2018

Gender differences in perceived stigma among sexual minorities and their related health practices

Sara Kay Richardson
University of Northern Iowa

GENDER DIFFERENCES IN PERCIEVED STIGMA AMONG SEXUAL MINORITIES AND THEIR RELATED HEALTH PRACTICES

An Abstract of a Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Master of Arts

Sara Kay Richardson

University of Northern Iowa

May, 2018

ABSTRACT

Stigma, which is partially determined by social norms within specific cultures, can affect individuals in many ways such as direct negative treatment and discrimination as well as medical, social, and psychological disadvantages and problems. Lesbian women, gay men, bisexuals, and pansexuals have endured a long history of stigmatization in the United States (Herek, 1991). There is further evidence suggesting that bisexuals are especially susceptible to stigmatization, not only from heterosexuals (Herek, 2002), but from lesbian women and gay men as well (Ochs, 1996).

I hypothesized that among sexual minorities men would report higher levels of perceived stigma than would women, but especially so among bisexual men and women. I hypothesized the more open and "out" a person is about their sexual orientation identity, the more they will report perceived experiences of stigma. I also sought to further examine the relationship between stigmatization and health outcomes, such as visits to healthcare professionals and risky sexual behavior. There was a negative correlation between experienced stigma and openness for male and female participants. Future research should focus on assessing experiences of stigma in sexual minorities by employing measurements designed to assess the perception of the stigmatized individual's behavior.

GENDER DIFFERENCES IN PERCEIVED STIGMA AMONG SEXUAL MINORITIES AND THEIR RELATED HEALTH PRACTICES

A Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Master of Arts

Sara Kay Richardson

University of Northern Iowa

May, 2018

This Study by: Sara Kay Richardson

Entitled: Gender Differences in Perceived Stigma Among Sexual Minorities and Their Related Health Practices

has been approved as meeting the thesis requirement for the

Degree of Master of Arts

_____	_____
Date	Dr. Nicholas Terpstra-Schwab, Chair, Thesis Committee
_____	_____
Date	Dr. Helen C. Harton, Thesis Committee Member
_____	_____
Date	Dr. Elizabeth Lefler, Thesis Committee Member
_____	_____
Date	Dr. Patrick Pease, Interim Dean, Graduate College

TABLE OF CONTENTS

PAGE

LIST OF TABLES

TABLE PAGE

LIST OF FIGURES

FIGURE PAGE

CHAPTER 1

INTRODUCTION

What is Stigma

Stigma is the possession of an attribute resulting in widespread social disapproval. This discredited attribute results in a "spoiled social identity" (Goffman, 1963). Stigmatization essentially calls the stigmatized individual's humanity into question, whether in a conscious or unconscious manner. Stigma is dependent on social environments and circumstances because stigmatization often occurs in social interactions. An individual's social environment and context potentially differs considerably throughout her or his day, and especially throughout her or his lifetime; therefore, certain characteristics and attributes that are stigmatizing in one context may not be stigmatizing in another (Crocker, Major & Steele, 1998).

As the environmental context of the stigmatized individual shifts, stigma can be experienced from a variety of social constructs. Stereotypes, which are generalized ideas about an attribute (such as "Women perform poorly at math" or "poor people are too lazy to pull themselves out of poverty") are societal constructs that can help shape ideas and actions of the individuals within that society. Prejudice is the internalization and adoption of stereotypes to form attitudes about certain groups of people. This prejudice often influences the would-be stigmatizer's (hereafter referred to as "other's") behavior and interaction with others. Discrimination is the action taken based on these stereotypes and ideas such as refusing service to a marginalized person, or choosing to hire a person solely on characteristics attributed to a stereotype (Stangor, 2015).

In the earlier days of stigma research, there was debate on whether “stereotype,” “prejudice,” “stigma,” and “discrimination” were different phenomena or rather different labels for the same processes. A review of the literature on these phenomena (J.C. Phelan, Link, & Dovidio, 2008) suggests stereotypes, prejudice, and discrimination are all part of what others participate in, whereas stigma is the experience of the stigmatized individual. Ethnic and racial minorities are often the targeted participants when examining prejudice, and illness, disability or behavioral deviance (in the sense of deviation from established societal norms of behavior) are often targeted participants when examining stigma. Ignoring the demographics of the populations studied, the terms stigma and prejudice have described similar phenomena and processes. In their review, J. C. Phelan et al. (2008) suggest the term prejudice describes the negative attitudes and behavior of others and stigma describes the processes and experiences of the stigmatized individual.

There are four interrelated manifestations of stigma (Pryor & Reeder, 2011). The first is ‘public stigma,’ which represents people’s social and psychological reactions to someone who possesses a stigmatized attribute. Public stigma reflects the reactions and processes of others and is commonly researched within the field of prejudice (Bos, Pryor, Reeder, & Stutterheim, 2013). Public stigma is considered to be the core principle of this model and is necessary for the other three types of stigma to develop. The second form of stigma is referred to as ‘self-stigma,’ which reflects the social and psychological impact of being stigmatized or possessing stigmatizing attributes. Self-stigma addresses the general fear of being exposed to stigmatization as well as internalization of the

connotations associated with the stigmatized attribute. The third form of stigma is 'stigma by association.' Stigma by association entails reactions to people who are associated with a stigmatized person, although they do not necessarily possess the stigmatizing attribute themselves. The final manifestation of stigma is 'structural stigma,' which involves the systematic reinforcement and encouragement of stigmas through established cultural norms and processes (Pryor & Reeder, 2011).

Why People Stigmatize

Stigmatization serves several social and individualistic purposes that can generally be divided among three categories of oppression, adherence to group norms, and keeping undesirable people away (J. C. Phelan et al., 2008). The first of these categories suggests that stigmatization is a tool used by certain individuals to engage in exploitation and domination of other individuals. From a society-wide viewpoint, there will always be some individuals who must perform laborious, oftentimes unfavorable, tasks for the benefit of others. Attitudes develop to legitimatize the undesirable nature of the work, which separates those who do the work from those who do not do the work. This, in turn, deepen the ideologies and attitudes in a manner that further perpetuates inequalities between these groups of people (Jost & Banaji, 1994; Marx & Engels, 1976). An example of this can be found with American attitudes towards undocumented workers. Many of these laborers work on farms or other highly laborious and undesirable occupations. Much of this work is essential for the affordable production of many desired products and accommodations, but these workers are seen as unwelcome, thieving criminals who are so undesirable a wall must be built across our border to

protect ourselves from them. However, many businesses who employ undocumented workers struggle to find legal employees because labor intensive jobs are seen as much less prestigious compared to work requiring critical thinking such as office jobs or management positions (Martin, 2010).

The second general purpose of stigmatization is to keep people in, specifically to keep people in line within the group. Societies form social norms in an effort to provide a script to their members of what is and is not acceptable within that society. These norms must be followed by everyone within the society in order for that society to function efficiently. Evolutionary psychologists believe that stigma is evident, to varying degrees and nature, in all cultures and societies to allow humans to more cohesively live in groups, thereby enhancing our chances of survival (Kurzban & Leary, 2001). A person may be marked as unfit (usually on the basis of morality or character flaws; Morone, 1997) for group membership if this person does not follow prescribed norms. That individual could then be punished in an effort to force her or him to re-conform to group norms (Braithwaite, 1989), or if that individual does not re-conform, she or he could be cast out or ostracized in order to protect group cohesion and survival.

