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Early Relational Experiences and Poor Psychological and Social Outcomes as Mediated by
Internalized Heterosexism in Sexual Minority Women:
Illustration of a Theoretical Model

BY
Katharine Williams, Ph.D.

*A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the
requirements for the degree of Doctor of Psychology, The City University of New York*

2016

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THE CITY UNIVERSITY OF NEW YORK

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ABSTRACT

Early Relational Experiences and Poor Psychological and Social Outcomes as Mediated by Internalized Heterosexism in Sexual Minority Women: Illustration of a Theoretical Model

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Katharine Williams, Ph.D.

Advisor: Steven Tuber, Ph.D.

Research has indicated that LGB (lesbian, gay, bisexual) individuals are at elevated risk for psychopathology when compared with their heterosexual peers, a finding that was highlighted in the Institute of Medicine's report on The Health of LGBT People (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; IOM, 2011; King et al., 2008). Sexual minorities and sexual minority couples also have been found to have greater romantic relationship difficulties than heterosexual peers (Balsam & Szymanski, 2005; Frost & Meyer, 2009; Mays, Cochran, & Roeder, 2003; Meyer & Dean, 1998; Otis, Rostosky, Riggle, Hamrin, & Cramer, 2006; Spencer & Brown, 2007). Therefore, this study targeted sexual minorities exclusively and separately from their heterosexual peers to elucidate the patterns of vulnerabilities that underlie poor outcomes and to better account for resilience and positive outcomes when observed. This study premised that individuals in society are often exposed to homophobic beliefs. For LBG persons, this exposure occurs at an early age and throughout the lifespan. These beliefs are subsequently internalized and can lead to negative feelings about oneself as a sexual being with same sex attractions. This last process is termed "internalized homophobia" or "internalized heterosexism" abbreviated as (IH). However, many sexual minorities are able to counter, manage, and even learn to accept that they have internalized

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certain heterosexist assumptions from the larger society, even as they love, form healthy romantic relationships, work, and lead fulfilling adult lives --- in a word, these individuals tend to have a lesser degree of internalized heterosexism and suffer less from negative psychological and social outcomes, even in the face of heterosexist attitudes held by society, and often held by those whom they value most.

This study found that negative psychological and social outcomes, including psychological distress, low self-esteem, poor romantic relationship quality, and poor social supports, related to negative early relational experiences and negative evaluations of the self as a sexual being. Specifically, negative outcomes were moderately, but significantly, predicted by negative early relational experiences, a factor comprised of the following three variables: insecure attachment to the primary caregiver/s, early relational trauma, and negative parental attitudes toward homosexuality. In addition, one-third of the relationship found between early relational difficulties, and later negative outcomes, was explainable by the presence of a high degree of internalized heterosexism within the sexual minority women in this sample. Overall, this study has provided empirical support for the mediating role of internalized heterosexism in the lives of sexual minority women who have had early traumatic, rejecting, and abusive experiences, and now suffer from negative psychological and social outcomes. Therefore, this study supports the need for the creation of better social and clinical interventions aimed at understanding and ameliorating internalized heterosexism to reduce risk and foster adaptation in this marginalized group with relational difficulties and psychological distress.

Keywords: sexual minority, LGB, internalized heterosexism, internalized homophobia, psychological distress, early trauma, relational problems, same sex couples, insecure attachment

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CHAPTER 1

Introduction

The issue of why lesbian, gay, and bisexual individuals (LGB), or for short, “sexual minorities,” experience elevated rates of psychological and social difficulties is a complex one, this study offered a theoretical model that was both explanatory and testable. This targeted study of sexual minority women, focused on separately from males, transgendered individuals, and heterosexual women, was based on a belief that there are patterns of vulnerabilities that underlie poor outcomes that have been reported, as well as experiences that increase resilience and the likelihood of positive outcomes.

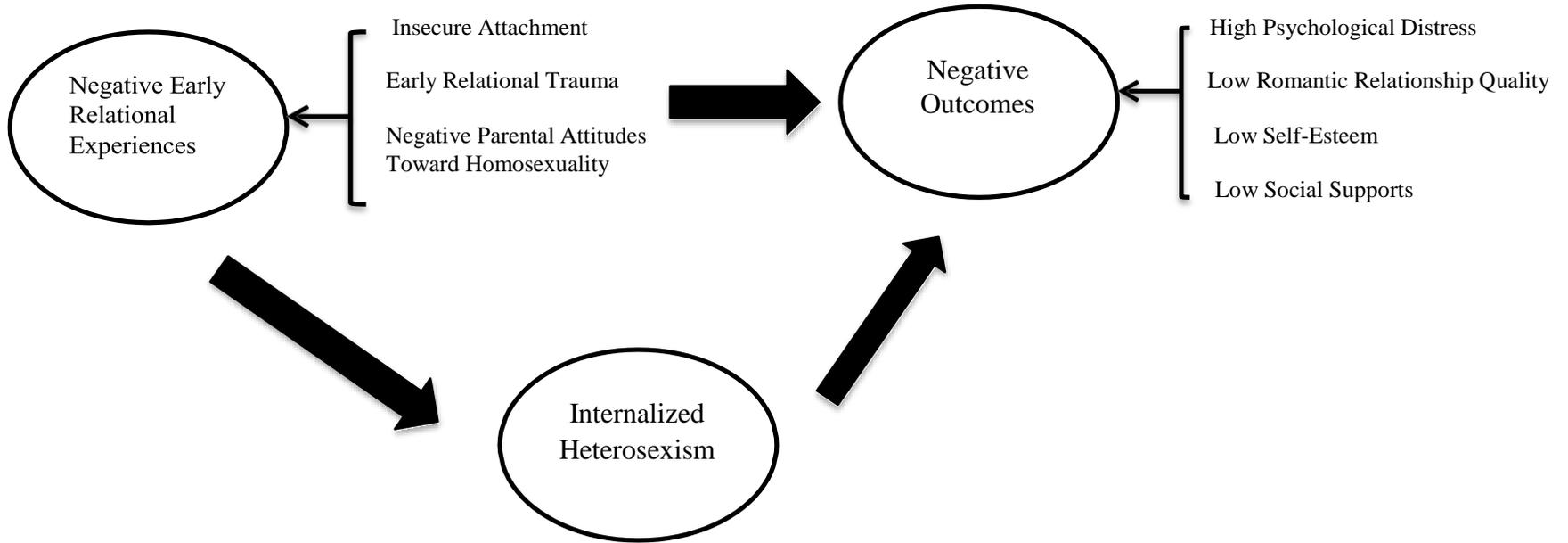
It was hypothesized in this study (see figure 1) that negative outcomes were related to an overall latent construct or factor of negative early relational experiences that included the following three variables: insecure attachment to a primary caregiver/s, early relational trauma, negative parental attitudes toward homosexuality. This study also looked at whether the construct of early relational trauma predicted the construct of negative outcomes occurring in the present day, which includes psychological distress, poor self-esteem, poor romantic relationship quality, and poor social support. This relationship was also hypothesized to be mediated by the construct of high internalized heterosexism, which was defined as negative feelings about oneself as a sexual being with same sex attractions.

The model proposed that early relational problems included problematic attachment with the primary caregiver/s, the experience of early relational trauma (i.e., physical, sexual and/or emotional abuse), and parental models that were intolerant of homosexual desire that were then introjected, leading individuals to feel especially conflicted when they came to recognize their

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sexual minority attractions. The explanation for the increased risk for the negative outcomes was via an identificatory process (identification with an aggressor). Ferenczi (1933) introduced the concept of “identification with the aggressor,” focusing on the experience of emotional abandonment of the traumatized individual, and his or her subsequent dissociative identification with the aggressor that then was projected onto others. The helplessness of the abused child was thereby disowned, and the recognition of helplessness, vulnerability, or need in others was often violently rejected as it served as a painful reminder of the self-experience. This process caused the individual to internalize heterosexist beliefs in a particularly rigid manner, resulting in the deleterious adult outcomes previously cited. Specifically, levels of internalized heterosexism were hypothesized to mediate the negative outcomes of increased psychological distress, decreased self-esteem, decreased romantic relationship quality, and decreased social supports.

Figure 1: Theoretical Model for the Proposed Study



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Delimitation of Scope and Definition of Major Terminology

In this study, “women” was used to refer to individuals who were born female, and continued to identify as such, as this study did not include transgendered individuals. The term “lesbian” was used broadly to define those women who experienced ongoing sexual attractions to women, have had some sexual experiences with a woman, and/or who self-identify as lesbian. In this review, “bisexual” was used broadly to refer to women who experience ongoing attractions to both men and women, have had some sexual experience with men and women, and/or who self-identify as bisexual. Women who primarily have sexual activity with men are included in this definition of bisexual as long as these women experience ongoing attractions to women and have had at least one sexual experience with a woman. It is worth noting that self-identification or labeling of sexuality can be complicated by the fact that sexual orientation can be viewed as both fluid and changeable, and self-definition may be predicated on different aspects of sexuality for different people, i.e., by attractions, behavior, self-concept, affiliation to a particular group or community. However, attractions, rather than self-identity, or even behaviors, was privileged in this study. This is because there are many societal and internal pressures on individuals with same sex attractions to behave or identify in ways that may differ from their attractions.

For the purposes of the review and study, a “romantic relationship” was defined as involving feelings of being attracted to another person, emotionally close to that person, and it must have included at least some in-person contact, and may have also included other kinds of contact, for example, phone calls or online chatting. Romantic relationships in this context also involved feelings of sexual or erotic attraction that were usually expressed with a partner via some form of sexual activity. A romantic relationship was not defined as a non-sexual friendship,

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nor was it nonsexual feelings of admiration for another person for their personality, physical beauty, or other positive qualities.

Weinberg (1972) first introduced the term “homophobia” to describe a heterosexual person’s fear of sexual minority individuals, and the term “internalized homophobia” to describe the same phenomena as it occurs within the sexual minority individual. Szymanski and Chung (2003) have criticized the term internalized homophobia for focusing on the phenomena as an individualized irrational “phobia,” and for failing to locate the prejudice in the wider social institutions that promote heterosexuality. These authors prefer the term “internalized heterosexism” (or IH). This will be the preferred term in this review because it better underscores the way sexual minority status calls into question the dominant position of heterosexuality.

Downey and Friedman (1995) have also criticized the term internalized homophobia for other reasons, i.e., because the phenomena does not fit with the defensive processes typically seen in a phobia. They argue that what is seen intrapsychically are object relationships that “symbolically represent narratives expressing antihomosexual attitudes and values” with resulting feelings of guilt and shame about oneself as a sexual being with same sex desires (p. 435). This psychodynamic explication of the origins of the negative feelings that underpin the process of internalized heterosexism is the closest approximation to the aspects of the phenomena that will be the subject of this review and proposed study.

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Purpose of Study

- (1) To examine a theoretical model in which a latent factor of negative psychological and social outcomes, comprised of four indicator variables (increased psychological distress, poor self-esteem, poor romantic relationship quality, lack of social supports), was hypothesized to be a function of the predictor factor of negative early relational experiences, also with three indicator variables (insecure attachment to caregiver/s, early relational trauma/abuse, negative parental attitudes toward homosexuality). (Figure 1).
- (2) To examine whether the factor of high internalized heterosexism mediates the effects of the negative early relational experiences factor on the negative psychological and social outcomes factor (Figure 1).

CHAPTER 2

Literature Review

The literature states that LGB (lesbian, gay, bisexual) individuals are at elevated risk for psychopathology when compared with their heterosexual peers (Cochran & Mays, 2000; Cochran et al., 2003; King et al., 2008). For example, in a meta-analysis of research on mental health among LGB people published between 1966 and 2005, King and colleagues (2008), found that LGB individuals had a 1.5 times higher risk for depression and anxiety disorders, over a period of 12 months or a lifetime, than heterosexual individuals. Increased risk for psychopathology among sexual minorities was also highlighted in the recent Institute of Medicine's report on *The Health of LGBT People* (IOM, 2011). Sexual minority women's health was identified as a priority by the IOM in both the 2011 report and their 1999 report on lesbian health (Solarz, 1999), where they documented important health disparities such as higher rates of smoking, alcohol use, and substance use.

Studies have found sexual minority women to have poorer mental health, lowered self-esteem, and more negative feelings (Balsam & Mohr, 2007; Peterson & Gerrity, 2006). Specifically, these women are at increased risk for depression (Igartura, Gill, & Montoro, 2003; Koh & Ross, 2006; Lewis, Derlega, Griffin, & Krowinski, 2003; Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002; Meyer, 1995), eating disorders and body image issues (Pitman, 1999), anxiety disorders (Bucci, 1995; Igartua; Litt, Lewis, Blayney & Kaysen, 2013), substance abuse disorders (Cochran & Mays, 2000; Litt et al. 2003; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002), self-injury (Bennett & O'Connor, 2002), and suicide ideation and attempts (Igartua et al., 2003; D'Augelli & Hershberger, 1993; McDaniel, Purcell, & D'Augelli, 2001).

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A recent Institute of Medicine report (2011) confirms that sexual minority women do have increased mental health risks that can be attributed to the stress stemming from social stigma and discrimination that frequently occurs in the lives of LGB persons (Matthews et al.; Mays & Cochran, 2001; Otis & Skinner, 1996). Therefore, the pressures of heterosexist expectations and the psychic pain caused by societal heterosexism can be connected to the elevated levels of subjective psychological distress found among LGB persons when compared to heterosexuals (Matthews et al.; Mays & Cochran; Otis & Skinner).

In sexual minority women, negative feelings about oneself as a sexual being with same sex attractions (a high degree of internalized heterosexism [IH]), will not only affect mental health, but will affect feelings about the self. The degree to which an individual believes himself or herself to be valuable or adequate is known as self-esteem (Rosenberg, 1979). Self-esteem is a good indicator of general feelings about the self, which is separable from negative feelings about the self as a sexual being that are encompassed within the construct of IH.

Internalized heterosexism also affects indicators of romantic relationship quality in sexual minority couples (Balsam & Szymanski, 2005; Frost & Meyer, 2009; Mays et al., 2003; Meyer & Dean, 1998; Peplau & Fingerhut, 2007; Rostosky, Riggle, Gray, & Hatton, 2007, 2006; Spencer & Brown, 2007; Suter, Bergen, Daas, & Durham, 2006; Todosijevic, Rothblum, & Solomon, 2005). For example, in a qualitative study by Spencer and Brown, they found that internalized heterosexism had a more significant connection to relationship dissatisfaction than did level of differentiation from self. However, contrary to their expectation, the authors did not find that lesbian couples did not differ from heterosexual couples in whether they were well-differentiated, which they defined as independent yet realistically dependent on one another, or poorly differentiated, which they defined as overly dependent on one another.

