilience in adults. According to the model, development is something that occurs throughout life. In this view, resilience can be studied well into adulthood.

There is a need to study resilience among LGBTQ individuals (Brown, 2008). According to Brown (2008), there is an overemphasis on the negative aspects associated with LGBTQ identities, such as IHN. However, there is a need:

- to learn who is resilient in the face of stigma, to study and uncover their personal and collective strategies, and to generate affirmative psychotherapy and counseling strategies utilizing lessons learned from those who thrive even in the midst of toxicity (Brown, 2008, p. 641).

Walker and Longmire-Avital (2013) support the need to study resilience among sexual minorities who are also racial/ethnic minorities.

In light of the health disparities related to minority sexual orientation/identity and race, the purpose of this study was to investigate how IHN and resilience are associated with the health of sexual and racial/ethnic minorities. Potential study implications include the development of interventions to reduce or mitigate the
detrimental effects of IHN on sexual minorities. The following hypotheses were explored in this study utilizing hierarchical multiple regression:

1) it was predicted that a negative relation between IHN and mental health would be found

2) it was predicted that a negative relation between IHN and physical health would be found

3) it was predicted that resilience moderates the relation between IHN and mental health

4) it was predicted that resilience moderates the relation between IHN and physical health
CHAPTER 3

Method

Participants

The online survey was accessed by 218 individuals. Due to various factors (see Figure C), only 99 responses were included in this analysis. The 99 participants were all over the age of 18 and self-identified as sexual minorities. The average age of the participants was 29.43 years ($SD= 9.96$, range: 18-60 years). Of the total participants, 53 identified as female, 39 as male, five as transgender and two as other. In regards to gender, 45 participants identified as woman. The other participants identified as man ($n =$39), genderqueer ($n =$10) or other ($n =$5).

In the survey, participants were allowed to select as many race/ethnicity categories as applied. Most participants identified as Hispanic/Latin@ ($n =$29). Other participants identified as Arab American ($n =$17), Black ($n =$16), White ($n =$16), Asian/Pacific Islander ($n =$11) and other ($n =$10). All White participants also identified with other racial/ethnic minority groups. A total of 39 participants identified as gay, 32 as bisexual, 24 as lesbian and 3 as other (e.g., queer).

About a third of participants had a bachelor’s degree ($n =$34) and a little over a third had a post-graduate degree (master’s degree or doctoral degree) ($n =$37). Other participants reported having an associate’s degree ($n =$2), some college ($n =$19), or a high school diploma/GED ($n =$6). Approximately a third of participants reported being born outside of the United States (first generation, $n =$39); approximately a third had at least one parent that was not born in the U.S. (second generation, $n =$31) and 25
participants reported that both parents were born in the U.S (third generation) (see table 5 for a display of the participants’ characteristics).

Procedure

A purposive sample was recruited for this study. Participants were recruited with emails sent to listservs from institutions such as non-profit organizations, health centers, colleges/universities and community centers across Rhode Island, New York and New Jersey; these organizations provide services to sexual minorities (see Appendix V). Participants were also recruited through facebook groups and flyers (see Appendix G and Appendix O). Participants completed a 15-20 minute survey on Survey-Monkey (no identifying data was collected). All of recruitment material and measures were available in both English and Spanish. Rodriguez created all of the Spanish material. Rodriguez consulted with fellow bilingual researchers (Dr. Mena and Dr. Gorman) at the University of Rhode Island and two monolingual (Spanish speaking) individuals.

The survey began with an electronic consent form (see Appendix H, Appendix P), along with resources (see Appendix W, Appendix X). Then, demographic data was collected (see Appendix I, Appendix Q). The surveys followed: IHN, resilience, physical health and mental health (see Appendix J-N, Q-T). A page with the same resources presented during the consent process was presented again at the end of survey. Lastly, participants were directed to a link that led them to a separate SurveyMonkey survey (to protect confidentiality). The second link allowed participants to enter their email for a chance to win one of three Amazon e-gift cards ($25, $50, $75) and/or to provide their email address for updates on the study,
including the results of this study. Data collection of responses to the English survey ended on April 2015.

Measures

Participants were asked demographic data, including age, educational attainment, gender, sex, sexual orientation, generational status and race/ethnicity. Participants were allowed to select as many multiple identifiers of race/ethnicity and gender. In addition to the categorical options, participants were provided with an open-ended answer box in which they were able to identify their preferred race/ethnicity, gender and sexual orientation term.

Internalized Heteronegativity (IHN)

Although the construct of internalized heterosexism is preferred, it cannot be measured directly because there are no direct measures. Instead, a modified version of Mayfield’s Internalized Homonegativity Inventory was used to capture IHN (Mayfield, 2001; see Appendix K). The original measure was designed to only capture the experiences of individuals who identified as gay. Modifications were made in order to have a more inclusive measure that could be used to capture the experiences of individuals who identified with other sexual minority identities. Items 1-5, 7-17, and 19-23 of Mayfield’s original inventory were reworded. Only items 6 and 18 were left unchanged. The rewording including changing gay to gay/lesbian/bisexual, changing homosexuality for sexual orientation, and men to women or women to men when applicable. An example of such as change is to item 3, which originally stated, “When I think of my homosexuality, I feel depressed.” After the modification, the item stated, “When I think of my sexual orientation, I feel depressed.” Another
example of such modification is to item 21, which originally stated, “I am proud to be gay.” Item 21 was modified to “I am proud to be gay/lesbian/bisexual.”

The modified version of Mayfield’s Internalized Homonegativity Inventory (IHNI-M) was translated from English to Spanish. The translation process included translations, back-translations and consultations. Rodriguez, who is bilingual and a native Spanish speaker translated the modified IHNI. After translating the items, the survey was given to another bilingual individual to conduct verbal back-translations. For items that did not have direct Spanish translation, Rodriguez consulted with fellow bilingual researchers (Dr. Mena and Dr. Gorman) at the University of Rhode Island. After this consultation, the translated IHNI-M was administered to two monolingual (Spanish speaking) individuals and asked to verbally explain what the items were asking (paraphrase in Spanish). Word frequency and difficulty were maintained as similarly as possible.

According to the factor analytic data conducted by Mayfield (2001), the original inventory has three factors: personal homonegativity, gay affirmation, and morality of homosexuality (Mayfield, 2001). The Internalized Homonegativity Inventory consists of 23 items that follow a Likert-type scale. Responses range from 1 (strongly disagree) to 6 (strongly agree). The original inventory contains items such as “I feel ashamed of my homosexuality” and “I am thankful for my sexual orientation.” The responses are added to obtain a total score; higher scores indicate higher levels of internalized homonegativity. The overall IHNI and its subscale scores rendered “moderate to high internal consistency reliability estimates” in previous research by Mayfield (2001). Research supports the use of this inventory with individuals that
identify as gay and the modified version with individuals that identify as lesbian; however, it has not been validated with other sexual minorities. In this study, the Cronbach’s alpha for the 23-item global IHN subscale was 0.93 (see Table 1).

**Resilience**

Resilience was measured utilizing the Connor-Davidson Resilience Scale-10 (CD-RISC-10; Campbell-Sills & Stein, 2007). The CD-RISC-10 is a shorter, revised version of the Connor-Davidson Resilience Scale -25, which is composed of 25 items. The CD-RISC-10 is a 10-item unidimensional scale. Some items of the CD-RISC-10 include “I can deal with whatever comes my way,” “I believe I can achieve my goals, even if there are obstacles,” and “I am not easily discouraged by failure.” Responses are measured on a 5-point scale with responses ranging from 0 (not true at all) to 4 (true nearly all the time). The responses to all ten items are added to obtain an overall score, with higher scores indicating greater levels of resilience. The CD-RISC 10 has been validated with young Hispanics, but not with other racial/ethnic minorities or sexual minorities (or with individuals that identify with groups). Previous studies have found good reliability scores for the CD-RISC-10; Campbell-Sills and Stein (2007) reported a 0.85 alpha and Coates, Phares and Dedrick (2013) reported a 0.87 alpha [95% confidence interval (CI: 0.84, 0.90)]. Similar reliability scores were obtained in this study for the CD-RISC-10 (10 items; α = .86) (see Table 2).

**Physical Health**

Physical health was measured with the Health Perceptions Questionnaire (HPQ; Ware, 1976). The questionnaire “records perception of past, present, and future health; resistance to illness and attitudes towards sickness” (McDowell, 2006, p. 253).
The HPQ consists of 33 items and six subscales: current health (nine items), prior health (three items), health outlook (four items), resistance to illness (four items), health worry/concern (five items), and sickness orientation (two items). A general health rating index can be obtained utilizing 22 items. Responses are Likert-type and range from 1 (definitely false) to 5 (definitely true). Some of the items of the HPQ are “I try to avoid letting illness interfere with my life” and “I feel about as good now as I ever have.” Items C, E, F, I, K, L, R, T, Z, CC and DD were reverse scored (by subtracting 6). The (raw) subscale scores and general health rating index can be transformed (to a 0-100 scale) if necessary. The HPQ underwent the same translation process as the IHNI-M.

The HPQ has not been validated with sexual minorities or with individuals who are both racial/ethnic and sexual minorities. McDowell (2006) reported tolerable (0.59) and good (0.91) reliability for the overall indexes and subscales. In this study, the general health subscale of the HPQ rendered good reliability scores (22 items; α = .88) (see Table 3).

**Mental Health**

Mental health was measured with the Mental Health Inventory-18 (MHI-18; Veit & Ware, 1983). The MHI-18 consists of 18 items; it is a shorter version of the MHI-38. The responses are Likert-type, ranging from 1 (all the time) to 6 (none of the time). The scale has four subscales (anxiety, depression, behavioral control, and positive affect). Items of each corresponding scale and subscale were added and then divided by the number of items in the scale and subscale. These raw scores were not transformed, as sometimes suggested, because no non-normal distributions were
obtained. The scores for the scales and subscale range from 0 to 100, with higher scores indicating better mental health. Some of the items of the MHI-18 are “Did you feel cheerful, light-hearted” and “Have you felt restless, fidgety or impatient”; these responses are answered in reference to the past four weeks. The 18-item version of the Mental Health Inventory has good reliability (0.93) (Meybodi et al., 2011). The MHI-18 has not been validated with sexual minorities or with individuals who are both racial/ethnic and sexual minorities. Good reliability scores were obtained for the global mental health scale (18 items; α = .95) in this study (see table 4).
CHAPTER 4

Results

Preliminary Analysis

Basic assumptions of the general linear model were assessed including normality, multicollinearity/singularity, linearity and homoscedasticity (homogeneity of variance). Tables 6 and 7 depict the mean, variability, skewness and kurtosis of IHN, resilience, (perceptions of) physical/general health and mental health. As displayed in Table 7, all skewness values were between -1 and +1. Similarly, kurtosis values were all within the acceptable range of -1.5 to +2.0. Histograms were also utilized to assess normality.