For example, many conservative Christian groups have deeply entrenched symbolic views towards sexual minorities (Tranby & Zulkowski 2012). Some Christian groups view sexual minorities as an affront to their core beliefs specifically, the belief that sexual relationships are only to be enjoyed by a committed (married) man and woman (“Official Statements,” 2017; “Does the Bible Comment on Same-Sex Marriages?” 2017; “Assemblies of God: Homosexuality, Marriage, and Sexual Identity,”

2017). The belief is that this husband and wife will then produce offspring to raise within the culture of the Christian group and carry on the beliefs and essence of the group is pivotal to the well-being and continued success of the group. Any sexual interaction other than this interaction is seen as counter-productive and thus deemed to be morally reprehensible. While the practice is slowly diminishing (Schnabel, 2016), a common solution to the "problem" for sexual minorities who wish to remain a part of their church or conservative Christian identity is conversion "therapy." During this "therapy" psychological, emotional, and at times physical manipulation and abuse are used in an effort to re-conform the person to group norms. Often, if this "therapy" is unsuccessful, the person may decide to stay "closeted" (where their true sexual identity is hidden or disguised), or the person may leave their group entirely (Drescher & Zucker, 2013; Ford, 2002).

The third category of stigma's function is to keep undesirable people away. This function of stigma often affects individuals who suffer from contractible diseases such as influenza or AIDS, but it also affects individuals who suffer from other physical and/or mental abnormalities. Certain parasites and infectious diseases can lead to many abnormalities such as deformations, asymmetries, lesions, discoloration, and abnormal behaviors. There may be some evolutionary pressures to avoid others who are infected by parasites and other infectious diseases (Kurzban & Leary, 2001; Neuberg, Smith, & Asher, 2000). Because contraction of these parasites and infectious diseases can be detrimental to the individual, and potentially the group as a whole, the cost of misses – failing to recognize a dangerous infection when there is in fact a dangerous infection

present – is quite high. Because the cost of misses is high, evolutionary pressures dictate that the system should be biased in favor of false positives – believing a dangerous infection is present when in fact the abnormality is caused by an innocuous factor.

As our understanding of mental illness has developed, people have generally come to understand and accept that it is impossible to "catch" something like a mental illness or disability just by being in contact with another person who has this illness or disability. However, portrayal of the mentally ill as violent has increased, especially from 1950 through 1996 (Olafsdottir, 2011; J. C. Phelan, Link, Stueve, & Pescosolido, 2000). Thus, fear of violence and unpredictability within the mentally ill population still plays a large role in the stigmatization of these populations.

Some evolutionary psychologists theorize that stigmatization as a means of disease avoidance extends beyond the target avoiding personally contracting a pathogen to the target avoiding potentially passing the genetic trait that has caused the stigmatizing traits to pass along to future generations (Dietrich, Matschinger, & Angermeyer, 2006; Lee et al., 2014; J. C. Phelan, 2005; Rusch, Todd, Bodenhausen, & Corrigan, 2000). Genetic contingency theory (Schnittker, 2008) suggests people prefer a greater deal of social distance (which is a covert form of discrimination e.g. "I wish you all the best, but I don't want to be near you or associated with you in any capacity.") when the person is provided with a biological (genetic) reason for the stigmatized attribute compared to a non-biological reason (e.g., culture or environment). For example, when examining perceptions of people with schizophrenia, people who believed the disorder was the result of a genetic or biological reason also reported higher levels of fear of violence from these

schizophrenic people. This general fear is rooted in the idea that there is little to nothing that can be done to "cure" the schizophrenic person of their unpredictable and perceived violent ways (Schnittker, 2008). Genetic contingency theory further suggests this desire for social distance is contingent on the stigmatized attribute, especially when examining how dangerous the others believe the target to be (Lee et al. 2014; Schomerus, Matschinger, & Angermeyer, 2013). These theories suggest that stigmatization is not only a way to preserve the current status quo of the dominant group for the present, but to continue this preservation for the next generation through reducing further propagation of potentially "deviant" genetic traits.

At its core, stigma serves a function of protection and preservation for the dominant group. Stigma allows the dominant group to control the actions of their members, but also the actions of the stigmatized individuals. By controlling the actions of the members of the dominant group, the culture and rituals which have served the group can be maintained. Subsequently, by controlling the actions of outside groups, the dominant group can either exploit the stigmatized individuals for their own gain (e.g. undocumented laborers), or can ostracize them and reduce the risk of infiltration of infectious diseases or behaviors (which may threaten the group norm).

Who is Stigmatized

There are four constructs that must exist and interact with each other for stigma to exist (B. G. Phelan & J. C. Phelan, 2001). The first component relies on people recognizing and labeling human differences. There are innumerable differences between any two people, and therefore most differences are overlooked (e.g., the color of one's

eyes, preferences of entertainment choice, and the type of car one drives). However, certain attributes are socially salient depending on the culture one is in (e.g., skin color, perceived socioeconomic status, religious classification, sexual orientation, and illnesses). The second component necessary for stigma to exist is the association of these differences with negative attributes and attitudes. An example of this is considering former mental health patients to be considerably more dangerous than former back pain patients (Link, Cullen, Frank, & Wozniak, 1987). Both groups of people could be classified as having an illness or malady, yet only one group is associated with negative attributes. The third component B. G. Phelan and J. C. Phelan (2001) propose is the separation of the "us" from "them." Essential to this component is the linking of undesirable attributes to the differences. Typical social groups do not see themselves as bad or amoral, and as a result of linking undesirable attributes to these acknowledged differences will attempt to distance and differentiate themselves from those who possess these differences. This in turn leads to status loss, the fourth component of stigma, by the targeted people. For example, if previous mental health patients are viewed as more dangerous, it might not be a stretch to believe they are capable of participating in violent criminal activity. In general, criminals possess a lower status than non-criminals, therefore, through this association, former mental health patients will also lose social status, regardless of criminal activity.

There are different ways that an individual may be "marked" or labeled for stigmatization. Goffman (1963) suggests three categories of stigmatizing attributes that an individual may possess. The first category, abominations of the body refer to physical

attributes that are easily observed by other individuals such as a physical deformation, being wheelchair bound, or having an illness (even as simple as a common cold), that are easily observed -- with exceptions of race, ethnicity, and gender. The second category that Goffman (1963) proposes is tribal stigma, which refers to belonging to a specific group or tribe. Membership in these groups is not usually considered to be the stigmatized individual's choice by the perpetrating population, but these groups often elicit a threat if the tribe or group is considered to be a minority or out-group. An example of this can be found in negative attitudes towards black people in the United States. These people did not choose their race, but they are seen by some in the United States as a threat based on their race alone. The third category is blemishes of individual character, which also refers to the victim of stigma belonging to a specific group. However, unlike tribal stigma, blemishes of individual character are usually assumed to be a choice – whether this assumption is correct or not – made by the stigmatized individual. These stigmatized individuals often elicit threat among most of the group because they threaten group cohesion. For example, bisexual people are often stigmatized in heterosexual and homosexual groups because bisexual people are neither exclusively heterosexual nor homosexual. While laying groundwork for understanding the nature of stigma and stigmatizing, a glaring problem with Goffman's (1963) idea of types of stigma is the lack of empirical evidence to support his claims.