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Research supports the general belief that social supports and/or social constraints are key factors that affect levels of distress among sexual minorities, e.g., perceived acceptance by family and friends (Luhtanen, 2003; McGregor et al., 2001). Social support is an important variable to consider overall, as social isolation is a risk factor for sickness, and social supports help people live longer, healthier lives; Moreover, strong social support predicts health (Antonovsky, 1980; Berkman & Breslow, 1983). Social support relating to sexual minority identity is particularly important, as the threat to the self when identity is concealed is considerable and certainly impacts psychological distress levels. Identity concealment has been found to negatively influence mental health (Bucci, 1995) and physical health (Cole et al., 1996). In addition, extensive identity concealment hinders the individual from seeking affiliation with the minority group that often serves a protective function and allows individuals to thrive even in the context of wider oppression (Meyer, 2003). Indeed, Floyd and Stein (2002) found that comfort with sexual orientation was greatest in persons with early patterns of coming out and was lowest within the group with late trajectories and limited LGB social immersion. IH remains a reality that must be better understood, even as in the last fifteen years there has been increasing acceptance and a movement toward equal rights for LGB persons, along with more representation and openness about minority sexual identities (Leipold, 2014; Loftus, 2001; Garretson, 2015). Especially as changes toward more positive LGB representations are relatively recent, are not evenly distributed among groups, and cannot erase the individual and group effects of a history of bias and oppression of sexual minority identity (see later discussion of IH specifically for a more detailed explication of the impact of recent changes in public perceptions and political realities).

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Taken together, previously cited research supports the conclusion that the external environment of the sexual minority individual greatly affects their experience of psychological distress and self-esteem. It also points to some patterns, by inference, regarding who tends to be resilient in the face of stigma, highlighting the importance of the process of coming out and connecting in some meaningful way to the sexual minority community as a way that individuals enhance self-acceptance and facilitate the development of healthy romantic relationships. It also points out that LGB affirmative psychotherapy that encourages such goals may reduce the virulence of internalized heterosexism within the individual and help them take steps toward identity consolidation.

Attachment Difficulties with Caregivers Leads to Poor Outcomes

Attachment theory highlights the way that beliefs about self and others are shaped by early experiences and how those experiences are processed and interpreted internally. Bowlby's early concept of "internal working models" of self and other elucidated a model of how the child learns to mentally represent secure and insecure patterns of attachment via relationships with primary caregiver/s that unfold over time (1969, 1973, 1980). One primary way that insecure patterns of attachment develop, patterns that tend to persist throughout life, is via early traumatic experiences. The secure and insecure attachment styles described in the infant literature (Ainsworth, Blehar, Waters, & Wall, 1978) tend to be maintained in adult romantic love through patterns of transference that are manifestations of early attachment relations that form a prototype for later adult relationships. Adult attachment theory (Hazan & Shaver, 1987) conceptualizes adult romantic love as an attachment process with similar secure and insecure patterns as those found in infancy research, and relates in theoretically meaningful ways to Bowlby's internal working models of self and other that originate in early relationship

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experiences with parents. These adult patterns differ predictably in terms of beliefs about the trustworthiness of partners and one's own desirability. Therefore, attachment status may provide one way of understanding and operationalizing characteristic difficulties in relationships among sexual minority women.

Mikulincer, Shaver, and Pereg (2003) state that insecure adult attachment consists of two dimensions: anxiety and avoidance. Adult attachment anxiety is defined as involving a fear of interpersonal rejection or abandonment, an excessive need for approval from others, and distress when one's partner is unavailable or unresponsive. Attachment avoidance is defined as involving fear of dependence and interpersonal intimacy, an excessive need for self-reliance, and reluctance to self-disclose. People who score high on either or both of these dimensions are assumed to have an insecure adult attachment orientation. By contrast, people with low levels of attachment anxiety and avoidance can be viewed as having a secure adult attachment orientation (Brennan, Clark, & Shaver, 1998).

The development of romantic relationships has long been associated with the relationship between parents and their children and the manner in which these children were raised. Although most people begin to form intimate romantic relationships in their early adulthood, much research suggests that the development of romantic intimacy traits and qualities begins in early childhood. The quality and type of attachment children have with their mothers and fathers has been found to strongly suggest the future quality of attachment in romantic relationships that the child later experiences as an adult (Collins & Read, 1990; Hazan & Shaver, 1987).

Individuals who do not have serious character pathology have internalized both positive and negative identifications, even amidst a backdrop of Winnicottian "good enough" caregiving (Friedman & Downey, 2002). In such individuals, internalized heterosexist beliefs may become particularly problematic during periods of increased stress, interacting with other stressors to

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create elevated levels of distress. Where early abuse and/or neglect have occurred and these experiences have resulted in poor self-esteem, these beliefs may be enduringly problematic.

Early Relational Trauma Leads to Poor Outcomes

Traumatic experiences disrupt the attachment system, and there is evidence that a significant number of sexual minority women have had such experiences. Higher risk of child maltreatment, including emotional, physical, and sexual abuse, among LGB individuals relative to heterosexuals has been found across many research studies with a wide range of sampling methodologies (e.g., Austin et al., 2008; Balsam, Rothblum, & Beauchaine, 2005; Balsam, Lehavot, Beadnell, & Circo, 2010; Bradford, Ryan, & Rothblum, 1994; Descamps, Rothblum, Bradford, & Ryan, 2000; Corliss, Cochran, & Mays, 2002; Tjaden, Thoeness, & Allison, 1999). For example, Balsam et al. (2005), found rates of childhood sexual abuse ranging from 31.6% to 47.6% among LGB women and men. Corliss et al.'s (2002) representative study of the U.S. population found higher rates of physical maltreatment by both maternal and paternal caregivers in homosexual and bisexual women as compared to heterosexual women. They found rates of emotional maltreatment by a parent were 45.5% for sexual minority women, and rates of physical maltreatment were 43.6% for sexual minority women.

Thus, being a sexual minority is a significant risk indicator for having experienced parental maltreatment. It is unsurprising that sexual minority individuals with a history of trauma or neglect would have internalized a clear message that those who wielded power and love frequently could not be called upon to help. They would then bring these ideas with them into adult romantic relationships.

Negative Parental Attitudes Toward Homosexuality Leads to Poor Outcomes

When parents convey heterosexist attitudes explicitly or subtly, youth fear rejection. Consequently, sexual minority youth report lower levels of parental support and they tend to have poorer health outcomes. Using data from the National Longitudinal Study of Adolescent Health (n = 11,153; 50.6% female; mean age = 21.8 years), Needham and Austin (2010) found that lesbian and bisexual youth reported lower levels of parental support than their heterosexual peers. These youth had higher odds of suicidal thoughts and recent drug use. Interestingly, parental support either partially or fully mediated these associations.

Even though the transition to adulthood is characterized by increased independence from parents, parental support or rejection remains an important correlate of adult health-related outcomes. Individuals may face varying degrees of threat of withdrawal of social support in connection with sexual identity disclosure. The likelihood of experiencing distress is compounded in those instances where the sexual minority individual must contend with additional specific pressures from his or her social environment that make positive adjustment more difficult to negotiate. Positive adjustment to one's sexual minority identity generally involves a reduction of the concealment of this identity, and some degree of being "out," which is openly and publicly disclosing one's sexual minority identity. Growing up with parents or caregivers with homophobic attitudes may also affect one's belief systems about relationships in general and romantic relationships specifically. When these homophobic attitudes are introjected then the individual may have multiple lasting negative effects even later in life.

Internalized Heterosexism Mediates Paths to Poor Outcomes

Sexual minorities are at greater risk for increased psychological distress, given the additional stressors and stigmatization they often face (Meyer, 1995; Igartua, 2003). In a study of gay men, Malyon (1982) first identified “internalized homophobia” as a construct that helped to explain the increased levels of distress associated with negative beliefs about homosexuality in general, and in particular, the internalization of negative beliefs about the self as an individual and a sexual being. This internalization process is affected by a number of intrapsychic processes, including psychological development, defensive configurations, and object relations. The process is also affected by the influences of the external environment and the relative levels of external heterosexism that the individual must contend with in their daily lives.

In *Three Essays on the Theory of Sexuality* (1905), Freud writes, “All human beings are capable of making a homosexual object choice and have in fact made one in their unconscious” (p. 11). Thus, Freud acknowledged that all individuals have some capacity for same-sex desires, whether or not they behave or identify accordingly. This view of sexuality expressed by Freud more than a century ago, can be interestingly compared to a more nuanced view of sexual identity that has taken hold in some circles at the turn of this century. For heterosexual individuals, it has become harder to ignore, discriminate, and marginalize sexual minorities as a group because what had once been an invisible group has become increasingly visible, e.g., through openly LGB celebrities and media figures. The struggles of sexual minorities have become experience-near among many in the majority group with those in their lives who now choose to be more open about their minority sexual identity, i.e., family, friends and coworkers (Dyck & Pearson-Merkowitz, 2013; Herek, 2003; Webb & Chonody, 2014). In addition, the ubiquity of social media usage, especially among the younger generation, has made interaction

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with and connection to sexual minority experience a part of the lives of most users of social media and media culture more generally (Riggle, Ellis, & Crawford, 1996; Mazur & Emmers-Sommer, 2002). Indeed, the confessional nature of some social media outlets, and the tendency of people to expose more and more intimate information, stories, pains and struggles, has made the experiences of marginalization of sexual minorities something that has touched the majority group -- one story, one connection, one call to action at a time – with lightning speed. This new age of information has caused the tide of opinion to move in a favorable direction at a rate not seen before in earlier civil rights struggles (Lupton, Singh, & Thornton, 2015). This is partially attributable to changes in how we connect interpersonally and how we share information, including information that affects sexual minority rights and the political processes that guide them.

Shifts in perception have ushered in openly gay and lesbian politicians, e.g., Barney Frank, (Leipold, 2014), and allowed President Obama to repeal legislation that allowed sexual minority Armed Service members to live openly without fear of reprisal. Gallup's (1977-2001, 2013) analysis of public opinion from 1992 through 2008 shows that gay rights issues became more salient to the public, and opinions about gay rights began to exert a significant effect on vote choice (Haider-Markel & Joslyn, 2013; Riggle, Rostosky, & Horne, 2010). Republicans and conservatives have been overall more likely to hold anti-gay attitudes than their Democratic and liberal counterparts, in part because of beliefs that homosexuality is a choice (Rhodebeck, 2015). Gallup results (1977- 2001, 2013) support the importance of the link between the "cause" of homosexuality and levels of acceptance, for example in 1977, 12% of respondents believed that it was innate, in 2001, 40% of respondents believed that it was innate, and in 2015, 51% of respondents believed that it was innate. Those who believed that homosexuality was innate were more likely to hold a positive view.

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One key piece of evidence supporting the impact of the changes just outlined, is the recent Gallop poll (2013) that stated that 52% of Americans would vote to legalize same-sex marriage nationwide. Compare this to 57% of Americans in 2003 that *opposed same-sex civil unions*, a time when then President Bush had also indicated his willingness to amend the Constitution to ban gay marriage (Gallup, 1977-2001, 2013). Indeed, in one of the most monumental steps towards equality, a 2015 Supreme Court ruling made same-sex marriage legal nationwide. In a recent study of sexual minorities (Haas & Whitton, 2015), the majority (90%) highlighted the importance of gaining this right, pointing to the symbolic significance of the contract, as well as the financial and legal benefits it conferred.

The evidence of the trends outlined above show that sexual minorities can expect to have more protections, acceptance, representation, and legitimacy moving forward. However, civil rights movements show clearly that the ugly realities of oppression continue to leave a psychic mark, even as outward changes move in a favorable direction for minority groups. The sexual minority rights movement is relatively recent, and many have, and continue to struggle mightily against oppressive influences. Even as the political climate becomes more welcoming, socialization involves the internalization of majority group norms, and those in the sexual minority must struggle with societal pressures to conform to heteronormative expectations that have not disappeared. The loss of differing degrees of heterosexual privilege must therefore be mourned when one discovers one is a sexual minority. Gordon Allport (1954) notes that minority groups may deal with societal inequity by employing defenses that allow identification with the dominant group by adopting the attitudes of that group. Herek applies Allport's ideas about the internalization of societal homophobia by sexual minorities, saying "internalized homophobia necessarily implicates an intrapsychic conflict between what people think they

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should be (i.e., heterosexual) and how they experience their own sexuality (i.e., as homosexual or bisexual)” (2004, pg. 19). One such way that sexual minorities identify with the dominant group is through internalized heterosexism (IH), which is the taking in of social sexual stigma into the sexual minority individual’s self-concept. It is assumed that individuals in society are exposed to heterosexist beliefs, both at an early age and throughout the lifespan, which are subsequently internalized, especially given that sexual minority individuals are generally born into a heterosexual family and expected by the family to adopt that model. Therefore, because of the ubiquity of societal and familial heterosexism, it is possible for some individuals to have a high degree of IH, even in the context of otherwise healthy upbringing and development. In other words, a defensive structure attempts to contain negative feelings about the self as a sexual being and the self in the context of romantic relationships with same-sex others, alongside other positive representations of the self, and positive representations of the self and other in various platonic constellations.

Much has been written about the destructive consequences that internalized heterosexism can have on sexual minority members’ mental, physical, and relational health (Friedman & Downey, 2002; Meyer, 1995, 2003; Meyer & Dean, 1998; Szymanski & Chung, 2003). These outcomes include less self-acceptance, lower self-esteem, less disclosure of sexuality, beliefs that one will be rejected because of one’s sexuality, difficulties in romantic relationships, and the foreshortening of aspirations. Empirical studies have found that IH has a direct negative association to the psychological health of sexual minority individuals (Balsam & Mohr, 2007; Meyer, 1995; Peterson & Gerrity, 2006; Szymanski, Kashubeck-West, & Meyer 2008a-b). There is evidence that this finding is more significant for bisexuals than for homosexuals (Dodge & Sandfort, 2007). Bisexual identity places the individual under greater stress, and

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greater risk for IH and psychological distress, because it often involves invalidation by both heterosexual and gay/lesbian people (Eliason, 2001). This invalidation stems from a popularly held belief that bisexual identity is a transitional state between heterosexual and homosexual orientations (Eliason; Rust, 2000), and therefore indicative of a delay or arrest in sexual identity development (Fox, 1995, 2000; Israel & Mohr, 2004).