Scatterplots were used to assess linearity and homoscedasticity. The scatterplots rendered elliptical-like patterns for all variables of interest. The results of the tests of normality, multicollinearity/singularity, group differences, homoscedasticity and linearity all suggested that the data met the required generalized linear model assumptions. Moreover, because all statistical assumptions were met, the data did not need to be transformed.

The data were also scanned for outliers and missing data. Outliers were assessed by observation of z-scores. For the scales of interest, no z-scores over three were identified. In regards to missing data, all 99 participants completed the IHN (MIHI-M) measure, 98 completed the resilience (CDRS-10) scale, 92 completed the health perceptions questionnaire (HPQ) and 83 completed the mental health inventory (MHI-18). To evaluate systematic patterns of missing data, Little's Missing Completely at Random (MCAR) Test was conducted on the items of the four
measures of interest (see Figure F). The results indicated that the missing data was completely random ($\chi^2 = 1424, df=1356; p=0.097$). Further assessment of the missing values revealed that only 7.52% of the total values were missing. Simple Imputation, based on Estimation Maximization (EM), was used to impute missing values because no major concerns or patterns emerged from the missing data analyses. Lastly, all scales and subscales of interest rendered good reliability coefficients: IHN ($\alpha = 0.93$), resilience ($\alpha = 0.86$), general health ($\alpha = 0.88$), mental health ($\alpha = 0.95$), anxiety ($\alpha = 0.88$) and depression ($\alpha = 0.92$).

Pearson’s correlations were conducted as an initial exploratory step to assess the relationships (e.g., multicollinearity/singularity) among variables in the study. Various statistically significant correlations were found (see Table 8). Significant correlations were found between age & IHN ($r = -0.38, p < 0.001$) and age & resilience ($r = 0.22, p = 0.036$).

IHN was correlated with resilience ($r = -0.40, p=0.01$); however, because the correlation was below 0.70, there is no concern for collinearity between the independent variable and the moderator. According to Table 8, all other significant correlations fell below 0.70, which eliminated concerns for multicollinearity and singularity.

$T$-tests were conducted to assess group differences because various significant correlations that emerged in the initial correlation analyses. The $T$-tests were conducted for sex and gender. The $t$-test results for sex and IHN rendered non-significant differences ($t= 0.45, p=0.65$). Levene’s test of homogeneity/equality of variance rendered non-significant results ($F=0.19, p=0.66$), which indicates that there
were no significant group differences and that the variance of IHN among the different sexes was not disproportionately distributed. Similarly, no main effect was found on gender and general health ($t = -0.62, p = 0.54$). Again, Levene’s test of homogeneity/equality of variance rendered non-significant results ($F = 0.1, p = 0.67$), which indicated that there was no unequal variance of general health perceptions among the different genders. It should be noted that for these analyses, participants that identified as transgender were included if they also identified other identities (e.g., transgender male).

ANOVA analyses were also conducted to identify potential group differences. The ANOVA analyses conducted with education levels could not be interpreted because the assumption of homogeneity of variance was violated. Levene’s test of homogeneity of variance for IHN by educational levels rendered significant results, $F(4, 93) = 4.95, p = 0.001$. Given the unequal variance of educational levels, the proceeding ANOVA analysis could not be interpreted.

In contrast, the ANOVA analysis that assessed differences based on generational status did not violate homogeneity assumptions (Levene’s test, $F(2, 92) = 1.42, p = 0.25$). According to the ANOVA analysis, there are no significant differences in IHN ratings based on generation status ($F(2, 94) = 0.00, p = 1.00$). Nor were there any significant generation status differences for mental health ($F(2, 94) = 1.52, p = 0.22$), physical health ($F(2, 94) = 0.46, p = 0.63$) and resilience ($F(2, 94) = 0.20, p = 0.82$).
Main Analysis

Hypotheses one and two were evaluated by way of correlation analyses (see Table 9). Unlike the correlations conducted for the preliminary analyses, these correlations utilized the imputed data. Hypothesis I, which predicted a negative relationship between IHN and mental health, was not supported by the results ($r = -0.15; p = 0.15$). Hypothesis II, which predicted a negative relationship between IHN and physical health, was supported. IHN and general outlooks of physical health was negatively correlated ($r = -0.32; p < .01$).

Hierarchical multiple regressions were conducted to assess the last two hypotheses. Hypothesis III stated that resilience would moderate the relationship between IHN and mental health. All three steps of the hierarchical multiple regression model yielded non-significant results (see Table 10). The results suggest that IHN does not predict general mental health and that resilience does not moderate this relationship.

Hypothesis IV stated that resilience would moderate the relationship between IHN and (perceptions of) general physical health. According to the results of the first regression model, IHN significantly predicted general health perceptions ($R^2 = 0.10$, $F(1, 97)= 11.18, p=0.001$) and accounted for 10% of the variance (see Table 11). In Step 2 of the first model, adding resilience to the model did not result in a statistically significant improvement of the model ($R^2 = 0.11$, $F(1, 96)= 6, p=0.36$). The last step of the hierarchical model introduced the interaction between IHN and resilience which rendered statistically significant results ($R^2 = 0.15$, $F(1, 96)= 5.76, p=0.03$), ($\beta = -1.12$, $t = -2.19, p = 0.03$). The results of the regression analyses are displayed in Table 11.
The model with the interaction accounted for an additional 4% of variance in perceptions of general health. Together, the last model accounted for 15% of the variance, which represents a medium effect (Cohen, 1988).

The results of the third step show that resilience is a moderator for the relationship between IHN and general health perceptions. In order to examine the effect of resilience further, the moderator was grouped into three levels (low, moderate, high). Figure E depicts the nature of the relationship between IHN and perceptions of general health at low, medium, and high levels of resilience. The results revealed significant interactions for the moderate and high resilience group. According to the moderation analysis, resilience helps mitigate the negative relationship between IHN and general health perceptions.
CHAPTER 5

Discussion

Mental and physical health disparities among sexual minorities are well documented in the research literature. Sexual minorities are more likely to report psychological distress, endorse symptoms of depression or anxiety, engage in risky sexual behavior, contract HIV or report a physical illness (Berg, Munthe-Kaas & Ross, 2016; Frost, Levahot & Meyer, 2015; Hatzenbuehler, Jun, Corliss & Austin, 2014; Hughes, Matthews, Razzano & Aranda, 2002; Lick, Durso & Johnson, 2013; Meyer, 2003; Newcomb & Mustanski, 2010; Rosario, Hunter, Maguen, Gwadz & Smith, 2001; Waldo, 1999; Wong et al., 2013). Although these disparities are well-documented, it is important to recognize that these relationships have been mainly explored with White sexual minorities. Few studies have attempted to understand multiple marginalized identities which is needed because different identities can yield different sociocultural, political and economic implications.

In light of this gap in the research, this study aimed to obtain a deeper understanding of the experiences of sexual minorities who also identify with a racial/ethnic minority group. More specifically, this study was conducted to examine the relationship between internalized heteronegativity (IHN), resilience, general physical health and mental health among racial/ethnic minorities.

Four hypotheses were evaluated in this study. The first hypothesis predicted a relationship between IHN and mental health. The results of the correlation analysis were not statistically significant. The non-significant results suggest that there is no relationship between IHN and mental health among the sample of participants in the
present study. These results are not in line with the overwhelming research that states that IHN and mental health are related (Meyer, 2003). There are five (main) potential reasons for these contradictory results. One possibility relates to what is known as the file-drawer effect (or publication bias). The file-drawer effect states that researchers are not likely to publish or have their studies accepted for publication if their results are negative or non-significant (Rosenthal, 1979; Scargle, 2000). The file-drawer effect may explain the lack of published studies that also rendered non-statistically significant results between IHN and mental health. According to the file-drawer effect, such studies may not be available in the public realm.

The second possible explanation for these results is that most other research on IHN and sexual minorities has mainly been conducted with sample of White sexual minorities. This study is one of the few studies to focus exclusively on sexual minorities that also identify with a racial/ethnic minority group. It is possible that this study is capturing the unique experience sexual minorities that also identify with a racial/ethnic minority group because as intersectionality theory postulates, experiences are affected by social identities and statuses (Cole, 2009; Collins, 2008; Crenshaw, 1991; Warner & Shields, 2013). Moreover, these results support the notion that there is substantial “heterogeneity within and between minority populations” (Zahm, Pottern, Lewis, Ward & White, 1994).

The third possible explanation for these findings relate to the relationship between education and physical health. In this study, approximately one third of the participants had a bachelor’s degree and another third had a post-graduate degree. According to most studies on health and socioeconomic factors show that education
and health are directly (positively) correlated (Ross & Wu, 1995). It is possible that this study did not find support for the relationship between mental health and IHN/IHN because of the factors associated with higher levels of education.

It is important to consider the locations from which this sample was recruited. Geographically, participants were recruited from New York, New Jersey and Rhode Island. New York, New Jersey and Rhode Island are located in the Northeast and New England area. When compared to the other states of the US, New York, New Jersey and Rhode Island can be described as liberal (Newport, 2015) and supportive of sexual minorities. Given these geographical differences, it is possible that this study’s sample is not representative of the experiences of sexual minorities, especially of sexual minorities that live in non-supportive states. It is possible that sexual minorities that live in other states face an increased amount of discrimination or have less access of resources. Another important factor about the locations from which this sample was recruited pertains to the recruitment sites. This sample was recruited from sexual minority friendly centers and groups. It is possible that this study’s sample is not representative of the experiences of sexual minorities because not all sexual minorities have access to sexual minority supportive groups, centers and communities.

Lastly, it is possible that the sexual minorities from this sample were coping well with their general and minority stressors. If the participants of this study were coping well, it is unlikely that they would endorse symptoms of a mood or anxiety disorder. If we consider the supportive locations from which this sample was recruited, it is possible that the participants were in a supportive environment and received social support that could mediate the negative effects of IHN. According to
the Minority Stress Model, (Meyer, 2003) social support can buffer the negative effects of IHN on mental health.