The "Attribution-Value" model of prejudice (Crandall et al., 2001) is an empirical approach to categorizing stigma that contends the degree of stigmatization experienced by the target is predicted by the perception of controllability of the stigmatized attribute,

and the degree of value the culture places on the negative stereotypical attribute. If a target is believed to be in control of their negative attribute (e.g., choosing to be lazy rather than look for a job, or choosing to participate in homosexual behavior), others are more likely to exhibit more overt and harsh prejudice against the target. This is especially true if the stereotypical negative attribute is highly important or salient in cultural norms. For example, the elderly are often stigmatized as frail, unproductive, and generally seen as a burden due to their higher need for care in the United States and Western cultures. In many Eastern and collectivist cultures, the elderly are seen as a privilege to serve and care for and are esteemed as wise and highly valued members of the culture.

The Stereotype Content Model (Fiske, Cuddy, Glick, & Xu, 2002), suggests there are two primary dimensions that define the type of stigma that is being exhibited: competence and warmth. The dimension of warmth is how likeable and approachable a particular group of people are. For instance, the elderly are a population that would generally be scored as highly warm (although the authors are quick to point out that this is not always the case, depending on the person who is stigmatizing). The dimension of competence is defined as a group's ability to contribute to society in a certain way. Asians or CEOs would be classified as highly competent in most cultures (Cuddy, Fisk & Glick, 2007).

When these two dimensions are combined to create a competence by warmth matrix, they enable stigma and stereotypes to be classified into four factors: admiration, paternalistic prejudice, envious prejudice, and contemptuous prejudice. People and

groups who fall under the admiration factor are scored highly on both warmth and competent scores. Examples of people who would be admired would be religious leaders who are typically viewed as both a welcoming and guiding presence. People and groups who fall under the paternalistic prejudice factor tend to be scored highly on warmth, but low on competency. Overall, people and groups that fall under this category are disrespected, but pitied such as elderly adults, children, or sometimes people in a low socioeconomic class. People and groups categorized into the envious prejudice tend to be scored low on warmth, but highly on competency. Generally, people and groups that fall under this category are respected, but not well liked. Asian Americans typically are perceived to be exceptionally competent and smart, but not approachable or sociable (Lin, Kwan, Cheung, & Fiske, 2005). Finally, people and groups that fall under the contemptuous prejudice category are scored low on both warmth and competency. Generally, individuals and groups that fall into this category are disrespected and not well liked, which typically results in dehumanization by others. People who may fit into this category would be people who are homeless, people who are sexual minorities (especially gay or bisexual men), and criminals.

While these two models are complimentary in some ways, they also differ in key aspects. The Attribution-Value model is dependent upon the perception of controllability (Crandall et al., 2001) whereas the Stereotype-Content model explores the nature of the stereotypes, and what factors are involved in the content of the stereotype without presuming the degree of severity of the prejudice that may be imposed upon the target (Fiske et al., 2002). Both models are useful in understanding the nature of stigma

experienced by the targeted individual or group, as both models assess different but important aspects of stigma.

There are, of course, many empirically tested models and theories of stigma and why stigma occurs (outlined through the lens of mental illness in Otatti, Bodenhausen & Newman, 2005), but the Stereotype-Content model and Attribution-Value model provide empirically tested dimensions of stigma across a multitude of stigmatized identities such as Asian Americans (Lin et al., 2005), older adults (Cuddy & Fiske, 2002), mothers (Cuddy, Fiske, & Glick, 2004) overweight adults (Crandall et al., 2001; Fiske, 1980), overweight women (Crandall, 1991), and homosexuals (Sakalli, 2002) to name a few. Stigma is entirely dependent upon the target's identity in relation to the other's identity and the value the other places on the targeted individual's identity. The Stereotype-Content and Attribution-Value models focus on studying the nature of stigma experienced through characterization of the target's identity, whereas many other models lack the specific dimensions and classification of the type of stigma experienced.

Effects of Stigmatization

There are at least four ways stigma can affect the target: expectancy confirmation processes, automatic stereotype activation, identity threat processes, and negative treatment and direct discrimination (Major & O'Brien, 2005). Victims of stigma engage in expectancy confirmation processes, or self-fulfilling prophecies, as a result of their stigmatized status (Jussim, Palumbo, Chatman, Madon, & Smith, 2000). Because others expect the target to act in a certain way or follow stereotypical behaviors, others will often act in specifically different ways towards the target. This then leads the targeted

individual to respond to the other's behavior, which may then confirm the other's beliefs (Darley & Fazio, 1980; Deaux & Major, 1987).

If the targets of stigma are aware of the stereotypes imposed upon them, these stereotypes can affect their behavior through ideomotor processes, which are involuntary reactions – sometimes physical in nature – evoked by thoughts or mental processes rather than sensory stimulation. These processes can occur regardless of whether or not others are present and actively engaged in stigmatizing behavior such as exhibiting prejudicial attitudes or engaging in discrimination. Because the target links the stereotype and the behavior associated with it in his or her memory, exposure to or activation of the stereotype can lead to the behavior associated with it, seemingly automatically (Dijksterhuis, Aarts, Bargh, & van Knippenberg, 2000), and is especially likely to happen if the target is under cognitive load (Bargh, Chen, & Burrows, 1996). For example, if a person is attempting to conceal his or her sexual orientation in a work setting, he or she would likely be acutely aware of certain traits associated with his or her orientation so as to better hide these attributes from his or her co-workers. This person would need to be constantly vigilant to avoid displaying or exhibiting too many traits associated with their orientation. Because of this hyper-vigilance, cognition of the traits is regularly activated in the target's mind making them readily accessible. If the person comes under a higher than usual amount of cognitive load (a tight deadline, personal pressures away from work, exposure to prejudicial or discriminatory behavior from others, etc.) she or he is more likely to display the very traits they have been attempting to suppress due to the

recent cognitive activation of these traits and the now reduced or eliminated cognitive capacity to repress them.

Stigma may also put a person at risk of experiencing threats to his or her social identity. Stigmatization threatens self-esteem – both personal and collective – and can lead to an uncertainty as to whether the stigmatized individual's perceived stigmatization is due to his or her personal or social identity. This uncertainty may eventually lead the two selves (the stigmatized self and the personal self) to integrate and become indistinguishable to the stigmatized individual (Crocker & Major, 1989; Crocker et al., 1998; Herek, Gillis, & Cogan, 2009; Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995), resulting in self-stigma. Additionally, this uncertainty may also lead the stigmatized individual to question whether her or his experience was discriminatory, or rather a response to their person (Ruggiero & Taylor, 1997) potentially resulting in experiences of stigma by the target which were not intended to be such by others.

Negative treatment and direct discrimination is the most easily measured effect of stigmatization, and likely has the most direct effect on the stigmatized individual's mental and physical health. If an individual is discriminated against because of his or her stigma, he or she will have less access to quality healthcare (Alencar et al., 2016; Buchmueller & Carpenter, 2010; Goldsen, Kim, Barkan, Muraco, & Ellis, 2013; Heck, Randall, & Gorin, 2013; Herrick et al., 2013; Hoffman, Freeman, & Swann, 2009), housing (Westwood, 2016), occupations (Puhl & King, 2013; Swank, Fahs, & Frost, 2013) , and other amenities (Braine, 2014; Hatzenbuehler, J. C. Phelan, & Link, 2013) than non-stigmatized individuals have. This discrimination lowers the target's quality of

life and may allow otherwise easily treated diseases and disorders to take a physical and mental toll, if the stigmatized individual does not have access to preventative care (Williams, 1997).