In addition, IH may affect men and women differently. For example, Meyer (1995) found that IH moderates the relationship between external heterosexism and psychological distress in gay men, but Szymanski (2005-6) found that this relationship does not hold for lesbians, finding that societal heterosexism negatively affects lesbians' mental health regardless of levels of IH. Therefore, it is necessary to better understand the role of IH in sexual minority women specifically.

For youth, D'Augelli, Grossman, Starks, & Sinclair's 2010 study found that youths whose parents were aware of their sexual orientation reported less internalized homophobia than youths whose parents were unaware of their children's sexual orientation. One study found that parental homophobic attitudes in families with LGB youth correlated with the youth reporting lower self-esteem and greater difficulty managing relationships with parents (Holtzen & Agresti, 1990). Research findings indicate that having positive relationships with parents is related to fewer mental health symptoms in LGB youths (D'Augelli et al., 2012; Needham & Austin, 2010), and that perceived rejection increases risk for substance abuse (Rosario, Schrimshaw, & Hunter, 2009; Ryan et al., 2009); depression (Needham & Austin, 2010; Ryan et al., 2009), suicidality (Needham & Austin, 2010; Ryan et al., 2009), and sexual health risk (Ryan et al.). Therefore, parental openness to their child's sexual minority identity should not only reduce the youth's IH levels, but should serve to protect them from low self-esteem and psychological distress.

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Several studies have found that internalized homophobia has a direct effect on self-esteem in LBG persons (Meyer & Dean, 1998; Peterson & Gerrity, 2005). Since self-esteem is a good indicator of other general feelings about the self and proposed as both separable from, and related to the negative feelings about the self as a sexual being that are encompassed within the construct of IH, it is vital to include self-esteem into the study of outcomes related to internalized heterosexism (Szymanski et al., 2008a). Since IH researchers have found a correlation between lowered self-esteem and IH in several studies (Szymanski & Chung, 2003; Szymanski, 2005; Szymanski et al. 2008a-b; Szymanski & Gupta, 2009) this studies' premise that these two constructs are related, but separable, will be tested to ascertain whether there is empirical validation for such a distinction. It is hypothesized here that rather than being part of the same construct as self-esteem, IH is a specific kind of suffering resulting from a set of negative circumstances, and is a causal factor for negative outcomes at the individual, internal level, such as low self-esteem and psychological distress.

Physical and sexual relational abuse have been linked to the internalization of heterosexist beliefs among sexual minority individuals. For example, Balsam and Szymanski (2005) found that higher internalized heterosexism was associated with increased recent perpetration and victimization of physical or sexual abuse in women with a female partner, but they found that the association was fully mediated by the variable of romantic relationship quality. With respect to social supports, experiences of discrimination and gay-related stressful life events were found to increase distress (Morris & Balsam, 2003; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001), but connectedness to the gay community was found to be a protective factor (Balsam & Mohr, 2007; Frost & Meyer, 2009; Luhtanen, 2003). Looking specifically at lesbians, Szymanski (2006) found that external experiences such as recent perceived heterosexist harassment, rejection, and discrimination correlated positively with several indices of psychological distress. Current

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heterosexist-related aggressions perpetrated onto the sexual minority individual affects whether they use available social supports, and the degree of suffering, and the attributions they make, regarding such experiences.

There is such variability in outcomes associated with internalized heterosexism, and this is partly related to whether internalized heterosexist attitudes are ego-syntonic, or ego-dystonic. Sexuality is a complicated matter; it is quite possible to have some beliefs about one's sexuality that are ego-dystonic and some that are ego-syntonic. Ego-syntonic attitudes can be traced in some cases to experiences of trauma and social alienation in early life that lead to negative views of the self and an overly harsh, punitive superego. Thus, negative societal beliefs regarding homosexuality as sinful and degenerate are more easily taken into the self, leading the individual to condemn his or her desires and block the development of healthier views of the self as a sexual being with same sex desires. Early traumatic experiences that are harder to access and express can therefore be layered upon a faulty structure, affecting self-esteem and psychological distress. This internalization process is key to understanding why some sexual minority individuals suffer *more* in the face of experiences with strongly heterosexist important objects and experiences.

CHAPTER 3

Method

Participants

Sample Size

Participants were 250 "sexual minority women," i.e., defined as bisexual and lesbian women, who identify as having sexual attractions to women exclusively to occasionally, and who have had at least one sexual experience with a woman. The sample size of 250 was determined via an a priori statistical power analysis for the structural equation model (figure 1). Since participant completion of all measures is required for the structural equation model, the study allowed approximately 500 women in order to obtain 250 completed protocols.

Age

The age restriction of participants to 18-50 was determined in order to approximate the period following adolescence, known in America as adulthood, when individuals tend to partner and marry, yet still can reflect back on earlier salient experiences that have shaped their adult identity (Erikson, 1956, 1968). The upper limit for participation went up to age 50 because there is research supporting that sexual minority women have a later trajectory in some markers of adulthood that relate to sexuality and identity development as compared to heterosexual peers (Cass, 1979, 1996; Rosario et al., 2001; Troiden, 1989). Extending the sample into middle age was also based on data that suggested that some women have a fluidity to their sexuality that allows them to comfortably adopt same-sex relationships later in life (Diamond, 2008).

Sexual Identity

Since the study examined women's attractions to women, as well as women's experiences in romantic relationships, the requirements that the participants have both attractions to women and

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at least one sexual experience with a woman was established to include only participants who have experienced sexual and romantic desires toward women that they have also acted on sexually at some point. This will excluded women who were inappropriate for the study because their relationships with women could be characterized as platonic friendships, or because they had nonsexual feelings of admiration for a woman or women. Another criteria for exclusion of participants were for individuals who were not born female, or who no longer identify as such, because this study did not examine transgendered individuals. In addition, as this was a community-based sample that was not intended to include those individuals with severe psychopathology, women who reported a diagnosis of a psychotic disorder or endorsed multiple symptoms indicative of psychoticism on the Brief Symptom Inventory self-report measure (Derogatis, 1975) were excluded.

Procedure

Recruitment

Participants were recruited nationally online from a number of different sources (Craigslist, Facebook, Twitter) and an advertisement that broadly defined potential participants. Internet-based research has some disadvantages, most notably that it requires that participants have access to and some familiarity regarding how to use the web, and therefore creates a bias toward a technically savvy and younger demographic. Gosling, Vazire, Srivastava, & John's (2004) comparison analysis of preconceptions about internet questionnaires found that despite concerns, internet responders tend to be quite motivated. The ease of reaching members of the community with measures that require computer assistance to run made this a project best managed via the Internet. As previously discussed, anonymity provided certain advantages in the reporting of experiences of internalized heterosexism (IH). For example, individuals who had

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higher IH may have been less likely to respond to a study of sexual minority experiences, but may have been more likely to respond to this study because they were able to remain anonymous. Since the study was web-based and recruitment did not require that the individual be in an LGB-identified location, it could capture individuals who had less social support around their sexual identity, or perhaps those who avoided LGB-identified locations because of high IH. It allows anonymity when self-reporting which helped participants be more frank when questioned about sensitive issues, such as how they felt about their sexual identity, when reporting sexual behaviors and attractions, and when answering questions about early traumatic experiences.

Confidentiality

This study chose psychdata.com as the platform to collect data because of the protocols that this website had put in place that significantly minimized the risk of breach of confidentiality with participant data. Since this was an anonymous study, there was minimal risk that confidential information would be inadvertently released.

This study entailed internet-based survey research methods in which participants' IP address were not captured and identifying information was captured separately from the data. Participants' data were identified by participant ID number only. Moreover, when participants sign off psychdata.com, all of their information was erased from whatever computer they used to take the survey. In addition, participants were encouraged, in the consent language, to complete the survey in private conditions to protect their confidentiality. In addition, data was stored separately from identifying information in password protected electronic files on a USB flash drive in a locked file cabinet.

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Screening

Interested individuals who responded to the web recruitment advertisement were invited to complete a brief anonymous pre-study screening form that inquired about basic demographic information to rule out ineligible participants (e.g. younger than 18 or older than 50, heterosexual, born male or identifying as male). In order to keep the data as representative of lesbian and bisexual women without serious psychopathology who would be likely to be found in a community-based sample, the screening tool ruled out individuals who seem likely to have a diagnosis on the psychotic spectrum of functioning.

Eligibility and Raffle

Participants who were ineligible to participate were forwarded to a page stating that they were not eligible for the study and thanking them for their interest. Eligible women reviewed and completed a consent document on the study's webpage. Interested participants were enrolled in a raffle to win one of 10 raffle items for taking part in the online study, so that 1 out of 25 participants who enrolled in the lottery had an opportunity to win. Raffle items were 10 \$100 Amazon gift cards. Participants were asked for name and email so that a gift certificate could be sent to them if they won the raffle. The nature of the study was revealed when the gift certificates were distributed. The identifying information provided was not linked to the data. In addition, the identifying information was stored separately from other data in a password protected electronic file on a USB flash drive stored in a locked file cabinet.

Measures

Pre-Screening Form

Interested participants will be pre-screened for eligibility. The screening questions are: 1) What gender were you assigned at birth?, 2) What is your current gender?, 3) How old are you?, 4) When is your birthday?, 5) Has a doctor ever told you that you have a psychotic disorder (for example, schizophrenia, schizoaffective disorder, psychosis)?, 6) Do you have sexual attractions to women? These feelings of attraction to women may happen occasionally to exclusively., 7) Have you had at least one sexual experience with a woman?, 8) Do you have sexual attractions to men? These feelings of attraction to men may happen occasionally to exclusively., 9) Have you had at least one sexual experience with a man?.

Demographics Form

Once participants have been deemed eligible, they complete a simple form that was developed for the study that asks about basic demographic information, e.g., sex, relationship status or marital status, religion, education, race and ethnicity, employment, income, number of children. When possible, categories matched those used in the U.S. Bureau of the Census (2011).

Questions also assess current relationship configurations and current levels of commitment and feelings about relationships when thinking about the future. Several additional questions were culled from the Sexual Experiences Risk Behavior Assessment Schedule (SERBAS; Meyer-Bahlburg, Ehrhardt, Exner, & Gruen, 1991) and included in the demographics form to assess sexual identity, sexual fantasises, and recent and lifetime sexual partners and sexual practices in detail by gathering information about male and female sexual partners. The SERBAS assesses self-described labeling of sexual identity, sexual behavior, Kinsey ratings of

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sexual attractions, fantasies, and erotica. The SERBAS has demonstrated good two-week test-retest reliability, e.g. for 6 of the 7 measured items the mean test-retest reliability coefficient was: lifetime sexual behaviors ($M = .89$), sexual behavior in the last three months ($M = .96$), unprotected sexual behavior in the last three months ($M = .93$), sexual identity ($k = .89$), sexual orientation ($M = .82$), ages of sexual developmental milestones ($M = .77$) (Schrimshaw, Rosario, & Meyer-Bahlburg, 2006). It has demonstrated good validity as well (Rosario, Meyer-Bahlburg, Hunter, & Gwadz, 1999; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001; Rosario, M., Schrimshaw, & Hunter, 2006, 2012).

Negative Psychological and Social Outcomes Measures

Psychological distress measure.

The Brief Symptom Inventory (BSI; Derogatis, 1975) is a 53-item self-report measure (8-10 minutes to complete) that was used to gain an overview of the participant's emotional symptoms and severity, as well as to identify clinically relevant psychological symptoms via the primary symptom dimensions calculated. Questions were rated on a 5-point Likert scale, ranging from "not at all" (1) to "extremely" (5) distressing. Level of psychological distress was measured using the BSI's Global Severity Index (GSI), which quantified the severity of the participant's symptoms using Derogatis' preferred scoring method, a method that computed the overall average of the averaged scores on a number of individual subscales, e.g., depression. A high GSI score indicated elevated distress. Participants who endorsed multiple symptoms indicative of psychoticism on the BSI were excluded in order to keep the data as representative of lesbian and bisexual women without serious psychopathology who would be likely to be found in a community-based sample. Both test—retest and internal consistency reliabilities are shown to be very good for the primary symptom dimensions of the BSI, and high convergence between BSI

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scales and like dimensions of the MMPI provide good evidence of convergent validity. The BSI also has high internal consistency (Cronbach's alpha: 0.71-0.85), test-retest reliability, and convergent, discriminant, and construct validity. The BSI scores were summed and the mean was calculated.

Self-esteem measure.

Rosenberg's Self-Esteem Scale (RSES; Rosenberg, 1965) was used. It is a well-known 10-item self-report measure of self-esteem that scale that measures global self-worth by measuring both positive and negative feelings about the self. Psychologists and sociologists commonly use this instrument. RSES exists in several languages, including English, French, and Norwegian. Though this study uses the scale unidimensionally, it can also be used as a two-factor (self-confidence and self-deprecation) scale. Positive items are reverse scored and include items such as, "I feel that I have a number of good qualities," and "I am able to do things as well as most other people." Negative items include, for example, "At times I think I am no good at all," and "I certainly feel useless at times." All items are answered using a 4-point Likert scale format ranging from strongly agree (1) to strongly disagree (4). Lower scores indicate lower self-esteem. The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

The scale generally has high reliability: test-retest correlations are typically in the range of .82 to .88, and Cronbach's alpha for various samples are in the range of .77 to .88 (Blascovich & Tomaka, 1993; Rosenberg, 1986). Szymanski and Chung, (2009), who have used this scale with sexual minorities, report a reliability coefficient of reproducibility of (.93), which is over the minimum coefficient of reproducibility of 0.90 published by Rosenberg (1965). For this study, the RSES scores were summed and the mean was calculated.

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Romantic relationship quality measure.

Romantic relationship quality was assessed using a 9-item form of the Experiences in Close Relationship Scale - Relationship Structures questionnaire (ECR-RS; Fraley, Heffernan, Vicary, & Brumbaugh, 2011). The ECR-RS is a self-report instrument designed to assess attachment styles in various relational domains (e.g., parental, romantic) and in a relationship-specific manner. The questionnaire is designed to assess the way in which people mentally represent important people in their life, by asking them to rate the extent to which each item accurately describes their feelings in close relationships using a 7-point Likert response scale, ranging from “not at all” (1) to “very much” (7). The scale is designed to assess a general pattern of adult attachment as independently as possible, and does not preclude individuals who are not currently in a close romantic relationship from providing valid responses (assuming they have had a close romantic relationship at some point in time).