The second hypothesis of this study predicted a relationship between IHN and physical health. The result of the correlation analysis was significant. According to the results, there is an inverse relationship between IHN and (general) physical health. Therefore, increases in IHN is associated with decreased/worse perceptions of (general) physical. These results support the research literature on IHN, which states that as IHN is related to physical health. Although the measures used to capture ratings of physical health measure perceptions of general (physical) health, there is support for their relationship. It is assumed that perceptions of (general) physical health reflect a person’s health status. It is important to consider that these results might be related to the locations from which this sample was recruited. Participants were recruited from health centers, community centers and college/university groups. Given that individuals often visit health centers because they have physical health concerns, it is possible that the participants of this study had physical health concerns that were unrelated to IHN and not reflective of the sexual minority population.

The third hypothesis predicted a relationship between IHN and mental health and the moderating role of resilience. The hypothesis was assessed via hierarchical multiple regression in a three step model. The first model was composed of IHN and Mental Health. The second model added resilience to the previous model. The final model included IHN, resilience, an interaction variable for IHN and resilience and mental health. None of the three models rendered statistically significant results, which suggests that for this particular sample, resilience did not moderate the
relationship between IHN and mental health. These results differ from the existing research literature which depicts resilience as an important factor when considering mental health and related processes (Luthar & Cicchetti, 2000; Walker & Longmire-Avital, 2013). Moreover, as previously stated, these results differ from the literature on IHN and IH because the current literature shows that IHN is associated with adverse mental health (Feinstein, Goldfried, Davila, 2012; Meyer, 2003; Newcomb & Mustanski, 2010; Shildo, 1994; Szymanski and Kashubeck-West, 2008).

Foremost, this sample was composed of highly educated participants. Various environmental and social factors can affect physical and mental health. For example, socioeconomic status and education have been linked as factors that contribute to differing health outcome (Zimmerman & Woolf, 2014). In other words, it is possible that for this sample, educational attainment served as a moderator for the relationship between IHN, resilience and mental health by buffering the expected negative impact of IHN.

Similarly, this sample was composed of non-US born participants. Approximately a third of participants reported being born outside of the United States and another third reported having at least one parent that was not born in the US. Only a third of the participants reported being born in the US and having two US-born parents. The participants’ generation status is important to consider when interpreting these results because of the Epidemiological Paradox (Alegria et al., 2008; Markides & Coreil, 1986; Rubalcava, Teruel, Thomas & Goldman, 2008). The Epidemiological Paradox is also referred to as the immigrant paradox. According to the Epidemiological Paradox, immigrants, especially Latin@s, tend to have comparable or
better health outcomes than Whites or Blacks (Alegria et al., 2008; Hamilton, 2015; Rubalcava, Teruel, Thomas & Goldman, 2008). These health differences are considered paradoxically because immigrants tend to live in poverty, have lower income and educational levels than non-immigrant US individuals – all of which are associated with poor health (Hamilton, 2015). Given the sample of this study, it is possible that the observed results are due to the Epidemiological Paradox.

Another explanation for these results relates to the unique demographic characteristics of this sample. This sample was composed of sexual minorities that also identify with a racial/ethnic minority group. This is one of the first studies to assess the relationship between IHN and mental health with sexual minorities with another marginalized identity. It is likely that the results reflect the experiences of these individuals with multiple marginalized which differ from the experiences of White sexual minorities (Brown, 2008).

Moreover, when considering the experiences of individuals with multiple marginalized identities, it is sometimes assumed that there is an additive effect on the adverse experiences of individuals with multiple marginalized identities (Bowleg, 2012; Bowleg, 2008; Cole, 2009). For example, sexual minorities are subject to discrimination based on their sexual orientation/identity, while sexual minorities that also identify with a racial/ethnic minority group could experience discrimination based on both their sexual orientation/identity and/or their racial/ethnic identity. For such individuals, it is sometimes presumed that they will potentially face twice the discrimination and therefore, discrimination will have twice the adverse effect.
However, the experiences of individuals with multiple marginalized identities are far more complex (Bowleg, 2008).

Given the complexity of identities, particularly multiple marginalized identities, it is possible that this study is not capturing other salient factors that one should consider when assessing the experiences of individuals with multiple marginalized identities, such as sexual minorities that also identify with a racial/ethnic minority group. One of the factors that are important to consider when assessing identity and discrimination is ethnic identity. Ethnic identity can ameliorate the negative experiences associated with discrimination (Mossakowski, 2003; Umaña-Taylor, Tynes, Toomey, Williams & Mitchell, 2015; Umaña-Taylor & Updegraff, 2007). It is possible that ethnic identity is serving as a buffer for the participants of this study, which was not measured in this study and would help explain why no association between IHN, resilience and mental health was found.

The last hypothesis predicted a relationship between IHN and (perceptions of general) physical health and the moderating role of resilience; it was assessed via hierarchical multiple regression in a three step model. The first model was composed of IHN and (perceptions of general) physical health. The second model added resilience to the previous model. The final model included IHN, resilience, an interaction variable for IHN and resilience and (perceptions of general) physical health. The first and second model rendered statistically significant results, which suggests that for this particular sample, resilience moderates the relationship between IHN and (perceptions of general) physical health. These results are in agreement with the research literature that suggests that resilience is an important factor when

**Implications and Future Directions**

The results of this study have various implications for future research and potentially for clinical practice. One of the main implications of this study is that IHN does not affect all sexual minorities uniformly. As seen with this sample, IHN was not associated with mental health, but was associated with (perceptions of general) physical health. For future research, this means that studies should strive to recruit sexual minorities of diverse racial/ethnic identities, as well as other salient identities/statuses. This is important because the experiences of individuals with multiple minoritized identities/statuses differs from the experiences of individuals without multiple minoritized identities/statuses because they navigate their sociocultural and political environment differently.

Moreover, future research can focus on the other salient factors for sexual minorities that also identify with a racial/ethnic minority group. For example, future research can consider the role of ethnic identity given the substantial research that supports the importance of ethnic identity which may serve as a protective factor (Mossakowski, 2003; Umaña-Taylor & Updegraff, 2007). Other important factors to consider are educational level and SES given that higher levels of each imbues important resources. Other research on sexual minorities also suggests that social support should be considered when assessing the experiences of sexual minorities (Hsieh, 2014).
This study was not conducted in a clinical setting nor with a clinical population thus extrapolation to clinical populations should be made with caution. One potential clinical implication drawn from this research is that high IHN levels may trigger a response of resilience to cope. As the interaction demonstrated, the most adverse physical health (perception) ratings were associated with the group with the highest IHN and resilience levels. Professionals should be wary of neglecting IHN when working with resilient sexual minorities. By failing to address IHN in therapy, professionals can unintentionally perpetuate the invalidation that sexual minorities often face in their sociocultural environment. Furthermore, professionals treating sexual minorities should not assume that IHN is salient for the client because the experiences of sexual minorities are diverse. Instead, as Hays and Iwamasa (2006) suggested, professionals should engage in a collaborative effort with the client and ensure that they help their client feel comfortable about raising matters pertaining to sexual orientation/identity. For physicians, it is important for them to understand that IHN can be associated with (perceptions of general) physical health. Training sites, medical schools and service centers should provide training on how to best serve diverse patients, including patients that identify with a sexual minority group.

**Limitations**

This study was a non-experimental and cross-sectional; therefore, the generalizability of the results is limited. The results obtained in this study have limited generalizability to individuals of sexual minority and/or racial/ethnic groups. The conclusions discussed in this paper are applicable to the sample, but should not be considered as representative of all sexual minorities. Additionally, because of the
design, causality cannot be extrapolated from this cross-sectional study. In other words, it would be erroneous to conclude that IHN causes adverse perceptions of general/physical health.

It is important to consider the locations from which this sample was recruited. Geographically, participants were recruited from New York, New Jersey and Rhode Island. New York, New Jersey and Rhode Island are located in the Northeast and New England area. When compared to the other states of the US, New York, New Jersey and Rhode Island can be described as liberal (Newport, 2015) and supportive of sexual minorities. Given these geographical differences, it is possible that this study’s sample is not representative of the experiences of sexual minorities, especially of sexual minorities that live in non-supportive states. It is possible that sexual minorities that live in other states face an increase among of discrimination or have less access of resources. Another important factor about the locations from which this sample was recruited pertains to the recruitment sites. Participants were primarily recruited from community centers, health centers and college/university organizations. It is likely that the participants from this study are receiving actively receiving health and/or support services that could have influenced the participants’ responses and their experiences. It is likely that the participants

Another important set of limitations relate to the measurements utilized in this study. For example, currently, there is no measure of internalized heterosexism. Most measures capture other experiences, such as internalized heteronegativity, but this construct is different from internalized heterosexism because it does not capture how the sociocultural and political environment invalidates the experiences of sexual
minorities and reinforces heterosexism. As noted in the measures section of the methods for this study, a modified measure of homonegativity was utilized. In order to incorporate the suggestions made by various researchers that focus on issues relevant to sexual minorities, the term homonegativity was avoided and instead IHN was utilized. However, it should be noted that IHN is synonymous with internalized heterosexism (IH). A measure of IH is needed in order to make conclusions about internalized heterosexism.

The differing delineations and measures of physical health is another measure-related limitation. Some researchers operationalize physical health as the absence/presence of an illness; however, this operationalization fails to consider people with chronic illnesses that successfully manage their illness. Other researchers assess physical health through BMI, blood pressure and cholesterol levels, but these are all potential risk factors and do not necessarily indicate health status. Based on the noted limitations of measuring physical health, this study relied on self-rated perceptions of general physical health. Research suggests that sometimes, participants perceive themselves as healthier than they really are (Dunning, Heath, & Suls, 2004).

An important limitation of this study related to the screening process utilized to ensure that all potential participants met the study’s eligibility criteria. The screening question regarding sexual orientation/identity listed commonly used sexual orientation/identity terms to ask if participants identified as sexual minorities. Unfortunately, by listing terms and not allowing participants to enter their preferred identity term, various participants were excluded from the study. For example, participants who identified as queer or with other terms such as “same gender loving”
or “human lover” might be excluded from the study. Future studies should be cautious excluding individuals that do not identify with common sexual minority identity terms.