In general, stigma has many negative outcomes for the targeted person. The target can portray a stereotypical behavior around the others based on the way others are behaving towards them, thus confirming the other's beliefs in the stereotypical behavior. Sometimes the target's stereotypical behavior is completely involuntary due to the degree of effort they expend to control this behavior and the amount of cognitive load they may be under. If these types of interactions occur regularly over time, it may become difficult for the stigmatized person to differentiate between their personal identity and the identity of their stigmatized self. This also makes it more difficult to distinguish neutral or negative interactions that may have been the result of a stigmatized stereotype or some other attribute, resulting in otherwise neutral interactions with others triggering a stereotype response. These experiences can be even more pronounced when the target has a stigmatized identity which isn't always readily apparent (e. g. "Do they know my identity? Is that why they reacted negatively towards me? Or was it for some other reason?"), such as the target's sexual orientation.

Stigma Experienced by LGBT Individuals in the United States

The United States has a long history of fear-mongering and discrimination against sexual minorities. According to the New York Times (Associated Press, 2003), in 1960 every state in the United States legally penalized consensual same-sex relationships. If a man was caught in a consensual sexual relationship with another man, or a woman with

another woman, the consequence could have resulted in fines and even possible jail sentences. In 1970, a man was denied a driver's license solely on the basis of his homosexuality ("Homosexual to Fight Denial of Car License," 1970). It was not until 1973 that the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (Spitzer, 1981). In 2003, 14 states in the United States still upheld "sodomy" laws that criminalized consensual same-sex relationships until the United States Supreme Court struck them down (Associated Press, 2003).

Furthermore, negative attitudes and direct discrimination towards men who have sex with men is found among rural doctors, rural dentists, rural mental health specialists, and rural social workers (Bennett, Weyant, & Simon, 1993; Clarke, 1993; Lindhorst, 1997; Schwanberg, 1996; Willging, Salvador, & Kano, 2006). In fact, concerns of prejudice among healthcare workers are so prevalent that lesbian, gay and bisexual individuals often choose to hide their identity from these professionals (Bergeron & Senn, 2003; Eliason & Schope, 2001; Stein & Bonuck, 2001), or avoid medical professionals and treatment entirely (Petroll & Mosack, 2011). This heightened sense of perceived stigma, especially from professionals who are supposed to offer help and support, could potentially lead to higher levels of internalized homophobia as well as higher levels of risky sexual behavior (Preston et al., 2004; Preston, D'Augelli, & Kassab, 2007).

Because stigma is dependent on attitudes associated with an identity, the ability to conceal one's sexual identity from certain or all social groups is commonly referred to as

being “closeted” in the sexual minority culture. A person may choose to share or not share their identity with others on a case-by-case basis in either an attempt to avoid prejudice and discrimination (remaining closeted), or to attempt to foster open and deeper relationships with others. Being open about one’s sexual orientation comes with a degree of risk of being victimized, discriminated against, and ostracized (D’Augelli & Grossman, 2001; Kosciw, Palmer & Kull, 2015; Kosciw, Greytak, Bartkiewic, Boesen, & Palmer, 2012) but openness about one’s identity also has a multitude of benefits to one’s well-being (Marcia, 1980). Higher levels of outness (disclosure of one’s orientation) are associated with lower levels of perceived stigma with healthcare providers (Austin, 2013; Whitehead, Shaver & Stephenson, 2016), however the degree of outness with the healthcare professional was affected by many factors such as access to sexual minority friends and resources (including readily available LGBT friendly healthcare professionals or practices), and outness in general. It is unclear if increased outness is related to lower levels of perceived stigma in regard to interactions with non-medical groups.

Many of the aforementioned studies tend to focus their attention exclusively on specific groups within the LGBT communities such as lesbian women, gay men, men who have sex with men, women who have sex with women, etc. Collectively, these studies help to understand and analyze the experiences of the sexual minority culture, but also emphasize a specific need to understand the differences between the groups and subgroups within the LGBT community. Specifically, there are large differences between the cultural norms prescribed to men and women within the context of being a sexual minority.

Sex Differences in Experienced Stigma Among Sexual Minorities

The perception of the target's gender is important to consider when measuring attitudes towards sexual minorities because it influences raters' attitudes towards the target (Herek, 1994). Heterosexuals hold more positive attitudes toward lesbians than they do towards gay men (Kite & Whitley, 1996). While attitudes have shifted significantly since the 1990's towards more tolerance, implicit biases still imply less favorable attitudes towards homosexual men than towards lesbian women (Breen & Karpinski, 2013). More negative bias towards gay men may reflect societal sanctions placed on men when they violate expectations of masculinity (Lehavot & Lambert, 2007; Stockard & Johnson, 1979). Eroticization of gay male sexuality by heterosexual women is not as permeated and inundated in Western culture as eroticization of lesbian female sexuality by heterosexual men, therefore there is little to counteract prejudice against homosexual men in the same way as homosexual women.

Historically (Fiske et al., 2002) gay men have been rated neutrally competent and slightly warm along the Stereotype Content matrix. This relatively neutral rating could be explained by some gay men subgroups (Clausell & Fiske, 2005) which vary somewhat based on the perceived masculinity and femininity of the subgroups. It is possible that lesbians would be likely scored as more highly approachable, desirable (to interact with, not to become) and generally warmer than gay men due to the eroticization of lesbian sexuality.

Crandall's Value-Attribution model has not yet been used to examine differences in cultural value and controllability between gay men, lesbian women and bisexual

people. However, research examining Turkish attitudes towards homosexual individuals reinforce the model's premise that when others believe the culture they live in is unaccepting of homosexuals, and they believe homosexuality to be controllable (to a certain degree the homosexual individual chooses to be homosexual, act on homosexual urges, or chooses to engage in homosexual social groups and environments), they tend to elicit more prejudicial attitudes towards homosexuals (Sakalli, 2002). As attitudes on the degree of controllability shift with the advancement of medical science in the search for a "cause" of homosexuality, the degree of prejudice towards homosexuality is likely to decrease somewhat assuming others place credence on these findings.

Stigma Experienced Exclusively by Bisexuals and Pansexuals

Bisexuality is a label which was originally intended to describe a person who was attracted to both men and women. Pansexuality is a label which was originally intended to describe a person who was attracted to all genders, essentially discarding the idea of gender assigned strictly to a masculine and feminine binary system. Pansexuality has emerged as a label attempting to be more inclusive of non-binary gender identities (Rice, 2015). While there is likely significant overlap in the life experiences between bisexuals and pansexuals (Baldwin et al., 2016; Flanders, LeBreton, Robinson, Bian & Caravaca-Morera, 2016; Flanders, Robinson, Legge, & Tarasoff, 2016), there is some evidence to suggest pansexual people experience prejudice uniquely from bisexuals, and may experience less prejudice from lesbian and gay individuals than their bisexual peers (Mitchell, Davis & Galupo, 2014).

Heterosexual women tend to equally accept bisexuals, regardless of the sex of the bisexual individual. However, men are less accepting of bisexual men than bisexual women. This relationship between the rater's sex and the target's sex may be partially explained by the eroticization of female same-sex sexuality (Herek, 2002; Reiss, 1986). Moreover, male bisexuals are described as gender-nonconforming and believed to be secretly homosexual, whereas female bisexuals are described in a positive manner (e.g. sexy) and are believed to be secretly heterosexual (Yost & Thomas, 2012). In fact, heterosexual men are more likely than heterosexual women and sexual minorities in general to believe bisexuality is not a legitimate sexual orientation at all (Friedman et al., 2014).