Six items assess attachment avoidance and three items assess attachment anxiety. The test-retest reliability (over 30 days) of the individual scales are approximately .65 for the domain of romantic relationships (including individuals who experienced breakups during the 30-day period). Fraley et al. (2011) report that that these scales have been meaningfully related to various relational outcomes they have studied (e.g., relationship satisfaction, likelihood of experiencing a breakup, the perception of emotional expressions), as well as to one another. The alpha reliability estimates for when the scores are averaged across all relational contexts are .85 for anxiety and .88 for avoidance, and these estimates are comparable to those from longer ECR scales that are generally around .91. Per the measure authors' method of scoring, two scores, one for attachment-related avoidance, and the other for attachment-related anxiety, were computed separately for the romantic partner, then averaged together to create an overall insecure attachment score.

Social support measure.

The Duke-UNC Functional Social Support Questionnaire (DUFSS; Broadhead, Gehlbach, & Gruy, 1988) is an 8-item measure of two aspects of social support: (1) Relationships with those with whom one can discuss life concerns, (2) Affective support, which is a form of emotional caring. Three items measure affective support and five items measure confidant support. The five-point answer scales range from “as much as I would like” to “much less than I would like.” Two-week test- retest reliability for the items range from .50 to .77. The average item-total correlations are .62 for confidant support and .64 for affective support. The summary score used in this study was formed by adding the scores for the confidant and affective support, and the means were calculated.

Early Relational Trauma Factor Measures

Attachment to caregiver/s measure.

Adult attachment to caregivers/parents was assessed using a 9-item form of the Experiences in Close Relationships Scale - Relationship Structures questionnaire (ECR-RS; Fraley, Heffernan, Vicary, & Brumbaugh, 2011). Please see general discussion of the ECR-RS in the description for Romantic Relationship Quality above, as the same measure was used, but for different targets. The test-retest reliability (over 30 days) of the individual scales are approximately .80 in the parental domain. Data gathered indicates that there is the greatest similarity between the way participants relate to their mothers and fathers for attachment-related anxiety ($r = .41$).

Two scores, one for attachment-related avoidance, and the other for attachment-related anxiety, were computed for each interpersonal target (i.e., mother or maternal caregiver figure and father or paternal caregiver figure), then insecure attachment scores were calculated for each target by averaging the attachment-related avoidance and attachment-related anxiety scores.

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Then, the overall insecure attachment scores for each target were averaged together to form an overall insecure caregiver/parental attachment score.

Early relational trauma measure.

The Brief Early Trauma Inventory Self Report-Short Form (ETISR-SF; Bremner, Bolus, & Mayer, 2007) is a true/false self-report instrument that includes questions across multiple domains occurring during early life (prior to age 18). The general trauma section was excluded as this study focused on interpersonal trauma. The sexual abuse section was excluded as this topic was covered using another measure discussed below. Five physical punishment or abuse questions were included, with physical abuse defined as physical contact, constraint, or confinement, with intent to hurt or injure. Five emotional abuse questions were included, with emotional abuse defined as verbal communication with the intention of humiliating or degrading the victim. The ETISR-SF scores were summed and the mean will be calculated. The ETISR-SF was found to have high internal consistency across the domains (Cronbach's alpha: 0.78-0.90; Bremner et al.), and to be valid ($r = 0.39-0.47$; Bremner et al.) for correlation with the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995), a reliable and valid measure of PTSD symptom severity.

Sexual abuse was identified using two questions from the Sexual Experiences Risk Behavior Assessment Schedule (SERBAS; Meyer-Bahlburg et al., 1991) that assessed history of sexual abuse. Sexual abuse was defined as unwanted or uninvited sexual contact.

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Negative parental attitudes toward homosexuality measure.

To measure the construct of negative parental views toward homosexuality, the Attitudes Toward Lesbians and Gay Men Scale (ATLG-R; Herek, 1988) was used. The instructions were to report how the participant thinks her parents or caregivers would have answered the questions during the time period before they moved out of the home. The Attitudes Toward Lesbians (ATL-R, 1988) subscale of 9 items from the ATLG-R, with Likert-type scoring, assesses sexual prejudice toward lesbians. Higher scores indicate higher levels of sexual prejudice. A sample item includes, "Female homosexuality is an inferior form of sexuality." Internal consistency for this measure typically exceeds .90. The scores were summed and the mean was calculated.

Internalized Heterosexism Measure

To assess internalized heterosexism, Rosario's Adaptation (Rosario's adaptation, 2001, 2004, 2006) of the Nungesser Homosexuality Attitudes Inventory (NHAI; Nungesser, 1983) was used. The 34-item Nungesser Homosexuality Attitudes Inventory is a popular and widely used scale to assess IH in gay men. Nungesser conceived of IH as consisting of attitudes toward one's own homosexuality (self), attitudes toward homosexuality in general, and toward other gay persons (other), and reactions, toward others' knowing about one's homosexuality (disclosure). Example items include, "I wish I were heterosexual," and, "If it were made public that I am homosexual, I would be extremely unhappy." Each statement is rated on a 5-point Likert scale ranging from 1 "strongly disagree" to 5 "strongly agree". Higher scores indicate more IH. Internal reliability (coefficient alpha) for subscale scores range from .68 to .93, and the alpha for full scale scores is .94. Rosario's adaptation is a 33-item scale that simplifies the language, and makes the item content inclusive of both males and females. The scores were summed and the mean was calculated.

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Control Variables

Social desirability measure.

The Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) was used to assess whether there was a tendency to provide socially favorable responses. Reliability for this scale is high, eg., Crowne and Marlowe, show the internal consistency of the 33 items at .88. A factor analysis by Rosario found 12 items from the original scale's 33 items that loaded on a single factor for social desirability in a younger LGB population (Cronbach's $\alpha = .74$), so those 12 items were used for this study (Rosario et al., 2006, 2012). This instrument uses a true-false response scale a set of 12 true or false items that focus on either (a) desirable but uncommon behaviors or (b) undesirable but common behaviors. The scores were summed and the mean was calculated.

Age and Income

Age and income were used as control variables. This data was gathered in the demographics information form. The age and income categories matched those used in the U.S. Bureau of the Census (2011).

Data Analysis

Statistical analysis utilized structural equation modeling to examine the relationships between the three latent factors that comprised this model. In the theoretical model that guided the study (figure 1), the indicator variables had good psychometric properties (see descriptions for full psychometrics on measures). Therefore, the variables comprising the latent factors representing the theoretical constructs of interest were measured using instruments that would not be biased from a psychometric perspective. More specifically, negative early relational experiences, a latent factor comprised of three indicator variables, (1. insecure attachment to primary caregiver/s, 2. early relational trauma/abuse, 3. negative parental attitudes toward

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homosexuality), was hypothesized to affect a mediating latent factor. The mediating factor, internalized heterosexism, in turn, was expected to affect negative psychological and social outcomes. This final latent factor in the model was comprised of four indicator outcome variables (1. psychological distress, 2. poor self esteem, 3. poor romantic relationship quality, 4. poor social supports). The factor of negative early relational experiences was hypothesized to have both direct and indirect, i.e., mediated, effects on the negative outcomes factor. In addition, the measurement submodel tests how well the indicator variables represent their respective factors. Since the indicator variables are based on measures with sound psychometric properties, the measurement part of the SEM model will determine whether they accurately measure the theoretical construct, or latent factor, that the model proposes (Kline, 2005).

Structural equation modeling, or SEM, is a linear structural equation modeling technique that encompasses other techniques such as, factor analysis, path analysis and regression (Kline, 2005). SEM is an a priori technique that is often applied in a confirmatory manner. It was applied as such in this study to test a specific, predictive model that was developed based on research and theory (figure 1). SEM was selected for this study because the primary purpose of the study was to test this hypothesized model to describe the relationship among the specified factors. When the model was tested with the data gathered it was expected to have both direct effects, and indirect, or mediated, effects. Based on results of the SEM analysis the entire theoretical model, called the structural submodel, could be either accepted or rejected based on how it fits the data in the study.

Based on the recommendations of Kline (2005), an authority on SEM, the data will be analyzed in a stepwise fashion that includes testing the indicators first to ascertain that they suitably represent the latent factors, and testing the goodness-of-fit of the model to make sure it meets standard recommendations. SEM also involves: 1. testing the measurement model as

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described by the hypothesized latent factors and the causal relationships theorized, 2. testing the direct effects for significance to be certain that the predictive relationship is not all accounted for by this relationship, 3. testing the mediation effect for significance only if the direct effect was significant, 4. if a mediation effect exists, then testing the magnitude of that mediation effect.

The results of these analyses will be fully reported in chapter 4, the results section.

CHAPTER 4

Results

Introduction

The findings that will be discussed in this chapter are based on data that was collected to address the primary research questions that underpin the theoretical model laid out in figure 1 and chapter 2. Although numerous sexual minority stressors have been linked with poor psychological outcomes (Balsam & Syzmanski, 2005; Meyer, 1995; Morris and Balsam, 2003), the degree to which internalized heterosexism appears to impact the health and well-being of sexual minority individuals needs to be better understood as an independent phenomena.

Therefore, the first research question asks whether the factor of high internalized heterosexism will mediate the effects of negative early relational experience on the negative psychological and social outcomes factor. Secondly, a structural equation model will further test whether the latent factor of negative psychological and social outcomes, comprised of four indicator variables (increased psychological distress, poor self-esteem, poor romantic relationship quality, lack of social supports), is indeed a function of the predictor factor of negative early relational experiences, also with three indicator variables (insecure attachment to caregiver/s, early relational trauma/abuse, negative parental attitudes toward homosexuality).

Since this study places a great deal of importance on a potential mediating, or indirect, effect of internalized heterosexism on negative outcomes, testing this aspect of the model is as important to the integrity of the model as testing of the direct effects of the early relational

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experiences predictor on the negative psychological and social outcomes. Analysis of the structural equation model of the factors is of primary importance. However, if the measured variables used to induce the latent factors are not reliable, the ability to glean sound data from the structural equation model of the latent factors will be compromised. Therefore, the findings in this chapter will be addressed starting with the observed variables and ending with the relationship between the factors, in the following order: 1) Analyzing whether the observed variables used in the structural equation model are reliable; 2) Analyzing the direct effects of the early relational experiences predictor factor on the negative psychological and social outcomes factor; 3) Analyzing the potential mediating, or indirect, effect of internalized heterosexism on the negative outcomes factor. Chapter 4 will discuss the meaning and interpretation of the results reported in this chapter and summarized in figures 2-4.

Demographics

The pre-screening questionnaire excluded 104 interested participants who were deemed ineligible for the study according to the exclusionary criteria. This study had 516 participants that met criteria for the study, but 237 dropped out – almost all within 10 minutes into the 45- minute survey -- and thus they did not provide answers to all measures and therefore their data could not be used in the analysis. All 341 participants who could not be included in the data analysis were forwarded to a thank you page and given the opportunity to participate in the raffle (see details in chapter 2). The other 279 participants were deemed eligible according to the inclusionary criteria outlined in chapter 2 and completed all the survey measures necessary to be included in the study and have their data analyzed and have the opportunity to participate in the raffle.

Basic demographic information was collected and reported in table 2. When possible, categories matched those used in the U.S. Bureau of the Census (2011). The average age of participants was 29.5, ranging from 18-50, with a median of 29. When given the option to select all that apply, the majority of participants selected Caucasian (85.2%), followed by Hispanic

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(10.9%), with single digit percentiles in all other categories. This sample was not a particularly religious one, with almost half (42.2%) saying they belong to no religion, 15.9% reporting being agnostic, and 20.7% saying they were religious but did not belong to an organized religion, and single digit percentiles in all major religions. Household income varied quite a bit within this sample, with approximately one-fourth falling into one of the following four distributions: 0-\$25,000, \$25,000-\$50,000, \$50,000-\$100,000, \$100,000- over \$300,000. This was an educated sample with more than 95% attending at least some college, almost a third graduating from a 4-year college, and almost a third with a graduate degree. More than three-quarters of participants were employed (57.7% full-time, 24.1% part-time), and about a tenth were seeking employment. Almost one-third of participants were students.

Since this is a study of sexual minority women, several questions were asked to ascertain related aspects of gender, sex, and sexuality, as represented in this sample pool (see Table 1 and 1a). With regard to sexuality, a little over a third (38.3%) identified as lesbian, and almost exactly a third (33.8%) identified as bisexual. Seven percent identified as heterosexual, however they passed through the pre-screening by indicating that they both had had a sexual experience with at least one woman and had attractions to women.

More than a fifth (21.2%) of participant identified as “other.” When given the option to self-describe what “other” meant to them, 77 participants responded, with 28 unique responses, ranging from entering the common identifier, “queer,” to unique and less common responses such as: fluid, polysexual, queer kinky bitch, queer dyke, mostly straight, asexual. Multiple participants gave longer descriptions that gave a sense of the dynamics and difficulty of labeling their sexuality, saying, for example: “queer trapped in a heterosexist world, “heterosexual with bisexual tendencies,” “my own thing,” “I don’t identify with any sexuality,” “I consider myself on the spectrum. I most closely identify as straight, but I am sometimes attracted to women.

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Since my attractions are not quite 50/50, I do not feel comfortable identifying as bisexual/ I am somewhere between the two.,” “for some reason, I use the label gay,” “I am committed to my spouse, but I have interest in and desire for women,” “I am married to a woman but I don’t identify with being a lesbian.” The most common “other” labels provided by participants were: queer (39 participants), pansexual (8 participants), queer lesbian (4 participants), and heteroflexible (2 participants).

When moving from labels to dimensional scoring of sexuality via The Kinsey scale, which asks participants to choose a number ranging from 1= entirely heterosexual to 7= entirely homosexual, with a mean of 4 = equal attractions to both men and women, the participant data looked somewhat different. The mean score was 4.9, median 5, and standard deviation 1.6. From most to least prevalent, the Kinsey scale points were as follows: 26.4% (6), 18.8% (3), 17.6% (7), 15.5% (5), 14.9% (4), 6.2% (2).

Looking to Table 2, almost three quarters of participants are currently in a relationship, and almost 30% reported being married or domestic partners, with 40% committed but not living together, and 30% committed and living together. Current or most recent gender of partner was split, with slightly more participants reporting a female partner (59.9%), than male (40.1%). A small, but a notable 12.4% of participants in relationships had partners outside their primary relationship.