**Conclusion**

This study sought to obtain a deeper understanding of the experiences of sexual minorities that also identify with a racial/ethnic minority group. More specifically, this study was interested in the relationship between sexual orientation based internalized oppression (IHN), resilience, general physical health and mental health. Previous findings suggest that IH affects both mental health and physical health, but these findings were based on predominately White samples. To address this limitation, this study sought to recruit only participants that identified with at least one racial/ethnic minority group. The results support the role of resilience as a moderator in the relationship between IHN and (perceptions of general) physical health, but not the relationship between IHN, resilience and mental health. Further research is needed to understand the results and in order to develop more culturally sensitive and effective treatments.
Appendix A

**Heterosexism, Homophobia, Homonegativity and Heteronegativity**

Some terms used interchangeably with heterosexism are homophobia, homonegativity, heteronegativity or sexual prejudice. The term homophobia was coined by Dr. George Weinberg in 1969 (Herek, 2000). Homophobia refers to the discomfort or dread that people feel against nonheterosexual attractions, behaviors, and identities (Kertzner, Meyer, Frost, & Stirratt, 2009). Homonegativity has been used to describe negative attitudes against people that identify as gay; it is often aimed towards oneself (Mayfield, 2001; Morrison & Morrison, 2002).

Historically, homonegativity and homophobia were used to describe the experiences of gay men and later expanded to include lesbian women. Unfortunately, neither term incorporated the experiences of people that identified as bisexual or with other minoritized sexual identities (e.g., pansexual, asexual, queer). Unlike homonegativity or homophobia, terms such as heteronegativity and heterosexism recognize that there are various sexual identities and recognize its fluidity (Herek, 2000). There are two main definitions of heteronegativity. One definition refers to the spectrum of negative/prejudicial behaviors and attitudes that is aimed towards sexual minorities (Horn, Kosciw & Russell, 2009). The second delineation conceptualizes heteronegativity as a coping mechanism that sexual minorities use to combat the effects of heterosexism (Greene & Herek, 1994; White & Franzini, 1999).

Heterosexism and Heteronegativity tap into different processes, although the terms are similar. For example, Heteronegativity does not capture the extent to which sexual minorities are invalidated and subjugated by their environment at the
individual, social and political. Rather, the terms focuses mainly on the internal process of the individual and depending on the delineation, it can refer to a coping mechanism (Greene & Herek, 1994; White & Franzini, 1999).

Out of the different terms, heterosexism tends to be the preferred term because it is a “more appropriate and inclusive concept” (Waldo, 1999, p. 218; Herek, 1989, 2004, Neisen, 1990; Szymanski & Kashubeck-West, 2008). Internalized heterosexism, “unlike the other terms, focuses on the normalizing and privileging of heterosexuality…and calls into attention to the prejudice and social stigma, both institutional and interpersonal faced by GLB people…heterosexism includes a wide range of experiences of discrimination not limited to those related to phobias or violent episodes, and it conceptually includes prejudice toward bisexual men and women as well “ (Waldo, 1999, p. 218).

Heterosexism is the preferred term when addressing the social, political, economic and historical systems that create, maintain and perpetuate inequality and oppression for sexual minorities, it should not be utilized to refer solely to micro-level prejudice or discrimination. Herek recommends that when referring to prejudice or negative attitudes because of heterosexist processes the term sexual prejudice should be used (1990; 2000). According to Herek (2000), sexual prejudice incorporates negative attitudes, hostility/dislike and is directed towards sexual minorities.

In order to attempt to address the limitations with the previously defined constructs, this study will utilize the term heteronegativity. Internalized heteronegativity will be utilized instead of the preferred term (heterosexism) because there are no current internalized heterosexism measures and it would be misleading to
utilize this term. The term internalized heteronegativity will also be utilized because this study is interested in the internalized effects of heterosexism and on the experiences of sexual minorities.
Appendix B

Gender & Sexuality Terms

Homosexual

It is important to note that sexual minorities often reject the term “homosexual” because of its negative associations. The term “homosexual” was widely used in research and clinical settings to denote deviance or pathology (McIntosh, 1968). As the Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling of Alabama (ALGBTICAL) states, the term homosexual is “too clinical-sounding” (2013). Moreover, the term “is too focused on physical acts rather than romance or attraction, or too reminiscent of the era when homosexuality was considered a mental illness” (ALGBTICAL, 2013). The term gay is sometimes also rejected because of negative sociocultural connotations of the word (ALGBTICAL, 2013).

Sexual Orientation

According to the American Psychological Association (APA), sexual orientation “refers to an enduring pattern of emotional, romantic, and/or sexual attraction… [and it also] refers to a person’s sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions” (2008, p. 1). Sexual orientation is a broad term applicable to heterosexual, sexual minority and gender minority individuals. An individual’s sexual orientation may also serve as their sexual identity.

The common categories of sexual orientation in the research literature are heterosexual, homosexual and bisexual. Although sexual orientation is commonly
thought of in distinct categories, research suggests that sexual orientation is fluid and is better represented by a continuum (American Psychological Association [APA], 2008; Diamond, 1998) (see Figure A). A heterosexual individual has “emotional, romantic, or sexual attractions to members of the other sex” (American Psychological Association, 2008, p. 1). A homosexual individual has “emotional, romantic, or sexual attractions to members of one’s own sex” (APA, 2008, p. 1).

Sexual Identity

A person’s sense of identity based on attractions, related behaviors, and membership in a community of others who share those attractions” (2008, p. 1). An individual’s sexual orientation may also serve as their sexual identity. Although sexual orientation is commonly thought of in distinct categories, research suggests that sexual orientation is fluid and is better represented by a continuum (American Psychological Association [APA], 2008; Diamond, 1998).

Heterosexual

An individual that has “emotional, romantic, or sexual attractions to members of the other sex” (American Psychological Association, 2008, p. 1).

Gay/Lesbian

An individual has “emotional, romantic, or sexual attractions to members of one’s own sex” (APA, 2008, p. 1). Men with “emotional, romantic, or sexual attractions” to other men are referred to as gay. Women with “emotional, romantic, or sexual attractions” to other women are referred to as lesbian (APA, 2008, p. 1).

Bisexual
An individual that has “emotional, romantic, or sexual attractions to both men and women” (APA, 2008, p. 1).

**Pansexual**

An individual that has “emotional, romantic, or sexual attractions” to men, women, genderqueer and/or transgender individuals (APA, 2008, p. 1).

**Asexual**

An individual with little to no sexual attraction to anyone. It is sometimes used to refer to someone with no sexual orientation.

**Sex**

Sex refers to the biological features of an individual; it is “the anatomical, physiological, and genetic characteristics associated with being male or female” (APA, 2008, p. 1). It is important to note that research suggests that sex (as sexual orientation) is not binary and is better represented on a continuum (Fausto-Sterling, 1993; 2000, see Figure A).

**Gender**

Gender refers to the social and “cultural norms that define feminine and masculine behavior” (American Psychological Association, 2008, p. 1). Gender has an external and internal component: identity and expression.

**Gender Identity**

Gender identity refers to an individual’s internal and psychological identification as man or woman, both or neither (APA, 2011). Gender identity is also not a binary category. Scholars suggest that gender identity is better represented as a continuum instead of distinct categories.
**Gender Expression**

Gender expression refers to the external component of gender. Gender expression is the external and physical manifestation of gender (as woman, man, both, or neither; see Figure A).

**Transgender**

Transgender is an “umbrella term for people whose gender identity differs from what is typically associated with the sex they were assigned at birth” (GLAAD, 2015)

**Androgynous**

Androgynous refers to an individual whose gender expression is neither masculine or feminine.

**Genderqueer or Genderbender**

Genderqueer or genderbender refers to an individual whose gender expression is simultaneously masculine and feminine.

**Cisgender**

Cisgender refers to an individual whose gender identity & expression is congruent to his or her assigned sex.

**Drag King/Queen**

Drag queen or drag king refers to an individual who dresses in the opposite sex for entertainment/performance purposes.

**Transsexual**
Transsexual refers to an individual engaged in the transition process. The term transsexual limited to those engaged in hormone therapy or who have undergone any sort of reconstructive surgery.
Appendix C

Ecological Model of Development

**Microsystem**

The microsystem refers to the immediate environment of the individual. Proximal processes occur in the microsystem and these processes have a substantial impact on development.

**Mesosystem**

The mesosystem is the bridge between settings and the individual.

**Exosystem**

The exosystem is similar to the mesosystem because it is also the bridge or link between processes that occur in two or more settings; however, the exosystem does not contain the developing person in at least one of the settings of the exosystem. Examples of settings that fall under the Exosystem are workplaces, communities, schools, and other centers because they indirectly influence the individual.

**Macrosystem**

The macrosystem is an all-encompassing system that consists of the other systems and the “given culture or subculture, with particular reference to the belief systems, bodies of knowledge, material resources, customs, life-styles, opportunity structures, hazards, and life course options that are embedded in each of these broader systems” (Bronfenbrenner, 1994, p. 40). The Macrosystem is comparable to a social blueprint and each culture (and subculture) has its own blueprint (or Macrosystem).

**Chronosystem**
The Chronosystem is the consideration of the environmental time and setting of the individual. In the words of Bronfenbrenner, the Chronosystem “encompasses change or consistency over time not only in the characteristics of the person but also of the environment in which that person lives” (1994, p. 40). The Chronosystem takes into consideration things such as changes in employment, residency, schools, and family structures (Bronfenbrenner, 1994). In addition to the five systems, there are two main propositions of the Ecological Model (Bronfenbrenner, 1994). The first proposition states that in order for something to have an impact on development and throughout life, it must be present constantly – this is known as proximal processes. The second proposition pertains to the degree of effect that both the individual and the environment have. Together, proposition one and proposition two speak to the reciprocity between the individual and the environment.
Resilience

With the wider applicability of resilience, term differentiation is important. Resilience differs from hope, optimism, and self-efficacy (confidence). Resilience differs from hope because hope refers the willpower (agency) and the waypower (pathways) “people have toward a goal” (Luthans, Vogelgesang & Lester, 2006, p. 30; Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle and Harney, 1991). According to Snyder and colleagues (1991), the two components of hope (willpower and waypower) are necessary and this differentiates hope from resilience (Bonanno, 2004). Luthans, Vogelgesang and Lester (2006) explain this difference, “neither component of hope encompasses the reaction to a disruptive event” (p. 30). Though hope and resilience are similar because both acknowledge the importance of flexibility, the two constructs differ as hope is purely internal and does not account for external events (Luthans, Vogelgesang & Lester, 2006). On the other hand, resilience accounts for external events because it considers responses to adverse events and circumstances.