The understanding of the importance of explicitly acknowledging the target's gender has become more widely practiced, but sex and gender differences in stigma of sexual minority literature have often been ignored or overlooked in the greater body of literature of stigma experienced by and prejudice or discrimination towards sexual minorities. For example, many early assessments of negative attitudes towards bisexuals, specifically the Biphobia Scale (Mulick & Wright, 2002) used gender-neutral language such as "bisexual individual" or "bisexual person." However, when gender neutral language is employed, participants often make assumptions that the ambiguous "individual" is male, or possesses more masculine qualities (Hamilton, 1991; Merritt & Kok, 1995). It is therefore possible that the Biphobia Scale examines attitudes towards only bisexual men, or at the very least does not allow for an examination of the differences between men and women bisexuals.

Bisexual men and women may be viewed even less favorably than lesbian women and gay men by heterosexuals. In 1999, heterosexual men and women rated bisexual men and women as less trustworthy, intelligent, and moral than any other group assessed (e.g., religious groups, racial groups, homosexual men and women), with an exception of intravenous drug users (Herek, 2002). This finding suggests that it is possible that bisexual men and women are stigmatized more severely than are gay men and lesbian women. Additionally, bisexual men are more likely to exhibit internalized homophobia, resulting in a form of self-stigma, than lesbians, gay men, or bisexual women (Herek et al., 2009)

There are a couple reasons that heterosexual men and women seem to think less favorably of bisexual men and women than gay men and lesbian women. Bisexual behavior has likely been exhibited for as long as homosexual behavior, yet the label is relatively recently accepted as a legitimate identity in modern Western culture, which results in higher levels of uncertainty towards the group. This uncertainty of bisexuality could lead to fear and negative attitudes towards the group. It was not until the late 1980's that bisexual organizations gained nationwide legitimacy and notice by the general public (Rust, 1995). This recognition came in the midst of the nation's GRIDS (Gay Related Immunodeficiency Syndrome, sometimes referred to as "Gay Cancer" later to be called HIV and AIDS) epidemic. At this time, all sexual minorities were seen as the perpetrators of this mysterious and deadly disease (notice the name of the disease at the time started as "Gay Related"), which only heightened the fear of and stigmatization against sexual minorities (Dunlap, 1989). This was especially true of bisexual men and

women because the concept of bisexuality was so poorly understood (Doll & Beeker, 1996; Ekstrand et al., 1994; Morse, Simon, Osofsky, Balson, & Gaumer, 1991; O'Leary & Jones, 2006). One of the theorized evolutionary functions of stigmatization is that of disease avoidance, especially in the presence of uncertainty. Bisexuals were a new and unfamiliar concept and sub group emerging amid a widespread and largely uncontrolled epidemic. As such stigmatization was a convenient means of attempting to protect the larger population by dehumanizing and distancing from the "marked" population believed to be spreading the disease and danger.

Another important distinction between stigma experienced by homosexuals and bisexuals stems from the concept of mononormativity, which is the idea that attraction to only *one* gender is truly possible. This notion of mononormativity stems from the binary understandings of human sexuality which allow only for homosexuality and heterosexuality as valid orientations. The belief that everyone should be monosexual (only attracted to one gender) creates a structure of stigma directly targeting bisexuals, pansexuals, and other non-monosexuals for their non-compliance to this structure (Barker, Bowes-Catton, Lantaffi, Cassidy, & Brewer, 2008; Blackburn, 2012; Diamond 2003; Diamond, 2005; Fahs, 2009; Fairyington, 2008; Herek & Capitanio, 1999; Herek et al., 2009; Morrison Harrington, & McDermott, 2010; Mulvihill, 2012; Storr, 1999; Thompson, 2006). Bisexuals may induce uncomfortable feelings in some heterosexual men and women, as well as gay men and lesbian women (see Weiss, 2004) because bisexuality blurs the line between heterosexual and homosexual orientations, effectively dissolving some absolutes that allow for distinction between heterosexual and

homosexual groups (Ochs, 1996). Further, having a "need for closure" is associated with a higher degree of negative attitudes towards bisexuals, and a preference towards treating gay or lesbian patients in heterosexual medical students (Burke et al., 2017). Need for closure, in this instance is defined as an individual's need for a firm answer to a question and aversion to uncertainty and ambiguity. Because of this blurred line between sexualities, many people may view bisexuals as sexually promiscuous and as individuals who could potentially introduce "homosexual illnesses" (specifically HIV and AIDS) into the heterosexual population (Spalding & Peplau, 1997; Yost & Gilmore, 2011).

The attitude that a person is either gay or straight is especially prevalent in homosexual communities, demonstrated by the widespread use of the term "gold star lesbian" or "gold star gay." These terms are used to describe someone who has never had a heterosexual or non-mononormitive relationship as an ideal to be aspired towards (Zane, 2016a). Often the concept of identifying as bisexual is treated as a stepping stone for someone to come "out" as homosexual, or they are just confused or exploring their sexuality until they discover their true sexual orientation (Weinberg, Williams, & Pryor, 1995) in an effort to canonize mononormitive sexual orientations (Yoshino, 2000).

Further, there is a great deal of distrust among lesbians and gay men of bisexuals for fear that the bisexual individual will eventually leave their same-sex relationship for a more socially accepted heterosexual relationship ("Homophobia, Biphobia & Transphobia," n. d.) and continue to enjoy their "straight privilege" (Higgins, 2014; Zane, 2016b). But what some lesbian women and gay men refer to as "straight privilege" is actually an erasure of the person's bisexual identity (MacDowall, 2009). This erasing or

ignoring of bisexual identity is prevalent through both heterosexual and sexual minority cultures (Alarie & Gaudet, 2013), and largely isolate bisexuals from both communities (Deihl & Ochs, 2000; Fox, 1995; Robin & Hamner, 2000; Rust, 2002; Schueler, Hoffman & Peterson, 2009)

Stigma and Health Outcomes

I have discussed many of the internal and social tolls stigma can take on an individual. Increased risk of mental illness, discrimination, harassment, and isolation can in and of themselves result in adverse health outcomes. Stigma can take a direct and immediate physical toll on an individual as well (Harrell, Hall, & Taliaferro, 2003). People shape their perception of a potentially stigmatizing event through a series of factors, such as previous experiences with similar stimuli, internal psychological and physiological processes, and socioeconomic factors. After these factors aid in the interpretation of the event, the person can determine whether the event was stigmatizing or not. If the event is considered to be stigmatizing, the stigmatized individual may elicit coping responses that lead to psychological and physiological stress responses (Clark, Anderson, Clark & Williams, 1999).

If people believe that they are being stigmatized, even if it is an ambiguous situation that could possibly not be the result of the their stigmatized identity (Merritt, Benett, Williams, Edwards, & Soller, 2006), the brain reacts as if it is in a “fight or flight” scenario and directs the body to respond. This typically manifests itself as raised diastolic blood pressure, raised systolic blood pressure and higher heart rate (Armstead, Lawler, Gordon, Cross, & Gibbons, 1989; Brondolo, Rieppi, Kelly, & Gerin, 2003;

Clark, 2000, 2003a, 2003b; Clark & Anderson, 2001; Clark et al., 1999; Fang & Myers, 2001; Harrell et al., 2003; Jones, Harrell, Morris-Prather, Thomas, & Omowale, 1996; McNeilly et al., 1995; Steffen, McNeilly, Anderson, & Sherwood, 2003; Sutherland & Harrell, 1986).