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Table 1: Sex, Gender, Sexuality, and Relationships Demographics

Category Heading	Label	Frequency	Percent %
Biological Sex:			
	Female	277	99.28%
	Intersex	2	0.72%
Gender:			
	Female	275	98.92%
	Intersex	2	0.72%
	Transgender	2	0.36%
Sexual Identity:	(Select all that apply)		
	Lesbian	107	38.3%
	Bisexual	93	33.5%
	Heterosexual	19	7.0%
	(see table 4 for text provided for OTHER Label)	Other	77
Kinsey Sexuality Rating:			
	1 = Entirely heterosexual	0	0%
	2 = Largely heterosexual, only incidentally homosexual	18	6.5%
	3 = Largely heterosexual, more than incidentally homosexual	52	18.64%
	4 = Equally heterosexual and homosexual	42	15.05%
	5 = Largely homosexual, more than incidentally heterosexual	45	15.5%
	6 = Largely homosexual, only incidentally heterosexual	74	26.4%
	7 = Entirely homosexual	48	17.9%
	8 = Have had no sexual relations	0	0%

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Table 1a: Sexual Identity Descriptors for OTHER

	Direct Participant Quotes	Frequency of Response (n=77)	Percentage %
1	Queer	39	50.65%
2	Pansexual	8	10.39%
3	Queer lesbian	4	5.20%
4	Heteroflexible	2	2.60%
5	Asexual	1	1.20%
6	Fluid	1	1.20%
7	For some reason, I use the label gay	1	1.20%
8	Gay/queer	1	1.20%
9	Gay/not straight	1	1.20%
10	Gay/asexual	1	1.20%
11	Gay	1	1.20%
12	Heterosexual with bisexual tendencies	1	1.20%
13	I am committed to my spouse, but I have interest in and desire for women	1	1.20%
14	I am married to a woman but I don't identify with being a lesbian	1	1.20%
15	I consider myself on the spectrum. I most closely identify as straight, but I am sometimes attracted to women. Since my attractions are not quite 50/50, I do not feel comfortable identifying as bisexual/ I am somewhere between the two.	1	1.20%
16	I consider myself straight, but have sexual chemistry with females that I do not act on now.	1	1.20%
17	I like whoever the fuck I want. Mostly people that identify as female, tho.	1	1.20%
18	Mostly straight	1	1.20%
19	Queer, polysexual	1	1.20%
20	I don't identify with any sexuality	1	1.20%
21	Mostly hetero	1	1.20%
22	My own thing	1	1.20%
23	Queef	1	1.20%
24	Queer dyke	1	1.20%
25	Queer kinky bitch	1	1.20%
26	Queer. Also genderqueer.	1	1.20%
27	Straight. But I think about having sex with women and do not act on it.	1	1.20%
28	Queer trapped in a heterosexist world	1	1.20%

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Table 2: Additional Demographics

Category Heading	Label Endorsed	Frequency	Percentage %
	Race (check all that apply):		
	White/Caucasian	238	85.20%
	Hispanic, Spanish, or Latino	30	10.90%
	Black or African	26	9.20%
	American Indian or Alaska Native	12	4.50%
	Asian	23	8.40%
	Native Hawaiian or Other Pacific Islander	4	1.40%
	Religion:		
	Evangelical Protestant Christian	3	1.08%
	Other Protestant Christian	19	6.81%
	Catholic	16	5.73%
	Jewish	21	7.53%
	Muslim	1	0.36%
	Agnostic	44	15.77%
	Other	58	20.79%
	None	117	41.94%
	Education Attained:		
	Some high school	2	0.72%
	GED	2	0.72%
	High school diploma	11	3.94%
	Some college	54	19.35%
	2-year undergraduate college degree	21	7.53%
	4-year undergraduate college degree	88	31.54%
	Some graduate school	23	8.24%
	Graduate school degree	78	27.96%
	Employment Status:		
	Yes, full-time	161	57.71%
	Yes, part-time	67	24.01%
	No, but seeking employment	30	10.75%
	No and not seeking employment right now	21	7.53%
	Currently a student:		
	No, I am not enrolled in any school at this	197	70.61%

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Table 2: Continued

	Yes, I am a full-time student	59	21.15%
	Yes, I am a part-time student	23	8.24%
	Household Income:		
	Under \$10,000	34	12.19%
	\$10,000 - \$24,999	41	14.70%
	\$25,000-\$39,999	38	13.62%
	\$40,000 - \$54,999	27	9.68%
	\$55,000 - \$69,999	35	12.54%
	\$70,000 - \$84,999	35	12.54%
	\$85,000 - \$99,999	15	5.38%
	\$100,000 - \$124,999	17	6.10%
	\$125,000 - \$149,999	14	5.02%
	\$150,000 - \$199,999	8	2.87%
	\$200,000 - \$299,000	9	3.23%
	OVER \$300,000	6	2.15%
	Currently involved in a romantic relationship with a partner:		
	No	76	27.24%
	Yes	203	72.76%
	Gender of Most Recent Partner:		
	Male	112	40.14%
	Female	167	59.86%
	Do any of the following apply to you and your romantic partner? (If so, check the answer that best applies.)		
	Committed, not living together	109	39.07%
	Committed, living together	84	30.11%
	Domestic partners	13	4.66%
	In a legal civil union	0	0.00%
	Legally married	73	26.16%
	Do you have a romantic partner or partners other than your primary partner?		
	Yes	35	12.55%
	No	244	87.45%

Descriptive Statistics For Observed Variables

Examining descriptive statistics for the eight measures used to determine the latent factors, reported in table 3, we can see that the participants tended to have average scores in the midrange for many of the measures, such as, Insecure Attachment to Caregiver, High Early Relational Trauma, Negative Parental Attitudes toward Homosexuality, and Low Self-Esteem. On average, participants scored below the midrange on several of the other observed variables, such as, High internalized heterosexism, Low Social Supports, and Poor Romantic Relational Quality. The lowest average scores were actually on the measure of psychological distress. Overall, the sample had low to average mean scores on measured variables that induce the latent constructs of interest: 1) high internalized heterosexism factor; 2) negative psychological and social outcomes factor; 3) negative early relational experiences factor.

Table 3: Descriptive Statistics for Observed Variables

Measure	Scoring Range High Scores = Higher Levels of the Variable	Mean	Median	SD
Insecure Attachment to Caregiver	1-7	3.6	3.5	1.3
High Early Relational Trauma	1-20	13.5	14	2.9
Negative Parental Attitudes toward Homosexuality	1-5	2.6	2.3	1.5
High IH	1-4	1.5	1.4	.46
High Psychological Distress	0-4	.77	.611	.61
Low Self-Esteem	1-4	1.9	1.9	.57
Low Social Supports	1-5	2.0	1.7	.96
Poor Romantic Relational Quality	1-7	2.4	2.0	1.5

Reliability of Measures Used to Induce Latent Factors

As reported in the methods section, the standardized measurements for this study were selected because they had good reported validity and reliability, and had been used with sexual minority individuals in the literature. In order to confirm, however, that the measures used are indeed reliable for the specific pool of participants in this study, reliability coefficients for each measure used in this study were estimated and are reported in Table 4. These reliability coefficients quantify the internal consistency among the items data collected from participants for each measure using Cronbach's alpha coefficient (Cronbach, 1951; Cronbach, Nanda, & Rajaratnam, 1972; Lord & Novick, 1968). That is, it provides an estimate of reliability based on the covariation among items internal to the test. Cronbach's alpha increases with the number of test items and increases when the average inter-correlation among the test items is high. Coefficients at or above 0.70 are often considered sufficiently reliable to make decisions about individuals based on their observed scores, with .80 being considered good and a higher value of 0.90 considered excellent (Lord & Novick, 1968). As you can see in Table 5, the reliability coefficients are well above 0.90 and thus in the excellent range for almost all measured variables except romantic relationship quality, which is 0.88, and in the good to nearing excellent range. Given these results, the observed measures are more than sufficiently reliable to be used in the structural equation model that is presented below.

Table 4: Internal Consistency Reliability Estimates for Observed Variables in Factors

Factors 1,2,3	Measured/Observed Variables	Reliability
Factor 1: ERT	Insecure Attachment	.92
Factor 1: ERT	Early Relational Trauma	.95
Factor 1: ERT	Negative Parental Attitudes toward Homosexuality	.95
Factor 2: IH	Internalized Heterosexism	.91
Factor 3: NERE	Psychological Distress	.91
Factor 3: NERE	Low Self-Esteem	.91
Factor 3: NERE	Poor Social Supports	.92
Factor 3: NERE	Poor Romantic Relationship Quality	.88

KEY:

Factor 1 NERE = Negative Early Relational Experiences Latent Factor

Factor 2 IH = Internalized Heterosexism Latent Factor

Factor 3 NO = Negative Psychological and Social Outcomes Latent Factor

Data Analysis

Controlling for Confounding Variables

After generating the internal consistency reliability estimates for each of the variables to be used in developing and testing the structural equation model, the effects of several demographic and methodological variables were statistically “removed”, i.e., partialled, from each of these variables. More specifically, each of the eight variables to be used in constructing the structural equation model was regressed on (1) age, (2) income, and (3) social desirability, and the “residuals” from these eight regression models were used in the structural equation

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model. By so doing, none of the relationships among the variables used in the structural equation model can be attributed to these three factors. After residualizing the eight “core” model variables, the hypothesized structural equation model was fit to the data using the Mplus program.

Introducing the Structural Equation Submodels

The model to be estimated tests the two central claims or hypotheses of the investigation which are: (1) the adverse effects of early, negative relational experiences as measured by insecure attachment, trauma and negative parental attitudes toward homosexuality are expected to be directly and positively related to negative, current psychological and social outcomes as measured by greater psychological distress, lower self-esteem, inadequate social support and poorer romantic relationship quality. In addition, (2) the effects of early, negative relational experiences are also expected to manifest themselves in a greater level of internalized heterosexism which, in turn, negatively affects current psychological and social well-being.

The structural equation model to be used in testing these hypotheses is comprised of two different submodels: (1) a measurement submodel and (2) a structural submodel. The measurement submodel is a factor analysis model in which the indicators of each of the three “latent” constructs are used to “induce” these three latent constructs, again, (1) Early Negative Relational Experiences, (2) Internalized Heterosexism and (3) Negative Current Psychological and Social Outcomes. The structural submodel then examines the relationships among these three latent factors.

Testing for Goodness-of-Fit

Based on the most commonly used goodness-of-fit statistic, the χ^2 goodness-of-fit statistic, the model does not appear to adequately fit the data, i.e., $\chi^2 = 43.69$ (18) $p < .001$. However, it is well known that this particular goodness-of-fit statistic is sensitive to size of the sample. Given that the current study sample has nearly 300 ($n=279$) cases, this result is not particularly surprising. It is for this reason that other goodness-of-fit statistics are examined, i.e., the root mean square error of approximation (RMSEA) and the Comparative Fit Index (CFI).

With respect to this model, these two fit statistics indicate that the model does provide a reasonably good fit to the data: RMSEA = .072, the .90 confidence interval of the RMSEA = (.045, .099), and the Comparative Fit Index = .937. Kline (2005), a recognized authority on structural equation modeling, has suggested that an RMSEA value $\geq .05$ and $\leq .08$ indicates a “reasonably good fitting model” as does a CFI value $\geq .90$.

Table 5: Goodness-of-Fit Testing

Goodness-of-fit statistic	Estimate	DF	Confidence Interval	Significance
χ^2	43.69	18		No, $p < .001$
RMSEA	.072		(.045, .099)	Yes, RMSEA value $\geq .05$ and $\leq .08$
CFI	.937			Yes, CFI value $\geq .90$

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The Measurement Submodel

Visual inspection of the standardized factor loadings in Table 6 shows that they are all statistically significant ($p < .001$) and well above the value of $\geq .30$ which is often considered to be the minimal value of a standardized factor loading used to support the claim that an item “measures” a latent factor. As such, the measurement model suggests that the observed or measured variables are good indicators of their respective latent factors.

All three variables comprising this latent factor of Early Negative Relational Experiences, accounted for a moderate degree of variability of the latent factor. Figure 2 demonstrates that insecure attachment to the primary caregiver/s was the best indicator of the variability explained by the latent factor (accounting for $.838^2 = .703$ of the variability), and the other two variables provided information that was also a good indicator of the latent factor (see Table 6). The hypothesized latent factor of Negative Psychological and Social Outcomes, was well-supported by the indicator variables’ information provided. Self-esteem was the strongest indicator variable (accounting for $.824^2 = .678$ of the variability).

Table 6. Table of Standardized Factor Loadings

	Estimate	S.E.	Est./S.E.	P-Value
				* = significant at $p \leq .05$
Early Negative Relational Experiences BY				
Insecure Attachment	0.839	0.068	12.351	0.0001*
Early Relational Trauma	0.559	0.054	10.252	0.0001*
Negative Parental Attitudes towards Homosexuality	0.558	0.061	9.145	0.0001*

Table 6: Continued**Internalized Heterosexism BY**

Internalized Heterosexism	0.951	0.006	166.839	0.0001*
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Negative Psychological and Social Outcomes BY

Psychological Distress	0.696	0.044	15.907	0.0001*
Poor Self-Esteem	0.824	0.043	19.010	0.0001*
Poor Social Supports	0.552	0.059	9.355	0.0001*
Poor Romantic Relationship Quality	0.439	0.059	7.462	0.0001*

*= significant at $p \leq .05$

The Structural Submodel

Turning to the structural part of the model, figure 3 presents the standardized regression coefficients, i.e., the direct effects, in the model. As seen in this figure, and as hypothesized, Early, Negative Relational Experiences is related to, that is, predictive of, Negative Current Psychological and Social Outcomes ($\beta = .238$, $p < .001$). Similarly, Early Negative Relational Experiences are, as expected, positively and significantly related to Internalized Homophobia ($\beta = .274$, $p < .001$). The magnitude of each of these effects can be characterized as “modest”.

The final direct effect in the model is the relationship between Internalized Heterosexism and Negative, Current Psychological and Social Outcomes. This relationship is positive, statistically significant, and moderately strong ($\beta = .409$, $p < .001$).