Resilience also differs from optimism. Luthans, Vogelgesang and Lester (2006) describe optimism as a “generalized expectancy that one will experience good outcomes in life, which will lead to persistence in goal-striving” (p. 30). Luthans, Vogelgesang and Lester’s (2006) delineation of optimism is based on Scheier and Carver’s (1985) research. People who are optimists take responsibility only for positive outcomes and deflect negative events. In accordance to this tendency, optimists “may not delve into the true meaning of adversity and simply brush it off [on
the other hand] resilient people may take a more strategic and pragmatic approach to dealing with stress” (Luthans, Vogelgesang & Lester, 2006, p. 30). Moreover, optimism (as hope) does not consider the role of or responses to external events.

Resilience is not synonymous with self-efficacy (confidence) because efficacy refers to the belief that one can successfully take on and complete a task (Bandura, 1997). According to this delineation, success is a necessary condition for self-efficacy, but it is not necessary for resilience. According to Bandura (1997), the more self-efficacious a person is, the more likely they are to be on the path of resilience. This is especially true if the individual can “frame a negative event or failure as a learning experience” (Luthans, Vogelgesang & Lester, 2006, p. 31). Moreover, resilience “is what allows people to keep trying, and to restore their self-efficacy even after it has been challenged and predicted to decrease due to a setback” (Luthans, Vogelgesang & Lester, 2006, p. 31).

Another important construct differentiation relates to terms that are related, but not synonymous: resiliency and resilience (Luthar, Cicchetti & Becker, 2000). According to Luthar, Cicchetti and Becker (2000), resilience is a “dynamic process encompassing positive adaptation within the context of significant adversity. Implicit within this notion are two critical conditions: (1) exposure to significant threat or severe adversity; and (2) the achievement of positive adaptation despite major assaults on the developmental process” (p. 543). Luther and Cicchetti (2000) suggest that resiliency differs from resilience because resiliency implies a personal trait or innate characteristic. Additionally, resiliency does not imply exposure to adversity or adaptation, but resilience does. Garmezy (1985), Marin-Wexler, DiFluvio and Burke
(2009) and DiFulvio (2011), describe resilience as an amalgam of factors. Tusaie and Dyer (2004) go beyond the amalgam delineation; they describe it as a mediator between the individual and the environment and between the individual and outcomes. Resilience is more than a mediator; it is also a moderator for factors such as “positive peer relationships” (Criss, Pettit, Bates, Dodge, & Lapp, 2002). The various definitions suggest that resilience is complex and serves various roles.

It should be noted that although resiliency and resilience are distinguished here, there is a lack of consensus on the exact delineation of both terms. Some researchers use the terms interchangeably. To aid in term differentiation, Masten (2001) recommends using the term resilience only when referring to adjustment or adaptation under challenging life circumstances. Masten (2001) recommends using resilience over resiliency to describe a dynamic process. As elaborated by Luthar, Cicchetti and Becker (2000) resilience is the preferred term because resiliency “carries the connotation of a personality trait. Any scientific representation of resilience as a personal attribute can inadvertently pave the way for perceptions that some individuals simply do not “have what it takes” to overcome adversity” (p. 5). Masten also recommends caution when assessing resilience because resilience is a dynamic process that is subject to change and is developable (Masten, 200).

The literature on resilience suggests that resilience relates to health. Walker and Longmire-Avital’s research suggests that resilience buffers “negative psychological effects of social and structural injustice” (2013, p. 2). Various other scholars support the importance of resilience and its role as a buffer (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Dass-Brailsford, 2005; Garmezy, 1991; Miller & MacIntosh, 1999).
Resilience is a complex, multifaceted construct that implies exposure to adverse effects, while resiliency is not thought of as developable trait (Earvolino-Ramirez, 2007; Luthans, 2002; Luthans, Vogelgesang & Lester, 2006; Luthar, Cicchetti & Becker, 2000). For the purpose of this study, resilience is the preferred construct because it is a trait subject to change (development). Moreover, resilience is an important factor to consider because it relates to decreased severity of psychopathology (Garmezy, 1970; Masten, Best & Garmezy, 1990). Additionally, it can “protect against health risk behaviors such as suicide ideation or attempts” (Azlina & Jamaluddin, 2010). It can also “buffer the negative psychological effects of social and structural injustice” (Walker & Longmire-Avital, 2013).
Appendix E

Participant Recruitment Flyer

Hello! My name is Isabel Rodriguez and I am a doctoral student working with Dr. Jasmine Mena at the University of Rhode Island. I am currently conducting research that explores the experiences and health of sexual minorities. Currently, I am looking for non-heterosexual (lesbian, gay or bisexual) adults to respond to my study, and I need your help.

To participate, you must meet all of the following criteria:

1. You must be 18-years old or older
2. Self-identify as gay, lesbian or bisexual

If you agree to participate, you will respond to a questionnaire that will take 15-20 minutes to complete. Your participation in this study will be completely voluntary and anonymous. You will be free to withdraw from the study at any time. No personally identifying information will be required and therefore you will not be linked to any publications or presentations from this study. If you are interested in participating then visit the link below:

https://www.surveymonkey.com/r/BLGHealth

Survey participants will have the opportunity to win one of three ($75, $50, $25) Amazon E-gift cards.

If you have any questions or comments, please feel free to contact: Dr. Jasmine Mena at (401) 874-2665 or Jmena@uri.edu
Isabel Rodriguez at (401) 874-4606 or Irodrig@my.uri.edu.

Approved by the University of Rhode Island’s Institutional Review Board (IRB HU1415-021)

Thank you very much for your help!

***Please share this information with anyone else who might be interested***
Appendix F

Informed Consent Form

The University of Rhode Island
Psychology Department
Chafee Hall, Office 309
142 Flagg Road
Kingston, RI 02881
Office: (401) 874-2665
Project Title: The Role of Internalized Heterosexism in Relation to the Health of Sexual Minorities

CONSENT FORM FOR RESEARCH

You have been invited to take part in a research project described below. Please feel free to ask any questions by contacting Dr. Jasmine Mena at (401) 874-2665 or Jmena@uri.edu. You may also contact Isabel Rodriguez at (401) 874-4606 or Irodrig@my.uri.edu.

Description of the project:
This research study involves responding to a series of questions about your experiences as a Gay, Lesbian, Bisexual (LGB) adult. The goal of the study is to learn about the factors that affect the health of LGBT adults. The results will be analyzed to understand how discrimination affects health.

What will be done:
If you decide to take part in this study, your participation will involve responding to a series of questions online on SurveyMonkey that should take about 15-20 minutes.

Risks or discomfort:
There are no foreseeable risks involved in participating in this project. However, if any discomfort should arise, you have the right to immediately withdraw from the survey. You may also contact the investigators with any concerns that arise due to participation in this project.

Benefits of this study:
If you choose to participate, your answers will help increase the knowledge base about the health of LGBT adults. Additionally, answering the survey questions might increase self-awareness about your current health status.

Confidentiality:
Your participation in this study is anonymous. Your identity and individual responses will not be disclosed to anyone. Scientific reports and presentations will be based on group data and will not identify you as a participant in this project. All data will be stored in a locked facility.
Decision to quit at any time:
Your participation in this study is voluntary and there are no consequences for not participating. If you decide to take part in the study, you may refuse to answer any question or discontinue your participation at any time.

Rights and complaints:
If you are not satisfied with the way this study is performed you may discuss your complaints anonymously with Dr. Jasmine Mena at (401) 874-2665 or Jmena@uri.edu. You may also contact Isabel Rodriguez at (401) 874-4606 or Irodrig@my.uri.edu. In addition, if you have any questions about your rights as a research participant, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

Thank you for your time and participation.

Please print this consent form for your records. By clicking “NEXT” at the bottom of this screen you are acknowledging that you have read and understand the information above and freely give your consent to participate in this research study.
Appendix G

Demographics

Please indicate your:

1) Age ____________

2) Sex (select as many as apply)
   Female     Male     Transgender     Not listed, please
   indicate_______

4) Gender (select as many as apply)
   Woman     Man     Genderqueer     Not listed, please
   indicate_______

5) Race/ethnicity (select as many as apply)
   Black     White     Native American     Asian (Pacific Islander)
   Hispanic-Latino/a     Arab-Middle-Eastern     Not listed, please
   indicate_______

6) Sexual orientation
   Lesbian     Gay     Bisexual

7) Preferred sexual orientation term/identity
   ____________________________

8) Highest level of education completed
   Junior/Middle School     Some College     Bachelor’s Degree
   High School/GED     Associates Degree     Master’s/Doctoral
   Degree

9) Generational status in the United States
   1st generation (born outside the U.S.A)
   2nd generation (at least one parent was not born here)
   3rd + generation (both parents were born here)

10) How did you hear about this survey
    Flyer     Email     Friend     Website     Facebook
    Other_______
Appendix H

Mayfield’s Internalized Homonegativity Inventory

1) I believe being gay is an important part of me
2) I believe it is OK for men to be attracted to other men in an emotional way, but it’s not OK for them to have sex with each other
3) When I think of my homosexuality, I feel depressed
4) I believe that it is morally wrong for men to have sex with other men
5) I feel ashamed of my homosexuality
6) I am thankful for my sexual orientation
7) When I think about my attraction towards men, I feel unhappy
8) I believe that more gay men should be shown in TV shows, movies, and commercials
9) I see my homosexuality as a gift
10) When people around me talk about homosexuality, I get nervous
11) I wish I could control my feelings of attraction toward other men
12) In general, I believe that homosexuality is as fulfilling as heterosexuality
13) I am disturbed when people can tell I’m gay
14) In general, I believe that gay men are more immoral than straight men
15) Sometimes I get upset when I think about being attracted to men
16) In my opinion, homosexuality is harmful to the order of society
17) Sometimes I feel that I might be better off dead than gay
18) I sometimes resent my sexual orientation
19) I believe it is morally wrong for men to be attracted to each other
20) I sometimes feel that my homosexuality is embarrassing
21) I am proud to be gay
22) I believe that public schools should teach that homosexuality is normal.
23) I believe it is unfair that I am attracted to men instead of women

*The highlighted items were modified to create the IHNI-Modified

*Factors of the IHNI:
   A) Factor 1: Personal homonegativity (11 items)
Composed of items: 5, 3, 17, 20, 13, 18, 10, 7, 15, 23, 11