Exposure to stressful stigma over an extended period of time can cause further problems. When the brain is regularly in "fight or flight" mode as a response to the stressful stimulus in the individual's environment, the adrenal gland will continuously produce low levels of hormones that suppress the activity of certain lymphocytes. These lymphocytes, or more commonly known as white blood cells, are cells that aid the immune system in destroying invasive diseases such as harmful viruses and bacteria (Cohen & Herbert, 1996). Chronic exposure to stress can result in lowering the white blood cells' activities, including the cells' ability to recognize a harmful foreign infection (Antoni, et al, 2006; Dhabhar, 2014; Folkman, Chesney, Pollack, & Coates, 1993; Hall et al., 2012; Herbert & Cohen, 1993; Leserman et al., 1997; Kiecolt-Glaser, Glaser, Gravenstein, Malarkey, & Sheridan, 1996; Monjan, 1977; Padgett & Glaser, 2003) which eventually could lead to more visits with physicians and higher health care costs for the stigmatized individual (Huebner & Davis, 2007).

Additionally, some of the immediate physiological responses to stress can lead to prolonged health issues such as cardiovascular disease and hypertension (Brondolo et al., 2003; Krieger & Sidney, 1996). For example, significantly more African Americans suffer from cardiovascular disease than do European Americans. This is widely believed

to be correlated to the disproportionate amount of stigmatization (and subsequent discrimination) that African Americans are exposed to (Allison, 1998).

Other health risks for people who are exposed to chronic minority stressors are increased risks of developing a variety of mental illnesses, such as depression, anxiety disorders, or even posttraumatic stress disorder if the stressors are great enough (Herek & Garnets, 2007; Herek, Gillis, & Cogan 1999; Lewis, Derlega, Griffin, & Krowinski, 2003; Mays & Cochran, 2001; Meyer, 2003). Anxiety and depression, while costly health problems on their own, are also predictive of higher degrees of reported physical illness (Rawson & Bloomer, 1994, Shilo & Mor, 2014). Other health risks associated with sexual minorities stressors include risky sexual behavior (such as sexual contact without the use of a condom or dental dam), which increases one's risk of contracting HIV or other sexually transmitted infections (Meyer & Dean, 1998; Mor, Davidovich, McFarlane, & Feldstein, 2008). This relationship between mental and physical health could potentially further compound health outcomes related to minority stress responses.

Current Study

There are many factors that influence the experiences of stigma and corresponding health outcomes for sexual minorities. A history of distrust and disdain for people who do not follow heteronormative societal norms have set the stage for stigma against sexual minorities in general. Other factors such as a non-mononormative sexual orientation (such as bisexual or pansexual), the perceived sexual orientation of the target by the stigmatizer, and the openness of the individual about their sexual orientation are further violations of social norms and create opportunities for negative treatment and

discrimination from even some in certain sexual minority sub-populations. Further, the gender of the person being stigmatized also must be considered when examining experienced stigma among sexual minorities as there are distinct allowances offered to women (who are seen as "flexible" and "sexy" when they violate their gender norm) which are typically not extended to men. In recent years, these factors have begun to emerge in research examining stigma among sexual minorities and the corresponding health outcomes. We know that bisexuals tend to report higher levels of experienced stigma than their homosexual peers, and there is more tolerance and acceptance of female sexual fluidity than is present for men. This study sought to further expand upon this body of research by differentiating the experiences of stigma among male and female participants. Further, this study sought to discern experiences of stigma among male and female bisexual participants. In addition, levels of openness about one's sexual orientation are not always considered when examining health outcomes for sexual minorities. Logic dictates the more open one is about their stigmatizing attribute, the more likely they are to be stigmatized for this attribute. However, emerging research in regard to the individual's relationship with their healthcare provider seems to contradict this logic somewhat (Austin, 2013; Whitehead et al., 2016). These specific findings could have a large impact on health outcomes due to experienced stigma. However, there is still little research to expand upon this hypothesis beyond the non-medical professionals.

There are varying degrees of eroticization of lesbian sexuality and gay male sexuality among popular culture in the United States. Lesbian sexuality is typically

popular and desirable in Western heterosexual pop culture, whereas attitudes among heterosexuals towards gay male sexuality are typically neutral or negative. As a result, lesbians are generally more easily "forgiven" for their deviance from the accepted norm, as the deviance is seen as desirable and pleasing. However, without this "forgiveness" from pop culture, gay men have less social capital to buffer against prejudice and stigmatization which accompanies deviance from the norm. As such, I hypothesized that in general men would report higher levels of perceived stigma than would women, but specifically that bisexual men would report higher levels of perceived stigma than bisexual women.

A person's sexual orientation generally tends to be less readily available to the general public than other categorizing markers such as race or gender. While a person could display stereotypical indicators of a sexual orientation such as certain body postures, language choices, or clothing styles, these indicators could be disguised with a relative degree of self-awareness and self-discipline. Because each person has a considerable amount of control over how and when they disclose their sexual orientation, the degree to which an individual is publicly open about her or his sexuality could play a role in the amount of stigma the person experiences or perceives. I hypothesized the more open and "out" a person is about their sexual orientation identity, the more they will report perceived experiences of stigma.

The connection between minority-related stressors and health outcomes has been thoroughly examined through the perspective of ethnic minorities in the United States and Canada. In general, people who are exposed to a high degree of these minority

related stressors, including stigmatization, often experience a higher rate of health concerns such as higher blood pressure, chronic heart problems (Allison, 1998) and reduced efficiency of the immune system (Juster et al., 2015; Lick, Durso, & Johnson, 2013). This relationship has only recently been examined through the perspective of sexual minorities, however. While it is incredibly difficult, and practically impossible for most people, to hide one's ethnicity and thereby escape stigmatization, it is possible for sexual minorities to disguise their sexual orientation from those who they wish to, effectively avoiding many of the deleterious effects of their stigmatizing identity. Due to this confounding factor, I sought to further examine the relationship between stigmatization and health outcomes amongst sexual minorities further.

Due to the limited amount of resources available to me at the onset of this study, the data collection method was designed to be implemented on a volunteer basis (mainly through surveys sent to college LGBT groups). I knew the vast majority of the participants would be young and would likely not be monitoring the state of their blood pressure or other cardiovascular health indicators. I therefore decided to measure health outcomes related to the impaired functioning of the immune system. Research participant self-reports of previous doctor visits have been validated and shown to be an accurate representation of visits that actually occurred (Cleary & Jette, 1984; Reijneveld & Stronks, 2001; Ritter et al., 2001; Weissman et al., 1996). I explored the relationship between perceived stigma and the self-reported number of doctor visits as it was unclear whether the stress caused by potentially higher levels of perceived stigma will cause the individuals to be sick, and therefore seek medical help, or if the higher levels of stigma,

even among healthcare professionals, will discourage these individuals from seeking medical assistance. I also chose to explore additional health outcomes specific to sexual minorities exposed to stigma through analyzing self-reports of safe sex practices.

In conclusion, I hypothesized that in general men would report higher levels of perceived stigma than would women, but specifically that bisexual men would report higher levels of perceived stigma than bisexual women. I hypothesized the more open one is about their sexual orientation the more they would report higher levels of experienced stigma. I also examined the relationship between levels of experienced stigma and health care professional visits, and self-reported frequency of safe sex practices.

CHAPTER 2

METHODS

Participants

Based on previous reports of effect size in similar research (Herek et al., 2009; Pryor & Bos, 2016) an a priori power analysis was conducted using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) to determine that 1086 participants would be needed to detect a small effect size (.15) of any interaction between groups (Gender, df =4; and Sexual Orientation, df = 4) on perceived stigma with a power level of .9 for this study design. Requests for participants were provided to 452 college or university LGBT and Ally organizations in all 50 States and the District of Columbia (see Appendix A). Participants who chose to report the location they currently lived in were identified from 21 states and 1 county in the United Kingdom (1 participant). In total, 323 people responded to my request for participation by completing some or all of the questions in the study. The response rate could not be determined due to the unknown number of people who would have had access to the survey. While the survey was distributed to a distinct number of LGBT organizations, there is no way of knowing how many people the organization distributed the survey to.