With regard to the hypothesized mediated effect in the model, there is a statistically significant, positive, indirect effect of Early, Negative Relational Experiences on Negative, Current Psychological and Social Outcomes via Internalized Homophobia (indirect effect = $(.274 \times .409) = .112$, $p < .001$). The magnitude of this mediated effect can be calibrated by

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recognizing that the “total effect” of Early, Negative Relational Experiences on Negative Current Psychological and Social Outcomes is the sum of its direct and indirect effects on this outcome. Concretely, this total effect equals the sum of $.238 + .112$ or $.350$. Expressed as a proportion or a percentage of this total effect, the indirect effect contributes $(.112/.350 = .31)$ 32% of the total effect of Early, Negative Relational Experiences on Negative, Current Psychological and Social outcomes. Stated somewhat differently, the magnitude of this indirect effect is quite substantial.

The findings that will be discussed in this chapter are based on data that was collected to address the primary research questions that underpin the theoretical model laid out in Figure 1 and chapter 2. Although numerous sexual minority stressors have been linked with poor psychological outcomes (Balsam & Syzmanski, 2005; Meyer, 1995; Morris & Balsam, 2003), the degree to which internalized heterosexism appears to impact the health and well-being of sexual minority individuals needs to be better understood as an independent phenomena.

Therefore, the first research question is whether the factor of high internalized heterosexism will mediate the effects of negative early relational experience on the negative psychological and social outcomes factor. Secondly, the structural equation statistical procedure will further test whether the latent factor of negative psychological and social outcomes, comprised of four indicator variables (increased psychological distress, poor self-esteem, poor romantic relationship quality, lack of social supports), is indeed a function of the predictor factor of negative early relational experiences, also with three indicator variables (insecure attachment to caregiver/s, early relational trauma/abuse, negative parental attitudes toward homosexuality).

Since this study places a great deal of importance on the potential mediating, or

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indirect, effect of internalized heterosexism on negative outcomes, testing this aspect of the model is as much, if not more, important to the integrity of the model as the testing of the direct effects of the early relational experiences predictor on the negative psychological and social outcomes.

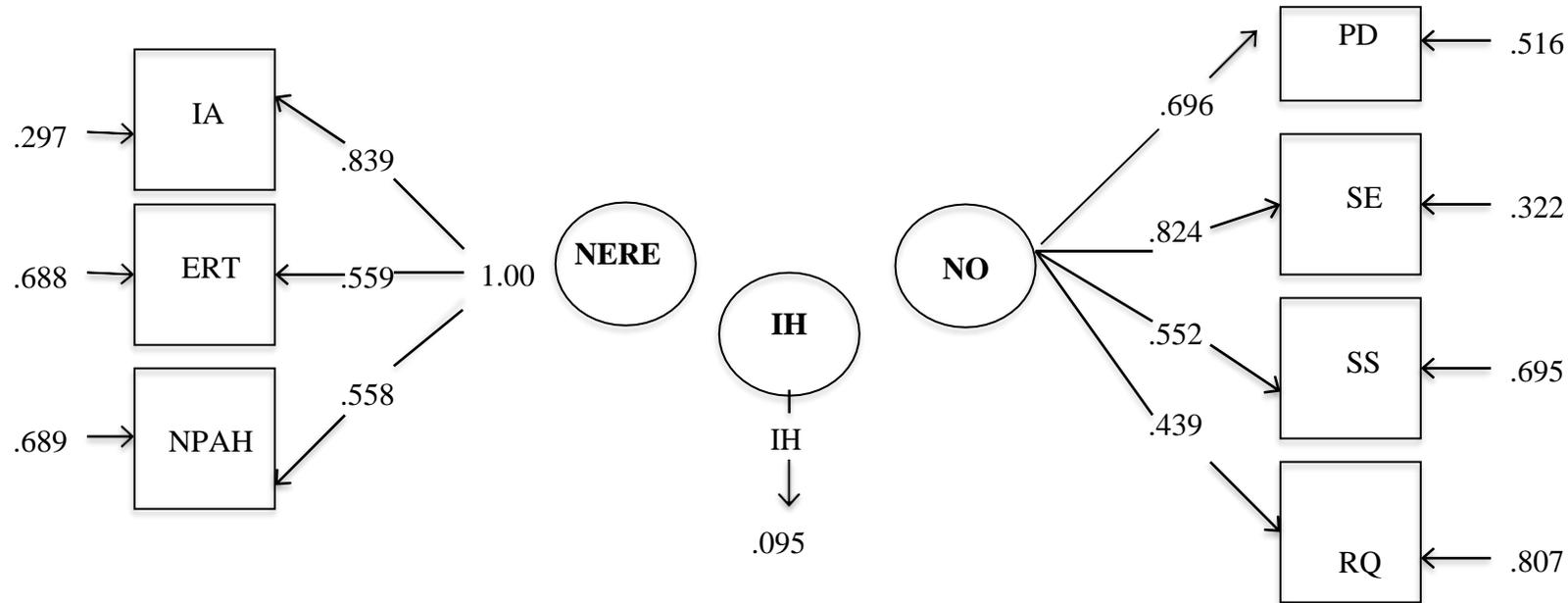
Analysis of the structural equation model of the factors is of primary importance, but if the measured variables used to induce these latent factors do not relate reliably to one another then the ability to glean sound data to interpret from the structural equation model factors analyzed will be compromised. Therefore, the findings in this chapter will be addressed in the following order: 1) Analyzing whether the observed variables reliably induce the latent factors; 2) Analyzing the direct effects of the early relational experiences predictor factor on the negative psychological and social outcomes factor; 3) Analyzing the potential mediating, or indirect, effect of internalized heterosexism on the negative outcomes factor. The final chapter will discuss the meaning and interpretation of the results reported in this chapter and summarized in figure 4.

Conclusion and Next Steps

In conclusion, the data was collected and analyzed according to the protocol laid out in chapter 3, and this chapter reported the key results. Specific interpretations of the findings and certain meaningful relationships that emerged in the analysis phase of the project will be more fully explicated in the chapter to follow this one. For example, the results just reported highlight the impact of internalized heterosexism on negative psychological and social outcomes. This finding validates the need for better understanding the role of internalized heterosexism in the lives of sexual minorities. Along with making recommendations about how to address these vulnerabilities, the next chapter will discuss certain limitations of the present study that should be considered. Limitations will be explicated and

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recommendations for further study will be suggested. Since a direct relationship has repeatedly been shown to exist between early relational trauma and later negative psychological and social outcomes, the results of this study support the widely accepted principal that early interventions targeting relational trauma is a priority among all traumatized populations in order to lessen the likelihood that these experiences will lead to deleterious outcomes. The next chapter will also consider ways to improve resilience among LGB individuals who experience difficulties associated with the phenomena of IH.

Figure 2: Measurement Submodel

* = Significant at $p \leq .05$

NERE=Negative Early Relational Experiences Latent Factor **NO**=Negative Psychological and Social Outcomes Latent Factor

Observed Variables that Comprise “NERE:”

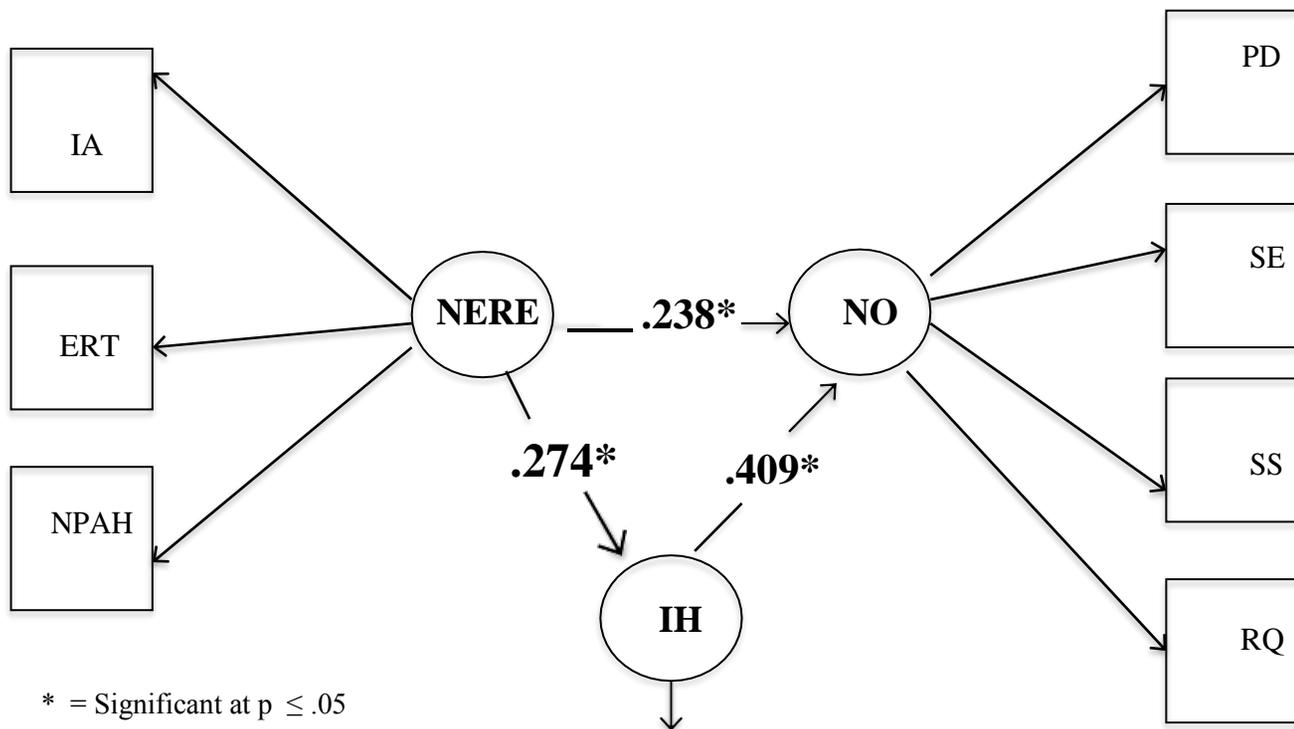
- (1) **IA** = Insecure Attachment
- (2) **ERT** = Early Relational Trauma
- (3) **NPAH** = Negative Parental Attitudes re Homosexuality

IH = Internalized Homosexism Latent Factor

Observed Variables that Comprise “NO:”

- (1) **PD** = Psychological Distress
- (2) **SE** = Low Self-Esteem
- (3) **SS** = Poor Social Supports
- (4) **RQ** = Poor Romantic Relationship Quality

Figure 3: Structural Submodel



KEY:

NERE=Negative Early Relational Experiences Latent Factor **NO**=Negative Psychological and Social Outcomes Latent Factor

Observed Variables that Comprise “NERE:”

- (1) **IA** = Insecure Attachment
- (2) **ERT** = Early Relational Trauma
- (3) **NPAH** = Negative Parental Attitudes re Homosexuality

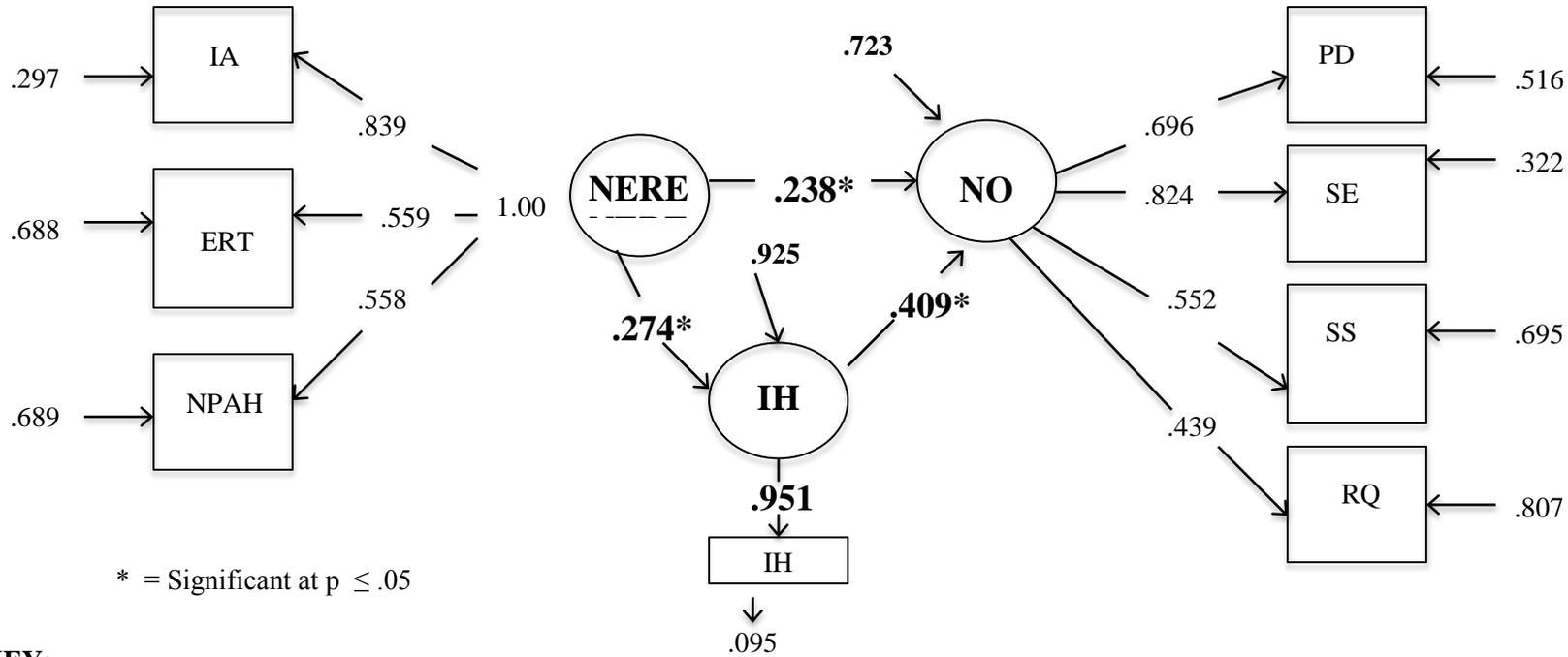
Observed Variables that Comprise “NO:”

- (1) **PD** = Psychological Distress
- (2) **SE** = Low Self-Esteem
- (3) **SS** = Poor Social Supports
- (4) **RQ** = Poor Romantic Relationship Quality

IH = Internalized Heterosexism Latent Factor

Figure 4: Structural Equation Model

(Includes both the Measurement and Structural Submodels of Negative Early Relational Experiences on Negative Psychological and Social Outcomes as Mediated by Internalized Heterosexism)



KEY:
NERE=Negative Early Relational Experiences Latent Factor **NO**=Negative Psychological and Social Outcomes Latent Factor

Observed Variables that Comprise “NERE:”

- (1) **IA** = Insecure Attachment
- (2) **ERT** = Early Relational Trauma
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IH = Internalized Heterosexism Latent Factor

Observed Variables that Comprise “NO:”

- (1) **PD** = Psychological Distress
- (2) **SE** = Low Self-Esteem
- (3) **SS** = Poor Social Supports
- (4) **RQ** = Poor Romantic Relationship Quality

CHAPTER 5

Discussion

Introduction

Homosexuality has been viewed as an indication of perversion in psychology extending back to Krafft-Ebing's *Psychopathia Sexualis* in 1886 (as cited in Domenici & Lesser, 1995). In 1980, homosexuality was removed from The Diagnostic and Statistical Manual of Mental Disorders (DSM) and was no longer classified as a psychological disorder by the American Psychiatric Association. As discussed in the literature reviewed in chapter 2, strides towards equality for LGB persons have moved forward since the 1960's, with major advancements made in the last ten years in terms of visibility and gains in rights (Leipold, 2014; Loftus, 2001) but still the experience of heterosexism is unavoidable for sexual minorities (see discussion in chapter 2). In addition, the public health literature continues to report mental health disparities among sexual minorities when compared to heterosexual peers (Cochran & Mays, 2000; Cochran et al, 2003; IOM, 2011; King et al., 2008).