B) Factor 2: Gay affirmation (7 items)
   Composed of items: 6, 9, 21, 1, 22, 12, 8

C) Factor 3: Morality of homosexuality (5 items)
   Composed of items: 19, 16, 4, 14, 21
Appendix I

Mayfield’s Internalized Homonegativity Inventory-Modified (IHNI-M)

Please rate your degree of agreement/disagreement with the following statements
○Strongly Disagree  ○Disagree  ○Somewhat Disagree ○Somewhat Agree  ○Agree  ○Strongly Agree

1) I believe being gay/lesbian/bisexual is an important part of me
2) I believe it is OK for individuals to be attracted to other individuals of the same gender in an emotional way, but it’s not OK for them to have sex with each other
3) When I think of my sexuality, I feel depressed
4) I believe that it is morally wrong for individuals of the same gender to have sex with individuals of the same gender
5) I feel ashamed of my sexual orientation
6) I am thankful for my sexual orientation
7) When I think about my attraction towards others, I feel unhappy
8) I believe that more gay/lesbian/bisexual individuals should be shown in TV shows, movies, and commercials
9) I see my sexuality as a gift
10) When people around me talk about sexual orientation, I get nervous
11) I wish I could control my feelings of attraction toward others
12) In general, I believe that the sexuality of gay/lesbian/bisexual individuals is as fulfilling as the sexuality of heterosexual individuals
13) I am disturbed when people can tell I’m gay/lesbian/bisexual
14) In general, I believe that gay/lesbian/bisexual individuals are more immoral than heterosexual individuals
15) Sometimes I get upset when I think about being attracted to individuals of the same gender
16) In my opinion, being gay/lesbian/bisexual is harmful to the order of society
17) Sometimes I feel that I might be better off dead than gay/lesbian/bisexual
18) I sometimes resent my sexual orientation
19) I believe it is morally wrong for individuals to be attracted to individuals of the same gender
20) I sometimes feel that my sexual orientation is embarrassing

21) I am proud to be gay/lesbian/bisexual

22) I believe that public schools should teach that being gay/lesbian/bisexual is normal

23) I believe it is unfair that I am attracted to men/women instead of women/men (or both)
Appendix J

**Connor-Davidson Resilience Scale-10 (CD-RISC-10)**

Please indicate how much you agree with the following statements.
- Not True at All
- Rarely True
- Sometimes True
- Often True
- True Nearly All of the Time

1) I am able to adapt to change
2) I can deal with whatever comes my way
3) I try to see the humorous side of things when I am faced with problems
4) Having to cope with stress can make me stronger
5) I tend to bounce back after illness, injury, or other hardships
6) I believe I can achieve my goals, even if there are obstacles
7) Under pressure, I stay focused and think clearly
8) I am not easily discouraged by failure
9) I think of myself as strong person when dealing with life’s challenges and difficulties
10) I am able to handle unpleasant or painful feelings like sadness, fear, and anger
Appendix K

Health Perceptions Questionnaire (HPQ)

Please read each of the following statements, and then circle one of the numbers on each line to indicate whether the statement is true or false for you.

There are no right or wrong answers.
If a statement is definitely true for you, circle 5
If it is mostly true for you, circle 4
If you don’t know whether it is true or false, circle 3
If it is mostly false for you, circle 2
If it is definitely false for you, circle 1

Some of the statements may look or seem like others. But each statement is different, and should be rated by itself.

<table>
<thead>
<tr>
<th>Definitely true</th>
<th>Mostly true</th>
<th>Don’t know</th>
<th>Mostly false</th>
<th>Definitely false</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

A. According to the doctors I’ve seen, my health is now excellent
B. I try to avoid letting illness interfere with my life
C. I seem to get sick a little easier than other people
D. I feel better now than I ever have before
E. I will probably be sick a lot in the future
F. I never worry about my health
G. Most people get sick a little easier than I do
H. I don’t like to go to the doctor
I. I am somewhat ill
J. In the future, I expect to have better health than other people I know
K. I was so sick once I thought I might die
L. I’m not as healthy now as I used to be
M. I worry about my health more than other people worry about their health
N. When I’m sick, I try to just keep going as usual
O. My body seems to resist illness very well
P. Getting sick once in a while is a part of my life
Q. I’m as healthy as anybody I know
R. I think my health will be worse in the future than it is now
S. I’ve never had an illness that lasted a long period of time
T. Others seem more concerned about their health than I am about mine
U. When I’m sick, I try to keep it to myself
V. My health is excellent
W. I expect to have a very healthy life
X. My health is a concern to my life
Y. I accept that sometimes I’m just going to be sick
Z. I have been feeling bad lately
AA. It doesn’t bother me to go to a doctor
BB. I have never been seriously ill
CC. When there is something going around, I usually catch it
DD. Doctors say that I am now in poor health
EE. When I think I am getting sick, I fight it
FF. I feel about as good now as I ever have
GG. During the past 3 months, how much has your health worried or concerned you? (circle one)
    A great deal ...................... 1
    Somewhat  ....................... 2
    A little  ......................... 3
    Not at all  ...................... 4

*General Health Rating Index Items:

**Six subscales:
    1) Current health (nine items)
       A, D, I, L, Q, V, Z, DD, FF
    2) Prior health (three items)
       K, S, BB
    3) Health outlook (four items)
       E, J, R, W
    4) Resistance to illness (four items)
       C, G, O, CC
5) Health worry, /concern (five items)
   F, M, T, X, GG
6) Sickness orientation (two items)
   P, Y
Appendix L

**Mental Health Inventory-18 (MHI-18)**

The next set of questions are about how you feel, and how things have been for you during the past 4 weeks. Please answer every question. If you are not sure which answer to select, please choose the one answer that comes closest to describing you.

**During the past 4 weeks, how much of the time...**

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

1. has your daily life been full of things that were interesting to you?
2. did you feel depressed?
3. have you felt loved and wanted?
4. have you been a very nervous person?
5. have you been in firm control of your behavior, thoughts, emotions, feelings?
6. have you felt tense or high-strung?
7. have you felt calm and peaceful?
8. have you felt emotionally stable?
9. have you felt downhearted and blue?
10. were you able to relax without difficulty?
11. have you felt restless, fidgety, or impatient?
12. have you been moody, or brooded about things?
13. have you felt cheerful, light-hearted?
14. have you been in low or very low spirits?
15. were you a happy person?
16. did you feel you had nothing to look forward to?
17. have you felt so down in the dumps that nothing could cheer you up?
18. have you been anxious or worried?

*Four subscales
  1) Anxiety
  2) Depression
  3) Behavioral Control
  4) Positive Affect*
Appendix M

Participant Recruitment Flyer- Spanish

¡Hola! Mi nombre es Isabel Rodríguez y soy una estudiante bajo la supervisión de la Dra. Jasmine Mena en la Universidad de Rhode Island. Estoy realizando una investigación que explora las experiencias y la salud de las minorías sexuales. Estoy buscando adultos que no sean heterosexuales (lesbiana, gay o bisexual) que pueda responder a mi cuestionario y necesito su ayuda.

Para participar, usted debe:

1. Tener 18 años o más
2. Identificarse como gay, lesbiana o bisexual

Si decide participar, usted responderá a un cuestionario que le llevará 15-20 minutos para completar. Su participación en este estudio será completamente voluntaria y anónima. Usted tendrá la libertad de retirarse del estudio en cualquier momento.

No se requiere información que le pueda identificar para participar en este estudio, por lo tanto, no será identificado/a en ninguna publicación o presentación. Si usted está interesado/a en participar, visite este sitio de web:

https://es.surveymonkey.com/r/SaludBLG

Participantes tendrán la oportunidad de ganarse una de tres ($75, $50, $25) tarjetas de regalo a Amazon.

Si usted tiene alguna pregunta o comentario, no dude en contactar a:
Dra. Jasmine Mena a (401) 874-2665 o Jmena@uri.edu
Isabel Rodriguez a (401) 874-4606 o Irodrig@my.uri.edu.

Aprobado por la Junta de Revisión (IRB) de la Universidad de Rhode Island (IRB HU1415-021)

Muchas gracias por su ayuda!

*Por favor, comparta esta información con alguien que le pueda interesar este estudio*
La Universidad de Rhode Island  
Departamento de Psicología  
Chafee Hall, Office309  
142 Flagg Road  
Kingston, RI 02881  
Oficina: (401) 874-2665  
Título del Proyecto: Bajo construcción  

FORMA DE CONSENTIMIENTO INFORMADO

Usted ha sido invitado/a a participar en una investigación que se describe a continuación. Si tiene alguna pregunta, por favor siéntase libre de contactar a la Dra. Jasmine Mena a (401) 874-2665 o Jmena@uri.edu. También puede contactar a Isabel Rodriguez a (401) 874-4606 o Irodrig@my.uri.edu.

Descripción del la investigación:
Esta investigación requiere que responda a una serie de preguntas sobre sus experiencias como un adulto/a lesbiana, gay o bisexual. El objetivo de esta investigación es aprender más sobre los factores que afectan la salud de los adultos LGB. Los resultados serán analizados para entender cómo la discriminación afecta a la salud.

Qué se hará:
Si usted decide participar en este estudio, su participación implicará responder a una serie de preguntas en el sitio de web SurveyMonkey. Tomará 15-20 minutos completar el cuestionario.

Riesgos o incomodidades
No hay riesgos previsibles involucrados con la participación en esta investigación. Sin embargo, si se presenta alguna molestia, usted tiene el derecho de retirarse inmediatamente del cuestionario. También puede contactar a las investigadoras de la investigación si tiene alguna preocupación debido a su participación.

Beneficios de este estudio:
Si decide participar, sus respuestas ayudarán a aumentar la base de conocimientos sobre la salud de los adultos LGB. Además, si responde al cuestionario, podría aumentar su conocimiento sobre su estado de salud.

Confidencialidad:
Su participación en este cuestionario es anónimo. Su identidad y sus respuestas no serán reveladas a nadie. Reportes y presentaciones científicas que se basan en los
datos de esta proyecto serán presentados en grupo y no abra forma de identificarlo/a. Además, todos los datos de esta investigación serán guardados bajo llave.

**Decisión de abandonar la encuesta en cualquier momento:**
Su participación en esta investigación es voluntaria y no hay consecuencias por no participar. Si decide participar en esta investigación, usted puede negarse a contestar cualquier pregunta o suspender su participación en cualquier momento.