The request for participants specifically requested that heterosexual individuals not participate in this study. Although there is a certain amount of stigma associated with being a heterosexual ally to sexual minorities, I believe that it is a different set of experiences from the main focus of the current study. Therefore, participants who both self-identified as heterosexual and self-reported having a history of sexual partners

exclusively with another gender other than their own were excluded from further analysis (*N* = 31).

Of the remaining participants recruited, 43% self-identified as homosexual, 14.9% self-identified as bisexual, 13.5% self-identified as pansexual, 11.8% self-identified as "other," .7% self-identified as heterosexual (though they reported a history of relationships at least somewhat with their own gender), and 15.3% chose not to respond. Nineteen percent of respondents reported having never had sex, 27.6% reported a history of sexual partners exclusively of their own gender, 18.3% reported a history of sexual partners of mostly their own gender but some with another gender, 5.5% reported a sexual history of partners of equally their own gender and another gender, 11.4% reported a history of sexual partners mostly of another gender but some with their own gender, 3.1% reported a history of sexual partners exclusively of another gender, and 14.8% of respondents chose not to answer. Twenty-five percent of participants were male (*N* = 72), 48.6% were female (*N* = 141), 2.4% were transgender (*N* = 7), 9.4% responded as "other" (*N* = 27), and 14.6% chose not to respond (*N* = 45). Participants ages ranged from 18 to 66 (*M* = 24.59, *SD* = 10.17, median = 21), and 68.1% of participants were White, 5.9% were multi-racial, 5.2% were Hispanic/Latino/a, 2.8% were Asian American, 1% were Black, .7% were Native American, and 14.6% chose not to respond. These demographic data compare to a recent Gallup Poll conducted (Gates & Newport, 2012) which reported approximately 67% of LGBT people in the United States are White (but non-Whites are more likely to identify as LGBT than are Whites). This

Gallup Poll did indicate approximately 53% of LGBT people are women and this disparity will be discussed further in the discussion section.

Measures

Initially participants completed a 10 item Outness Inventory to determine the degree to which the individual is open and disclosing about her or his sexuality with her or his social peers (see Appendix B). Originally developed by Mohr and Fassinger in 2000, this scale assesses the participant's level of openness about their sexual orientation and identity to three groups of people in their lives: family, relationships with religious leaders and members of a religious community, and everyone else (co-workers, friends, new acquaintances, etc.). Internal reliability of this scale in this study was $\alpha = .89$. The initial scale was validated based on factors from the Lesbian and Gay Identity Scale such a need for privacy, need for acceptance, and internalized homonegativity.

To assess each participant's level of perceived stigma I administered the Experiences of Discrimination Scale (King et al., 2007) to determine the individual's perceived general experiences with stigma (see Appendix C). This questionnaire was initially developed to assess experiences of stigma among individuals with a mental health diagnosis and was significantly correlated with measures of self-esteem (r=.63 $p <$ .001). While there are several questionnaires that assess various experiences with stigma, many of them were developed to target ethnic minorities. At the time of data collection, there was not a well-established experiences of stigma scale for sexual minorities. Because mental illness is not always readily apparent in much the same way as sexual orientation the Experiences of Discrimination scale was used for this study. The wording

in the questions was changed from “mental illness” or “illness” to “sexual orientation” but otherwise left the same.

Additional questions were added to the Experiences of Discrimination Scale in an attempt to target experiences specific to sexual minorities bringing the total number of items to 31. These items addressed such issues as loyalty in relationships, sexual orientation being a curiosity or a phase, cheating in a relationship due to the nature of one’s sexual orientation, others assuming one has an STI or HIV, obsession with sex, and having multiple partners with little emotional commitments. The items covered common themes among the previously cited research in the sections discussing stigma against LGBT persons in the United States, sex differences in perceived stigma in sexual minorities and stigma experienced exclusively by bisexuals. Without these sexual minority specific questions the internal reliability was $\alpha = .87$, however, when including these additional questions, the reliability improved to $\alpha = .94$.

Next, participants completed a brief six item questionnaire assessing the number of doctor visits, both planned and unplanned, in the last year. This measure also assessed the number of sexual partners the participant has had in the previous year, the typical status of the relationship (e.g., casual sexual encounter or serious romantic relationship), and the riskiness of their overall sexual behavior (e.g., “In the last year, approximately how many times have you been screened for an STI?,” “Approximately how many sexual partners have you had in the past year?” and “How often did you use protection when having sex?”; see Appendix D). These items each addressed specific and unique health measures of the participants and were not combined to create an overall health measure.

Finally, participants completed a demographics questionnaire which, amongst other things, not only asked the participant to self-identify their orientation, but provide information on the gender of their current or previous partner(s) with responses ranging from “My own gender only,” “My own gender mostly, but some with other gender,” “Both genders equally,” “Mostly other gender, but some with my own gender,” “Other gender only,” and “Does not apply because I have never had sex” (see Appendix E). This additional information was used to further examine the nature of perceived stigma as someone who self-identifies as heterosexual may be stigmatized as a sexual minority if they have a previous relationship with someone of the same sex or similar gender expression.

Procedure

In February of 2013, various college and university level LGBTQ centers and student organizations from across the United States were contacted (see Appendix A for a list of all schools) to request that the administrator of the contact email for the organization pass the link to the online survey along to the members of their organization’s email list serv. When participants clicked the link to the survey, they were taken to an informed consent page. If the participant consented, he or she continued with the study, and if the participant did not agree, he or she was exited from the study. This question was the only question that participants were required to answer throughout the entire study. Participants then completed the Outness Inventory, Experiences of Discrimination Scale, six item health questionnaire, and a demographics questionnaire before advancing to the debriefing page. This page thanked for their participation in the

survey and provided contact information for the principal researcher, research advisor, and the University of Northern Iowa IRB Board, should the participant have any questions, concerns or comments about the study or his or her rights as a participant. Further, the debriefing page encouraged participants to seek council from their campus mental health center or the Trevor Project (which is a 24 hour, toll free LGBT crisis hotline) if, in an unlikely event, at any time during or after completing the survey they felt disturbed and upset as a result of the questions they answered.

Plan of Analysis

Participants who did not respond beyond the informed consent page were eliminated from further study. Each participant's responses to the Outness Inventory and Experiences of Stigma measure were averaged to create an overall score for each participant on each measure. These averages were calculated based only on the number of completed items, accounting for varying response rates among participants. This "mean across available items" calculation is suggested as an acceptable means of measuring a construct, even with missing data (Newman, 2014). Eighty percent of participants reported answers for all questions on the Experiences of Stigma measure, and 60.3% of participants reported answers for all questions on the Outness Inventory. All other analyses performed were conducted on single item constructs and therefore, within these constructs, missing data were excluded from analysis. Outliers were tested using a boxplot method to determine if they were 2.2 times or greater from the inter-quartile range. This 2.2 times the inter-quartile range is less likely to falsely declare the data as

an outlier (Hoaglin & Iglewicz, 1987). There were no outliers detected using this method.