This study gathered data from a community-based sample of sexual minority women to ascertain whether the results would replicate certain deleterious outcomes that have been well-documented in the epidemiological literature (see chapter 1). Empirical literature has frequently attributed this suffering to the phenomena of internalized heterosexism (Balsam & Mohr, 2007; Peterson & Gerrity, 2006; Szymanski et al., 2008 a-b). The predominant theoretical framework used to conceptualize the higher distress experienced by sexual minorities in the studies reviewed in chapter 1 highlighted both the importance of the social environment and internal variables. The internal variables reviewed in the literature, and assessed directly in the survey developed for this study, included the appraisal of one's attitudes towards sexual minority

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identity generally, with attention directed towards the crucial role that internalized heterosexism plays in the experience of the self as a sexual being. Internalized heterosexism was evaluated as an observable and measurable data point through, for example, questions assessing the degree of concealment of sexual identity, as concealment correlates with struggles with internalized heterosexism (Balsam & Mohr, 2007; Balsam & Szymanski, 2005; Herek, 2009; Luhtanen, 2003; Meyer, 2003; Rosario et al., 2012). This study premised that individuals in society are often exposed to homophobic beliefs throughout the lifespan. Heterosexist beliefs are subsequently internalized to a greater or lesser degree by all sexual minorities. This study was based upon two primary hypotheses that were designed to explain how the previously outlined (chapters 1-4) negative outcomes come to fruition. The negative outcomes that were addressed in this study included experiences categorized as primarily external/social in the form of measurements of social support and romantic relationship quality, and experiences categorized as primarily internal in the form of measurements of self-esteem and psychological distress.

The main research questions guiding this study were: 1) Whether the latent factor of negative psychological and social outcomes, comprised of four indicator variables (increased psychological distress, poor self-esteem, poor romantic relationship quality, lack of social supports), was a function of the predictor factor of negative early relational experiences, also with three indicator variables (insecure attachment to caregiver/s, early relational trauma/abuse and negative parental attitudes toward homosexuality); 2) Whether the factor of high internalized heterosexism mediated the effects of negative early relational experience on the negative psychological and social outcomes factor. The study was undertaken to provide empirical support validating the predictive relationship between early relational trauma and later negative psychological and social outcomes, and to test the mediating role of internalized heterosexism in

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this relationship. This research protocol was developed to address the hypotheses that underpin the theoretical model illustrated in figure 1.

Given the results reported in this study (chapter 4), and in other studies reviewed (chapter 2), there is evidence supporting the considerable impact of internalized heterosexism on poor outcomes, particularly among those who are more vulnerable to deleterious outcomes due to early trauma. This chapter will address strategies that foster the creation of social and clinical interventions aimed at reducing risk, thereby increasing resilience and adaptation. This chapter will discuss certain limitations of the present study, particularly, within-group variance that was not analyzed due to being beyond the scope of this project, a lack of narrative data that could be used for comparative purposes, a relatively homogeneous sample with regard to race and education, and a sample that was relatively low on measures of trauma, internalized heterosexism, and negative social and psychological outcomes. These limitations will be explicated and recommendations for further study will be suggested. In closing, the chapter will focus on specific clinical and policy recommendations that will be posited to better address the needs of this marginalized group, particularly those most vulnerable to negative outcomes related to IH, for example, the development of best practices in treatment and policy and the promotion of LGB-affirmative therapy as standard practice.

Key Results that Integrate the Measurement and Structural Submodels

This study (see table 6 and figures 1-4) found a direct, predictive relationship between the factor of negative early relational experiences on later negative psychological and social outcomes. This relationship was in the modest to moderate range, positive, and significant. The relationship between the factors has broad implications, best understood by examining their

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respective indicator variables, with the predictive factor comprised of insecure attachment to the primary caregiver/s, early relational trauma, and negative parental attitudes toward homosexuality, and the outcomes factor comprised of psychological distress, low self-esteem, poor romantic relationship quality, and poor social supports. The variables comprising the two factors just described had factor loadings that were well above the minimum (.30) required to be a good measure of their factors (see table 6), and were all classified as either “moderate” or “strong” measures of their respective constructs. When tested, the overall model fit the data well, allowing the results of the structural equation model to be interpreted with confidence.

The second main finding was that one-third of the relationship found between early relational difficulties and later negative outcomes were explainable by the presence of a high degree of internalized heterosexism. That is to say, the effects of early, negative relational experiences were substantially manifested as a greater level of internalized heterosexism, which, in turn, negatively affected current psychological and social wellbeing. Overall, this study provides sound empirical support for the mediating role of internalized heterosexism in the lives of sexual minority women who have had early traumatic, rejecting, and abusive experiences, and now suffer from negative psychological and social outcomes. Although numerous sexual minority stressors have been linked with poor psychological outcomes (Balsam & Syzanski, 2005; Meyer, 1995; Morris & Balsam, 2003), the degree to which internalized heterosexism appears to impact the health and well-being of sexual minority individuals needs to be better understood (see also Section 3 to follow).

**The Data Supports the Relationship between, and the Concepts Defining,
the Predictor and Outcomes Factors**

Operationalizing the Theoretical Model

When the theoretical model (figure 1) was developed a priori, negative early relational experiences were expected to directly predict the construct of negative social and psychological outcomes and this relationship was expected to be mediated by the level of internalized heterosexism. The direct effects relied on somewhat abstract constructs, made verifiable and investigable by using indicator variables that effectively induced a predictor factor and an outcome factor. The indicator variables were chosen based on the existing literature reviewed in chapter one, and selected by the PI using knowledge gleaned from clinical experience working with sexual minorities. The mediating role of internalized heterosexism on at-risk individuals who struggle later with negative psychological and social outcomes was based on literature reported in Chapter 1 stating that IH has certain direct effects on the measured outcomes, but the study was slightly speculative in theorizing that IH would carry a sizable load as the sole mediator in the model – a relationship that was supported in the analysis phase.

Role of the Predictor Variables in the Measurement Submodel

The model that guided the study emphasized the primacy of insecure attachment, relational trauma, and the LGB-specific experience of parental condemnation of homosexuality, as risk factors that would cohere into an underlying factor negatively affecting the sexual minority individual's development. Statistical analyses reported in the previous chapter supported the focal point of the factor of negative early relational experiences based on the hypothesis, tested and supported by the structural equation model results, that the way individuals learn to deal with their relationships with their families of origin will influence the way they manage later relationships and affect later psychological health outcomes. Insecure

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attachment to the primary caregiver/s, early relational trauma, and negative parental attitudes toward homosexuality were selected as the indicator variables that would operationalize the concept of negative early relational experiences. The three variables selected were well-supported by the empirical and theoretical (attachment theory, complex trauma theory, LGB-related minority stress theory) literature reviewed in chapter 1.

Early relational trauma and parental homophobia had factor loadings showing moderate to strong indications that these two variables as measured were good indicators of the factor. Parental homophobia was included in the factor because it is an early aversive experience of great consequence for a young person becoming aware of their same-sex desires. Even if caregivers are not expressly condemning of homosexuality, they likely do not share their child's sexual minority identity, and differing from the family in this way can be alienating for the developing child with same sex attractions. Unlike other minorities, sexual minorities generally do not have primary caregivers who share this aspect of their identity. Misattunements can result, particularly through missing the opportunity to inoculate sexual minority individuals against the many societal pressures to conform to heteronormative expectations, e.g., entering into heterosexual monogamous relationships with the goals of procreation and childrearing. Parents often fall victim to heterosexual assumptions when it comes to their child, and even if they come to suspect that their child has a minority sexual identity, the parent may not see a need to seek out a strong sexual minority role model for their child. The lack of opportunity to experience validation and a sense of belonging regarding their sexual identity does not provide a crucial counterbalance to the many heterosexist messages that they have already internalized.

The study results showed that early insecure attachment patterns (measured by the square of the standardized factor loading, $.839^2 = .703$) was by far the strongest indicator measure of the

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factor of negative early relational experiences. The strength of the role of attachment status in the factor analysis, and the evidence of the transmission of insecure attachment patterns over time to romantic partners in this study, is a noteworthy result as it contributes information about attachment patterns in an under-studied population, i.e., sexual minorities. The strength of the role of insecure attachment in the study provides critical support for using attachment status as a means to operationalize the characteristic difficulties in relationships found in LGB samples and broadly described in chapter 1.

Role of the Outcome Variables in the Measurement Submodel

The negative outcomes factor cohered around indicators that arose out of the literature stating that in adulthood, sexual minorities tend to be vulnerable in certain characteristic ways. Sexuality is a dynamic part of identity that has sociocultural and intrapsychic dimensions. While sexual minority identity is certainly affected by the objective reality enacted within the social environment, this reality is experienced and given meaning by the individual. Thus, outcomes that can be said to be internal variables, i.e., self-reported self-esteem and psychological distress, are both affected by, and somewhat separable from, external variables such as a poor romantic relationship quality and social supports. The theoretical model hypothesized that these four variables would have a statistically significant and correlated relationship that would cohere together into a construct called the poor outcomes factor. The four indicator variables of interest did provide good explanatory information when analyzed, i.e., the variables were good measures of the induced factor.

However, this primarily partnered sample did not report a great deal of romantic relationship difficulties overall. Nor did they report a significant lack of social supports or

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particularly low self-esteem. These results seem to indicate that this predominantly Caucasian, well-educated sample is healthier psychologically and relationally than the reviewed samples in Chapter 1. This sample did not report higher than average experiences of psychological distress as measured by the Brief Symptom Inventory (BSI; Dergatis, 1975). Same-sex desire and identity is no longer considered to be inherently pathological within the psychological community, and one reason for the low levels of negative reported distress in this study is that the participants follow the trend in probability samples of LGB populations that indicate that the majority of LGB adults do not report mental health problems (Cochran & Mays, 2006; Institute of Medicine, 2011). Overall, the average BSI symptomatic distress levels were not of a nature or magnitude to be considered in the clinically significant range, meaning that the study participants did not differ significantly in the number of symptoms they reported, or in the intensity of their perceived distress, when compared to the norms developed for adult female non-patients in appendix A of the BSI manual. These findings contradict much of the literature reported in chapter 1 stating that sexual minorities overall have greater risk of poor mental health outcomes than heterosexual peers (Cochran & Mays, 2000; Cochran et al., 2003; Institute of Medicine, 2000; Jorm et al., 2002).

Gonsiorek (1991) reasoned that there was no indication that having a minority sexual identity was itself related to increased psychopathology, but rather that the unique stresses endured by this marginalized group accounted for the portion who do indeed have elevated rates of psychological distress. Therefore it is important to understand that negotiating a minority sexual identity entails contending with a number of external environmental stressors that accumulate over a lifetime, and can be evidenced in some individuals through the psychological and relational difficulties that comprised the negative outcomes factor (e.g. Cochran & Mays, 2000; Mays et al., 2003). Study findings supported the epidemiological literature indicating that

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sexual minorities may experience elevated levels of distress, but this relationship only held true in this sample in conjunction with having experienced early traumatic events and/or having a high degree of internalized heterosexism. The same relationship held true for all the outcomes variables, indicating that this relatively healthy sample of sexual minority women did not have greater than average struggles with psychological distress, poor self-esteem, poor romantic relationship quality, and/or poor social supports.

However, early negative relational experiences significantly predicted, in the modest to moderate range, negative psychological and social outcomes. In addition, the variables that comprised these two factors were good measures of their respective constructs, being highly correlated and significant. Therefore, while the sample was resilient in the face of the stressors of negotiating a minority sexual identity, as evidenced by low reported overall negative outcomes, in the subset who did struggle with these deleterious outcomes, it was not their sexual minority identity specifically that put them at greater risk, but their experiences of early relational trauma and internalized heterosexism.

It is expectable that this studies' results from a community-based sample interested in answering extensive questions about their sexual identity might be more comfortable with this identity, but the study did attempt to recruit widely from non-LGB websites across the country in the hope of drawing a more diverse sample. However, the results indicate that overall, participants did not have higher than average levels of IH as measured by the Nungesser Homosexuality Attitudes Inventory (NHAI; Nungesser, 1983). The next section considers in greater detail why this sample was overall healthier than many of those reviewed in the literature.

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However, by now turning attention to IH, the significant and important relationship found in the subset of individuals who did fit the pattern in the structural equation model will continue to be interpreted as this result is consequential, and greater understanding is needed to improve functioning in this vulnerable group.

Study Results Support the Substantial Role of Internalized Heterosexism

This study merits substantive consideration because one-third of the relationship found between early relational difficulties and later negative outcomes was explainable by the presence of a high degree of internalized heterosexism. Overall, these results provide sound empirical support for the mediating role of internalized heterosexism in the lives of sexual minority women. The early risk factors previously highlighted are strongly manifested in the construct of IH. Therefore, improving outcomes necessitates greater understanding of IH, as well as the relationships between IH and the predictors and outcomes.