**Derechos y quejas:**
Si usted no está satisfecho/a con la forma en que este estudio se lleva a cabo, usted puede contactar anónimamente a la Dra. Jasmine Mena a (401) 874-2665 o a Jmena@uri.edu. También puede comunicarse con Isabel Rodríguez a (401) 874-4606 o Irodrig@my.uri.edu. Además, si usted tiene alguna pregunta sobre sus derechos como participante en esta investigación, puede comunicarse con la Oficina del Vicepresidente de Investigación a (401) 874-4328 (70 Lower College Road, Suite 2, La Universidad de Rhode Island, Kingston, Rhode Island).

Gracias por su tiempo y participación.

Por favor imprima esta forma para sus archivos. Al hacer clic en "Siguiente" en la parte inferior de esta pantalla, usted reconoce que ha leído y entendido la información anterior y libremente da su consentimiento para participar en este estudio.
Appendix O

Demographics – Spanish (Datos Demográficos)

Por favor indique su:

1) Edad ____________

2) Sexo (seleccione todas las que correspondan)
   - Femenina
   - Masculino
   - Transgenero
   - No está escrito, por favor indique___

3) Genero (seleccione todas las que correspondan)
   - Mujer
   - Hombre
   - Genderqueer
   - No está escrito, por favor indique___

4) Raza/Etnicidad (seleccione todas las que apliquen)
   - Afro-Americano/a - Negro/a
   - Blanco/a
   - Asiático/a(Islas Pacificas)
   - Hispano/a – Latino/a
   - Indio/a Americano/a – Nativo de Alaska
   - Árabe/ Del Medio Oriente

5) Orientación sexual
   - Lesbiana
   - Gay
   - Bisexual

6) Termino preferido
   ___________________________________

7) Ultimo nivel de estudios completados
   - Escuela Primaria/Básica
   - Algunos años de universidad/collegio
   - Licenciatura
   - Escuela Secundaria
   - Asociado
   - Escuela de posgrado (maestría/doctorado)

8) Estatus generacional en los Estados Unidos (E.U.)
   - Generación 1 (Nació fuera de los E.U.)
   - Generación 2 (Al menos un padre nació fuere de los E.U.)
   - Generación 3+ (Nació en los E.U.)

9) Cómo se enteró de esta encuesta
   - Volante/ folleto
   - Correo electrónico
   - Amiga/o
   - Sitio de web
   - Facebook
   - De otra forma__________
Appendix P

Mayfield’s Internalized Homonegativity Inventory-Modified – Spanish

(Inventario de la Internalización de Homonegatividad-Modificado-IHNI-M)

Por favor índice su nivel de acuerdo o desacuerdo con las siguientes frases
○ Completamente desacuerdo ○ Desacuerdo ○ Algo desacuerdo
○ Algo de acuerdo ○ Acuerdo ○ Completamente de acuerdo

1) Yo creo que ser gay/lesbiana/bisexual es una parte importante de mi
2) Yo creo que está bien que hombres estén atraídos a otros hombres y mujeres a otras mujeres en una manera emocional, pero no está bien que tengan sexo
3) De que pienso sobre mi sexualidad, yo me siento deprimido/a
4) Yo creo que es moralmente incorrecto que hombres tengan sexo con otros hombres y mujeres con otras mujeres
5) Yo me siento avergonzado/a sobre mi orientación sexual
6) Yo estoy agradecido/a por mí orientación sexual
7) Cuando pienso sobre mi atracción a otros, yo me siento infeliz
8) Yo creo que más gente gay/lesbiana/bisexual deberían estar presente en programas de televisión, películas y comerciales
9) Yo veo mi sexualidad como algo especial
10) Cuando la gente a mi alrededor hablan sobre orientaciones sexuales, me siento nervioso/a
11) Yo deseo poder controlar mis sentimientos de atracción hacia otros
12) En general, yo creo que mi sexualidad me llena, igualmente como la sexualidad de alguien heterosexual
13) Yo me siento perturbado/a cuando la gente puede reconocer que soy lesbiana/gay/bisexual
14) En general, yo creo que la gente lesbiana/gay/bisexual es más inmoral que la gente heterosexual
15) A veces me entristezco al pensar sobre mi atracciones
16) En mi opinión, la homosexualidad/bisexualidad es dañino para la orden social
17) A veces yo siento que tal vez estaría mejor muerto/a que lesbiana/gay/bisexual
18) A veces yo resiento mi orientación sexual
19) Yo creo que es moralmente mal que hombres sean atraídos el uno al otro y que mujeres sean atraídas unas a otras
20) A veces siento que mi orientación sexual es embarazoso
21) Yo estoy orgulloso/a de ser lesbiana/gay/bisexual
22) Yo creo que las escuelas públicas deberían enseñar que la homosexualidad/bisexualidad es normal
23) Yo creo que es injusto que sea atraído a hombres en vez de mujeres o que sea atraída a mujeres en vez de hombres (o ambos)
Appendix Q

Connor-Davidson Resilience Scale-10 (CD-RISC-10) – Spanish

(Connor-Davidson Escala de Resiliencia – 10)

Por favor índice su nivel de acuerdo o desacuerdo con las siguientes frases
○ Nada cierto ○ Rara vez es cierto ○ A veces es cierto ○ A menudo es cierto
○ Cierto casi todo el tiempo

1) Yo soy capaz de adaptarme a los cambios
2) Yo puedo enfrentarme con todo lo que encuentro en mi camino
3) Yo veo el lado gracioso de las cosas
4) Lidiar con el estrés me fortalece
5) Yo tiendo a recuperarme después de una dificultad o enfermedad
6) Yo puedo conseguir mis metas
7) Bajo presión, me concentro y pienso con claridad
8) Yo no me desanimo fácilmente por el fracaso
9) Yo pienso en mí mismo como una persona fuerte
10) Yo puedo manejar los sentimientos desagradables
Appendix R

Health Perceptions Questionnaire (HPQ)

(Cuestionario de Percepción de Salud)

Por favor lea las siguientes frases y después circule uno de los números en cada linda para indicar si la frase es falsa o verdadera para usted.

No hay respuestas correctas o incorrectas
   Si esta frase es completamente cierta para usted, circule 5
   Si esta frase es mayormente cierta para usted, circule 4
   Si no sabe si esta frase es verdadera o falsa para usted, circule 3
   Si esta frase es mayormente falsa para usted, circule 2
   Si esta frase es completamente falsa para usted, circule 1

Algunas de estas frases pueden aparecer como las demás. Pero cada frase es diferente y debe ser evaluada por sí misma.

<table>
<thead>
<tr>
<th>Completamente Cierto</th>
<th>Mayormente Cierto</th>
<th>No Se</th>
<th>Mayormente Falso</th>
<th>Falso</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

A. Según los doctores que he visitado, mi salud ahora es excelente
B. Yo trato de evitar que las enfermedades interfirieran con mi vida
C. Parase que me enfermo más fácilmente que otra gente
D. Me siento mejor ahora que antes
E. Yo probablemente estaré enfermo/a bastante en el futuro
F. Yo nunca me preocupo de mi salud
G. L mayoría de las personas se enferman un poco más fácilmente que yo
H. A mí no me gusta ir al doctor
I. Yo estoy algo mal
J. En el futuro, yo espero tener mejor salud que otras personas que conozco
K. Una vez yo estaba tan enfermo/a que pensé que me podía morir
L. No estoy tan sano/a ahora como antes solía estar
M. Yo me preocupo sobre mi salud más que otra gente se preocupa sobre su salud
N. Cuando estoy enfermo/a, yo trato de seguir adelante como siempre
O. Mi cuerpo parece resistir enfermedades bien
P. Enfermarse de vez en cuando es parte de mi vida
Q. Yo soy igual de saludable como cualquier otra persona que conozco
R. Yo creo que mi salud va a estar peor en el futuro de lo que está ahora
S. Yo nunca he tenido una enfermedad que ha durado un largo período de tiempo
T. Otros parecen más preocupados por su salud que yo sobre la mía
U. Cuando estoy enfermo/a, yo no le digo a nadie
V. Mi salud es excelente
W. Yo espero tener una vida muy saludable
X. Mi salud es una preocupación en mi vida
Y. Yo acepto que a veces me voy a enfermar
Z. Me he estado sintiendo mal últimamente
AA. No me molesta ir al doctor
BB. Yo nunca he estado seriamente enfermo/a
CC. Cuando hay alguna enfermedad alrededor, generalmente yo la contraigo
DD. Doctores dicen que ahora estoy en mal estado de salud
EE. Cuando creo que me estoy enfermando, yo lo combato
FF. Yo me siento tan bien ahora como siempre
GG. Durante los últimos 3 meses, ¿Cuánto se ha preocupado sobre su salud? (circule uno)

   Bastante ................. 1
   Algo ...................... 2
   Un poco ................... 3
   Nada ...................... 4
Appendix S

Mental Health Inventory-18 (MHI-18) – Spanish
(Inventario de Salud Mental-18)

Las siguientes preguntas son sobre cómo se siente y como las cosas han ido para usted durante las últimas 4 semanas. Por favor responda todas las preguntas. Si no está seguro/a de que respuesta seleccionar, por favor elija la respuesta que más le describa

Durante las últimas 4 semanas, ¿cuanto tiempo...