With regard to the mediating factor of IH, attachment status proved to be one of the more complex relationships in relation to internalized heterosexism that was analyzed. This relationship was also supported in the literature; for example, Sherry (2007) found that secure attachment was negatively correlated with internalized heterosexism, and numerous studies link IH to poor romantic relationship quality (Frost & Meyer, 2009; Meyer & Dean, 1998; Balsam & Szymanski, 2005). In the study, the outcome variable of relationship quality was directly and negatively affected by IH, indicating that the affected individuals have likely internalized a belief that sexual minority relationships are inherently pathological. This belief may be conscious, unconscious, or some blend of the two, but it will have an adverse effect on romantic relationship quality, as well as on perceptions of sexual self-identity. The study found that romantic

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relationship dissatisfaction correlated with higher IH, a finding supported in the literature on couples (Mohr & Fassinger, 2006; Otis et al., 2006; Spencer & Brown, 2007). Relationship quality as assessed via scores on the Experiences in Close Relationships Scale (ECR: Brennan et al., 1998) supported the hypothesis that overall, patterns of insecure attachment to caregivers in childhood predicted patterns of insecure attachment in adult romantic relationships.

This study collected empirical data indicating that early experiences with a heterosexist caregiver or caregivers and/or an insecure attachment pattern with such individuals tended to predict both struggles with internalized heterosexism and/or insecure attachment with a romantic partner. Further studies could build on these results using narratives to flesh out exactly what messages were received and how they were internalized. Indeed the study highlights the complexity of IH, showing IH to be a psychological wound that increases vulnerability to negative outcomes.

The strong mediating role of IH in this model supported the construct of IH as a driving force in the relationship between early adverse relational experiences on later negative outcomes. Therefore, this study supports a call for the creation of better social and clinical interventions aimed at understanding and ameliorating internalized heterosexism, in addition to working through past trauma, to reduce risk and foster adaptation in this marginalized group with current relational difficulties and psychological distress.

Study Limitations and Recommendations

Sample Considerations

Since many studies of sexual minorities tend to recruit participants from LGB community events, groups, or organizations, those recruited are naturally more public regarding their sexual orientation (Diamond, 2008). Since this study aimed to better understand the lack of social supports regarding struggles related to sexual identity and the resulting lack of connectedness to

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the sexual minority community, avoiding this kind of sampling was a strategy employed in recruitment because such individuals could reasonably be expected to be less represented at LGB events.

The study recruited widely from free, general and non-LGB websites across the country hoping to draw a diverse sample. Data analysis revealed that these attempts did attract participants who had a good deal of variance in terms of the markers of sexual identity previously discussed. Since the sample was also healthier psychologically than many of the samples previously reviewed, the findings from the participants of this study cannot be readily generalized to the reviewed epidemiological studies with high distress cohorts. Central to understanding sexual identity development in relation to internalized heterosexism is the degree to which differences are mediated by culture, race, ethnicity and class, however, this sample was predominantly Caucasian and well-educated. The homogeneity of this sample in this regard is a limitation that should have been better addressed.

One problem that emerged was that the study privileged income over education when attempting to operationalize a proxy for class as a potentially confounding variable. In an attempt to draw lower-income participants, the study was advertised on free websites, and did draw participants with varied household income levels, including 25% earning between 0- \$25,000 and 25% earning between \$25,000-\$50,000. Income was also controlled for in the statistical analysis. However, education was the more salient indicator of class in this sample. Reviewing the data showed that about one-third of the sample were currently students, and therefore likely to have a lower income level while studying that could be expected rise after graduation. Almost all in the sample had attended some college and the sample would be categorized overall as well-

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educated. Therefore, controlling for education, rather than income, in the statistical analyses would have provided a better proxy for class for this population.

It is expectable that a community-based sample interested in answering extensive questions about their sexual identity might be more comfortable with this identity and therefore this might provide one explanation for why mean IH was low for the sample overall.

Additionally, the survey length of 45 minutes and the detailed nature of the line of questioning netted a sample of well-educated participants perhaps due to comfort with this kind of testing situation. The large (237) number of drop-outs indicated that many participants qualified for the study via the pre-screening tool, but fatigue, lack of interest, and frustration with a high-effort, low-compensation endeavor seems to have led to a high rate of attrition. The advertisement and consent used nonthreatening and enthusiastic language and tone, and stressed the contribution that the participants would be making in adding their important perspective and experiences to the field of study. This approach seemed to garner a motivated core group who completed a survey that was long, complex and personal. However, those who completed may have done so primarily because of academic or social justice interests, which might be more common among those who identify strongly with being a sexual minority and who value research and academic education more generally.

Those who are of lower socioeconomic class or of ethnic or racial minority status might have responded with more vigor had they been targeted directly in the appeal for participation. For example, the language could have also stated that those with multiple minority or oppressed identities were particularly needed to share their experiences if the field is to reflect and address

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the diversity of the population itself. Highlighting the lack of data that exists, and how these participants are key to helping to rectify their invisibility in the body of research, would have personalized the request and thereby attracted and retained a more diverse pool. In addition to enhancing the sense of responsibility and benefit for underrepresented groups, shortening the study and offering a guaranteed or larger financial incentive would have prevented some of the attrition. It might have provided a sample with greater diversity in the areas lacking, i.e., class and race/ethnicity, as the high attrition rate points to more than just a lack of personal responsibility for completing the study, but to the lack of personal benefit and compensation, something that could be perceived as disrespectful or overly-burdensome in the context of a life with many competing responsibilities that are more pressing.

In addition, providing general and free access to the study was not enough to address the need for greater diversity, and therefore targeted outreach and advertisement on websites specifically targeting racial and ethnic minorities, the working class, or those who have multiple minority or oppressed identities, might help provide a more generalizable pool in future. Knowing how the sample demographics trended, the most comprehensive plan to address the limitation would be to cap participants based on their demographics for education and race/ethnicity while collecting the data, either matching participants to percentages of said populations reported in the U.S. Bureau of the Census (2011), or by over-representing these populations to correct for their under-representation in LGB studies and within the IH field of research.

Narratives of Oppression

A limitation to this study is that since almost all data collected is quantitative, there are no individual narratives, i.e., qualitative data, to use for comparative purposes. Since the design reflects the limitations of the researcher with regard to time and finances, it is up to other projects to

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collect narrative data for comparative and illustrative purposes. Such data would add new layers of individual and group complexity to the topics of discussion in this project, e.g. insecure attachment patterns and internalized heterosexism. In particular, using narratives to understand oppression parses out the ways that exposure to the same social realities, experiences, and sometimes even the same personal factors, may lead at times to different outcomes because of differences in the meanings given to experience.

Discussion of meaning-making requires access not just to those who populate an individuals' external world, but to those who populate their internal world as well. Narratives would help to flesh out the results of this project indicating that early experiences with a heterosexual caregiver or caregivers and/or an insecure attachment pattern with such individuals tends to predict both struggles with internalized heterosexism and/or insecure attachment with a romantic partner. This finding is important and worthy of further study. Time spent gathering narratives that parse the complexity of how these objects are represented internally, as well as how one's identity as a sexual being is represented, would help underscore the way that these patterns emerge and endure, as well as help to better understand the variability that exists in the present data set.

Within-Group Variance

Further study is needed on the variability of sexual minority women and negative outcomes. Though this was not of primary importance in this study, since bisexuals may suffer more from the effects of stigma as compared to homosexuals, researchers who wish to focus more specifically on within-group variance could use the model of this study and look at these groups separately. This would contribute to existing literature and help understand the unique challenges that bisexual women as a group face, e.g., approbation by both heterosexual and

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gay/lesbian people as summarized in the first chapter (Eliason, 2001). Thus, separate research on bisexual persons to examine the impact of heterosexism and bisexism on bisexual persons' lives and to address their unique issues would be a useful extension to the present study (Eliason; Szymanski et al., 2008 a-b).

Avoiding convenience sampling by not using LBG-targeted outlets and recruiting via advertisements in free online websites did draw a sample that was variable in terms of how they characterized their sexual identity. A good portion reported being in the earlier stages of questioning their identity, or engaging in homosexual behaviors while not publicly disclosing their sexual minority identity (see table 1 and 1a). This sampling procedure drew a grouping of sexual minority women that did not fit neatly into discrete categories, thus elucidating the complexity of representing and attempting to describe, quantify and label sexuality. Since web-based research allows for anonymity, these findings indicate that it is a good way of getting useful information about the conflicting aspects of sexual identity that this sample reported, i.e. differing reports of attractions, behavior and self-definition of sexual identity. Since this difference was seen in this sample, further studies could include these demographics into the variables tested for differences in effects and patterns.

Time Constraints

Due to cost, time, and manpower constraints, all participant study data was collected at the same time, which is a limitation. The studies in the literature review varied with respect to whether sexuality and other variables of interest were assessed cross-sectionally or longitudinally, with longitudinal studies being quite rare among those reviewed (Herek, Gillis, & Cogan, 2009; Diamond, 2008; Rosario et al., 2004). While retrospective data are

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meaningful and were used in this study, longitudinal studies represent the most rigorous means for evaluating the relationship studied. Longitudinal studies are particularly useful in understanding feelings about sexual identity, which unfolds over time. However, this study did recruit adult women (aged 18-50, mean age 29) who were presumably farther along in their developmental trajectory of negotiating their sexual identity, and thus likely more stable in their identity than adolescents, for example.

This study relied on a snapshot of the symptoms and ratings relevant to the particular time of the study within this group of women, as well as gathering retrospective self-report data, but replicating this study longitudinally would likely reveal important shifts in perceptions of the self over time. Filtering longitudinal changes through the lens of internalized heterosexism would add an additional layer conceptually. Also, the evolution of reported internalized heterosexism is under-researched, thus, longitudinal research spotlighting IH would be a meaningful contribution to the body of literature regarding this concept.

Defining Sexual Identity

While it could be considered a limitation to define sexual minority so broadly in the proposed study, there have been some data that supports a more inclusive (bisexual and lesbian) definition of sexual minority identity, especially in the case of women. For example, in Rust's (1992) study of lesbian and bisexual women, while aggregate differences were found, many similarities in terms of overall experience were also found. However, since bisexual women particularly may experience conflicts that are uniquely related to the fluidity or multiplicity of their romantic desires (Diamond, 2008), another study might highlight sexual identity as a variable that exists on a continuum, and may affect the dependent variables of interest in different ways.

The Clinical Implications of the Study

Further study is essential for gaining sound evidence on which to base clinical interventions for individuals who are experiencing psychological distress, even when this distress reflects structural inequalities that should themselves be addressed. Clinicians should be aware of how the concepts measured in this project impact sexual minority women, particularly as mediated by the experience of IH. They can use the results to consider how early relational trauma predicts negative psychological and social outcomes, as well as how addressing these two constructs should include psychotherapeutic methods for reducing IH in patients, as IH plays a significant role in this relationship. Therefore, a good therapeutic treatment plan for a sexual minority women with panic disorder and a history of trauma, for example, might not only target panic symptoms and include trauma-focused treatments, but explore whether topics related to internalized heterosexism should be brought into the treatment.

Best Practices in Psychotherapeutic Treatment

In general, sexual minority individuals do tend to utilize mental health services more than heterosexual individuals (Bradford et al., 1994; Cochran et al., 2003), and therefore clinicians should be aware of how to best help this marginalized population. Policymakers and researchers should be developing and funding programs, creating best practices, and offering professional development that add to the knowledge base of proven methods for psychotherapeutic treatment of sexual minorities.

Furthermore, the American Psychological Association's (APA, 2000) guidelines for treatment of sexual minorities state that not only should mental health providers be free of bias,

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prejudice, and discrimination, but that providers should be trained in LGB identity issues.

Therefore, training in working with sexual minorities should be a required, comprehensive part of diversity education and professional development. As part of such a program, clinicians should be encouraged to better understand how heterosexism impacts their own experience and practice, and obtain supervision and/or treatment to begin to work through expectable unconscious biases if this has not already been a focus of the clinician's personal therapeutic and professional work.

Indeed, from a multiple identities framework, clinicians may need to examine complex interactions among culture, sexuality, race, religion, and more, when tailoring interventions to understand each unique patient. However, basic understanding of the challenges facing sexual minorities should be a starting point for meeting sexual minority patients' needs.

In all studies of minority and oppressed populations, the choice of which set of variables to focus on, and to what extent, carries both ethical and policy implications. Focusing primarily on internal variables can place greater responsibility on the individual, while focusing primarily on external variables can place greater responsibility on society. Placing the responsibility externally forces policymakers to broaden legal protections for LGB persons. With an eye toward adaptive development, interventions that address and protect against the negative effects of IH should include attention to not only psychological interventions, but to best practices in the community, and to funding for programs supporting sexual minorities in the following areas: vocational development, family and parenting education addressing unique needs, preventative and physical health programs, interventions that enhance coping skills generally, academic support, and strategies for preventing bullying

Clinicians Working with Same-Sex Couples

The link between relationship quality and IH found in this study points to the ways in which IH may include an idea that all sexual minority relationships are inherently pathological. This belief may then influence coupled sexual minorities to have decreased positive feelings about their relationship (Mohr & Fassinger, 2006; Otis et. al., 2006). However, clinicians can use research on what helps improve sexual minority relationships. For example, Biss and Horn (2005) found that living with a partner had a substantial positive impact on sexual minority individuals' sexual satisfaction levels, and that psychological wellbeing contributed significantly to sexual satisfaction for their sample. Sexual inhibitions, however, may also result from the deleterious effects of IH, as same-gender desire may result in signal anxiety and shame that then causes the ego to set about defending against the psychic conflict, thus derailing the experience of sexual intimacy. Sexual intimacy can be compromised in a number of ways, including 1) sexual avoidance within a stable, emotionally intimate relationship, 2) splitting of sexual and intimate desires that results in relationships that are either sexual or intimate (not integrated), and, 3) sabotage or abandonment of a sexual relationship before intimacy can be fully developed. Targeted couples' work can improve sexual minority relationships when problems related to IH arise. Clinicians treating same-sex couples should be trained in the above literature and consider how to use this knowledge in their clinical work.

Conclusion

Evidence from this study and the literature reviewed indicated that internalized heterosexism affected current romantic relationship quality, levels of self-esteem, levels of psychological distress, and whether an individual accessed important social supports (Balsam & Szymanski, 2005; Frost & Meyer, 2009; Meyer, 1995; Meyer & Dean, 1998). Early traumatic, rejecting, and abusive experiences, predicted these outcomes. Negative outcomes were mediated

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by certain negative evaluations of the self as a sexual being with same-sex attractions called Internalized Heterosexism. This study provides empirical support of the research just cited. In light of this study's results, some of the ways that the creation of social and clinical interventions aimed at understanding and ameliorating IH, thereby reducing risk and fostering adaptation among sexual minority individuals, have been highlighted.

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