<table>
<thead>
<tr>
<th>Todo el tiempo</th>
<th>Mayor parte del tiempo</th>
<th>Buena parte del tiempo</th>
<th>Una parte del tiempo</th>
<th>Un poco del tiempo</th>
<th>Nunca</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

1. ha sentido que su vida diaria estada llena de cosas que le interesan?
2. se ha sentido deprimido/a?
3. se ha sentido amado/a y querido/a?
4. ha sido una persona muy nerviosa?
5. ha estado en control firme de su comportamiento, pensamientos, emociones y sentimientos?
6. se ha sentido tenso/a?
7. se ha sentido calmado/a o tranquilo/a?
8. se ha sentido emocionalmente estable?
9. se ha sentido desanimado/a y triste?
10. ha sido capaz de relajarse sin dificultad?
11. se ha sentido inquieto/a o impaciente?
12. ha estado de mal humor o extremamente molesto/a por cosas?
13. se ha sentido alegre, contento/a?
14. se ha sentido mal o con moral bajo/a?
15. ha sido una persona feliz?
16. ha sentido como si no tiene nada que anticipar?
17. se ha sentido tan mal que nada podía animarlo/a?
18. se ha sentido ansioso/a o preocupado/a?
Appendix T

Examples of LGBT Recruitment Listservs

Rhode Island

Educational Institutions
- University of Rhode Island
- Rhode Island College
- Brown University
- Providence College
- Salve Regina University
- Bryant University
- Rhode Island School of Design
- Roger Williams University
- Johnson & Wales University
- Community College of Rhode Island
- New England Institute of Technology

LGBT Organizations
- Rhode Island Pride
- Rhode Island Association of Gay Professionals
- Options Rhode Island
- Meet Up: Lesbians Out and About Rhode Island
- Parents, Families and Friends of Lesbians and Gays
- Providence Gay Men’s Chorus
- Newport Out

New York

Educational Institutions
- Adelphi University
- The Ailey School
- Albany College of Pharmacy and Health Sciences
- Albany Law School
- Alfred State University
- Alfred University
- American Academy McAllister Institute
- American Academy of Dramatic Arts

LGBT Organizations
- Ali Forney Center
- American Civil Liberties Union (ACLU) LGBT Project
- Bridge, Inc
- Brooklyn Community Pride Center
- Callen-Lorde Community Health Center
- FIERCE!
- Gay & Lesbian Switchboard of Long Island
- Gay & Lesbian Youth Services
- Gay Alliance of the Genesee Valley - Rochester, NY
- Gay, Lesbian, Straight Education Network (GLSEN)
- GLYS is the acronym for Gay & Lesbian Youth Services of WNY!
- God’s Love We Deliver
- Long Island Gay and Lesbian Youth (LIGALY)
- Men of Color Health Awareness Project (MOCHA)
- Neutral Zone
- New York Area Bisexual Network
- The Center (The Lesbian Gay Bisexual & Transgender Community Center)
- The Door
- The Loft
- Youth Resource
Appendix U
Resource for participants

At the beginning of the survey
For resources, please follow one of the links below:

24-Hour Crisis Hotline
http://www.crisiscallcenter.org/
http://www.suicidepreventionlifeline.org/
800-273-8255

http://samaritansnyc.org/
212-673-3000

24-Hour Lifeline for LGBT Individuals
http://www.thetrevorproject.org/pages/get-help-now#lifeline
866-488-7386

LGBT Centers
National Gay and Lesbian Task Force www.thetaskforce.org
Out Proud and Healthy http://www.outproudandhealthy.org/
GLBT National Help Center
http://www.glbtnationalhelpcenter.org/

At the end of the survey
Some of the survey questions may have brought up unwanted thoughts/feelings
that you may want to discuss with someone. For resources, please follow one
of the links below:

24-Hour Crisis Hotline
http://www.crisiscallcenter.org/
http://www.suicidepreventionlifeline.org/
800-273-8255

http://samaritansnyc.org/
212-673-3000

24-Hour Lifeline for LGBT Individuals
http://www.thetrevorproject.org/pages/get-help-now#lifeline
866-488-7386

LGBT Centers
National Gay and Lesbian Task Force www.thetaskforce.org
Out Proud and Healthy http://www.outproudandhealthy.org/
GLBT National Help Center
http://www.glbtnationalhelpcenter.org/
Appendix V

Resource for Spanish-speaking participants

At the beginning of the survey
Para recursos, por favor llame o vaya a:

Línea disponible 24-horas para crisis
http://www.youmatter.suicidepreventionlifeline.org/get-help/getting-hel/#sthash.xu1kF2S2.dpuf
http://www.suicidepreventionlifeline.org/gethelp/spanish.aspx
888-628-9454

Línea disponible 24-horas para gente LGBT
http://www.thetrevorproject.org
866-488-7386

Centro LGBT
Somos Saludables http://www.saludlgbttta.org/

At the end of the survey
Algunas de las preguntas de esta encuesta pueden haber criado pensamientos o sentimientos no deseados. Si quiere hablar con alguien o desea recursos, por favor llame o vaya a:

Línea disponible 24-horas para crisis
http://www.youmatter.suicidepreventionlifeline.org/get-help/getting-hel/#sthash.xu1kF2S2.dpuf
http://www.suicidepreventionlifeline.org/gethelp/spanish.aspx
888-628-9454

Línea disponible 24-horas para gente LGBT
http://www.thetrevorproject.org
866-488-7386

Centro LGBT
Somos Saludables http://www.saludlgbttta.org/
Table 1

*Reliability Scores of Mayfield’s Internalized Homonegativity Inventory-Modified (IHNI-M)*

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHNI-M Global Scale</td>
<td>0.926</td>
</tr>
<tr>
<td>IHNI-M Personal Sexuality</td>
<td>0.943</td>
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<tr>
<td>IHNI-M IH Affirmation</td>
<td>0.761</td>
</tr>
<tr>
<td>IHNI-M Morality</td>
<td>0.650</td>
</tr>
</tbody>
</table>
Table 2

*Reliability Scores of Connor-Davidson Resilience Scale-10 (CD-RIS-10)*

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
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<tbody>
<tr>
<td>(CD-RIS-10)-Global Scale</td>
<td>0.862</td>
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Table 3

Reliability Scores of Health Perceptions Questionnaire (HPQ)

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPQ Prior Health</td>
<td>0.764</td>
</tr>
<tr>
<td>HPQ General Health</td>
<td>0.884</td>
</tr>
<tr>
<td>HPQ Resistance to Illness</td>
<td>0.775</td>
</tr>
<tr>
<td>HPQ Health Outlook</td>
<td>0.812</td>
</tr>
<tr>
<td>HPQ Health Worry</td>
<td>0.510</td>
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<tr>
<td>HPQ Sickness Orientation</td>
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</table>
Table 4

*Reliability Scores of Mental Health Inventory-18 (MHI-18)*

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
<th>Cronbach’s Alpha</th>
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</thead>
<tbody>
<tr>
<td>MHI-18 Global Mental Health</td>
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<tr>
<td>MHI-18 Anxiety</td>
<td>0.879</td>
</tr>
<tr>
<td>MHI-18 Depression</td>
<td>0.924</td>
</tr>
<tr>
<td>MHI-18 Behavioral Control</td>
<td>0.815</td>
</tr>
<tr>
<td>MHI-18 Positive Affect</td>
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Table 5

Sample Characteristics

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<td>Bisexual</td>
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<tr>
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</tr>
<tr>
<td>Associate's Degree</td>
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<td>Other</td>
<td>5</td>
</tr>
<tr>
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<td>Generation Status</td>
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<tr>
<td>Graduate Degree</td>
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<td>First Generation</td>
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<td></td>
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<tr>
<td></td>
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</table>
Table 6

*Central Tendencies of the Measures*

<table>
<thead>
<tr>
<th>Scale &amp; Subscales</th>
<th>N</th>
<th>Range (Min-Max)</th>
<th>Mean</th>
<th>Standard Deviation</th>
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<tr>
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<td>42 (18-60)</td>
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<td>9.962</td>
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<td>55 (7-62)</td>
<td>20.72</td>
<td>11.178</td>
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<tr>
<td>IHNI-M Affirmation</td>
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<tr>
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<td>91 (19-110)</td>
<td>65.93</td>
<td>16.346</td>
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<tr>
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<td>29 (11-40)</td>
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<td>28 (21-49)</td>
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<tr>
<td>HPQ Prior Health</td>
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<td>13 (2-15)</td>
<td>9.57</td>
<td>4.441</td>
</tr>
<tr>
<td>HPQ Health Outlooks</td>
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<td>16 (4-20)</td>
<td>13.46</td>
<td>3.497</td>
</tr>
<tr>
<td>HPQ Illness Resistance</td>
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<td>15 (4-19)</td>
<td>12.71</td>
<td>3.746</td>
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<td>HPQ Health Worry</td>
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Table 7

*Distribution: Skewness & Kurtosis of all Scales & Subscales*

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<th>Skewness Statistic</th>
<th>Skewness Std. Error</th>
<th>Kurtosis Statistic</th>
<th>Kurtosis Std. Error</th>
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<td>Age</td>
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<td>0.245</td>
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<td>IHNI-M Personal Sexuality</td>
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<td>2.668</td>
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<td>IHNI-M Affirmation</td>
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<td>IHNI-M Morality</td>
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Table 8

*Correlations of the Scales & Subscales of Interest (Pre-Imputation)*

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<th>MIHI Global Scale</th>
<th>CD-RIS-10 Resilience</th>
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*Correlations of the Scales & Subscales of Interest (Post-Imputation)*

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<th>MIHI Global Scale</th>
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Table 10

**Hierarchical Multiple Regression Results of Mental Health**

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Table 11

Hierarchical Multiple Regression Results of Physical Health

<table>
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<th>P</th>
<th>F</th>
<th>df</th>
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Figure A. Continuum depiction of sex, gender and sexual orientation.
Figure B. Models in which resilience is the moderator in the relationship between IHN and physical health (a) and IHN and mental health (b).
Total number of times the survey was accessed: **218**

Participants excluded because they did not meet the study’s eligibility criteria: **69**

Participants excluded because they did not agree to the consent process: **14**

Participants excluded because they did not complete any of the survey items post consent: **36**

Total number of participants left for analysis: **99**

*Figure C. Participant flow chart*
**Figure D. Survey Procedure and Items**

Preliminary Question 1: Age Criteria
- Meets Criteria
- Did not Meet Criteria

Preliminary Question 2: Sexual Identity Criteria
- Meets Criteria
- Did not Meet Criteria

Preliminary Question 3: Race/Ethnicity Criteria
- Meets Criteria
- Did not consent

Consent Form
- Consents
- Did not consent

Resources
- Declined to proceed

Demographics
- Declined to proceed

Internalized Heteronegativity (IHNI-Modified): **23 items**
- Declined to proceed

Resilience (CD-RISC): **10 items**
- Declined to proceed

Physical Health (HPQ): **33 items**
- Declined to proceed

Mental Health (MHI): **18 items**
- Declined to proceed

Resources
- Declined to proceed

Raffle & Further Contact
- Declined to raffle

Raffle Link
Figure E. Interaction effects of resilience on perceptions of global physical health. Results revealed that as IHN increases, global physical health decreases. The relationship is statistically significant for those with moderate and high levels of resilience.
Figure F. Summary of missing data
Bibliography


doi:10.1177/0011000008319285


Mink, M.D., Lindley, L.L., & Weinstein, A.A. (2014). Stress, stigma, and sexual