Participants' gender was recategorized into "Male," "Female," and "Other" due to the low number of participants who reported their gender to be either transgender or other ("Transgender M-to-F" *n*=1, "Transgender F-to-M" *n*=6, "Other" *n*=27). All categories of sexual orientation ("Homosexual," "Bisexual," "Pansexual," "Heterosexual," and "Other") were retained for further analysis. Participants who identified themselves as heterosexual were retained for analysis due to their reports of a past sexual history with someone of their own gender. All categories of previous partners' gender ("I have never had sex;" "My own gender only;" "My own gender mostly, but some with another gender;" "Multiple genders equally;" "Mostly other gender, but some with my own gender;" and "Other gender only") were also retained for further analysis. Participants who reported previous partners of another gender only were retained due to them self-reporting a sexual orientation other than heterosexual.

My first research question was whether men would report higher levels of perceived stigma than women, but especially so among bisexual men and women. A Factorial ANOVA was conducted to determine if there were significant main effects or interactions for participants' gender (male, female or other) and self-reported sexual orientation (homosexual, bisexual, pansexual, heterosexual, or other) on perceived stigma. A second Factorial ANOVA was conducted to determine if there were significant main effects or interactions for the participants' gender and participants' report of their previous partners' gender (never had sex, own gender exclusively, mostly

own gender but some with another, own and another gender equally, mostly another gender but some with own gender, and exclusively other gender) on stigma. Factorial ANOVAs were chosen to examine if mean differences exist on one continuous dependent variable (perceived stigma) by independent categorical variables (gender, sexual orientation, or previous partners' gender) with each categorical variable having more than two groups.

My second research question, is whether a person's level of "outness" about their sexual orientation is positively related to their perceived experiences of stigma. A Pearson's r correlation was calculated to determine the relationship between these two continuous variables. A One-Way ANCOVA was also conducted to investigate if perceived experiences of stigma are influenced by sexual orientation (homosexual, bisexual, pansexual, heterosexual, or other) when controlling for outness as well as if perceived experiences of stigma are influenced by participants' reports of their previous partners' genders (never had sex, own gender exclusively, mostly own gender but some with another, own and another gender equally, mostly another gender but some with own gender, and exclusively other gender) when controlling for outness. Outness was chosen as a covariate for this calculation due to the known potential influence it may have on perceived experiences of stigma due to sexual orientation and reports of previous partners' genders.

The third research question explored the relationship between perceived stigma and self-reported visits to healthcare professionals. A multinomial logistic regression was used to determine if perceived stigma predicts non-scheduled visits to healthcare

professionals and if perceived stigma predicts scheduled visits to healthcare professionals. Scheduled and non-scheduled visits to healthcare professionals were assessed by asking a close-ended question where participants were able to indicate visiting their healthcare professional "0," "1," "2," or "3 or more times" in the previous 3 months. These questions were worded in this manner due to the expectation of very low numbers of visits due to the targeted population's (LGBT college-aged adults) relatively limited access to healthcare (Collins, Robertson, Garber & Doty, 2012; Collins, Garber & Robertson, 2011). Individual predictors were assessed by the Wald coefficient. The logistic regression was selected for its ability to analyze a categorical dependent variable (number of visits to a healthcare professional). Further, the Wald test does not make the assumptions of linear regressions such as linearity or normality. However, one limitation of this analysis is reduced power due to the categorical nature of the dependent variable.

My fourth and final research question seeks to further explore the relationship between perceived stigma and use of protection during sex. When examining this question, participants who reported a history of no previous sexual encounters were excluded from statistical analysis. A Pearson's r correlation was calculated to determine the relationship between the continuous variables of reports of protection during sex and perceived stigma.

CHAPTER 3

RESULTS

Research Question 1

My first research question was whether men would report higher levels of perceived stigma than women, but especially so among bisexual men and women. See Table 1 for descriptive statistics. An Independent Factorial ANOVA concluded both gender (male, female and other; F (3, 245) = .77, p =.51, η^2 = .002) and self-identified sexual orientation (homosexual, bisexual, pansexual, heterosexual, or other; F (4, 245) = .767, p =.55, η^2 = .004) showed no main effect or interaction effect (F (7, 245) = 1.24, p =.28, η^2 = .019) on experienced stigma. A second Independent Factorial ANOVA (see Table 2 for descriptive statistics) also indicated there was no significant main effect for the participant's reported gender (F (2, 247) = .49, p = .69, η^2 = .021), reports of the participants' previous partners' gender (never had sex, own gender exclusively, mostly own gender but some with another, own and another gender equally, mostly another gender but some with own gender, and exclusively other gender; F (5, 247) = .75, p = .59, η^2 = .017), or an interaction effect between participants' gender and the reports of the participants' previous partner's gender on experienced stigma (F (10, 247) = 1.07, p = .39, η^2 = .019).

Table 1

Descriptives for Stigma Across Gender Identity and Sexual Orientation Categories

	Male				Female				Other			
			95% CI				95% CI				95% CI	
	M	SE	LL	UL	M	SE	LL	UL	M	SE	LL	UL
Homosexual	2.43	.12	2.19	2.66	2.33	.12	2.11	2.56	3.21	.35	2.53	3.89
Bisexual	2.41	.35	1.73	3.09	2.80	.16	2.49	3.12	2.58	.65	1.30	3.85
Pansexual	2.18	.91	.38	3.98	2.61	.17	2.28	2.94	2.61	.32	1.97	3.24
Heterosexual	*	*	*	*	1.06	.91	-.74	2.86	2.59	.65	1.32	3.86
Other	2.61	.37	1.88	3.35	2.43	.24	1.97	2.89	2.25	.25	1.76	2.75

*No participants reported being a male heterosexual were retained for this level of analysis.

Table 2

Descriptives for Stigma Across Gender Identity and Previous Partners' Gender Categories

	Male				Female				Other			
			95% CI				95% CI				95% CI	
	M	SE	LL	UL	M	SE	LL	UL	M	SE	LL	UL
I have never had sex	2.65	.20	2.24	3.05	2.49	.18	2.13	2.85	2.13	.25	1.62	2.64
My Own Gender Only	2.39	.15	2.10	2.69	2.22	.14	1.94	2.51	2.25	.40	1.46	3.04
My Own Gender Mostly	2.15	.25	1.64	2.67	2.46	.15	2.15	2.77	3.04	.31	2.41	3.67
Multiple Genders Equally	1.48	.89	-.28	3.25	2.70	.25	2.19	3.21	3.07	.51	2.05	4.09
Other Gender Mostly	2.78	.63	1.53	4.04	2.95	.17	2.61	3.29	2.76	.44	1.87	3.64
Other Gender Only	2.39	.63	1.14	3.64	2.11	.36	1.38	2.83	2.69	.89	.92	4.46

Research Question 2

The second research question, is whether a person's level of "outness" about their sexual orientation is positively related to their perceived experiences of stigma. Outness and self-reported stigma were slightly, yet significantly negatively correlated, r (269) = -.282, $p < .001$. This correlation, however, was not in the direction hypothesized (see Figure 1). The negative correlation between outness and perceived experiences of stigma was significant for both men, r (72) = -.436, $p < .001$, and women, r (141) = -.422, $p < .001$; however, outness and self-reported levels of perceived stigma were positively correlated for participants who identified their gender to be "other" r (27) = .549, p =.002 (see Figure 2). No outliers were detected using the method suggested by Hoaglin and Iglewicz (1987) to determine if any data points were 2.2 times greater than the 3rd quartile range and 2.2 times less than the 1st quartile range.

When controlling for the degree of outness by using a one-way ANCOVA, self-reported sexual orientation (homosexual, bisexual, pansexual, heterosexual, or other) had no effect on reports of perceived stigma F (4, 243) = 1.16, p = .33, η^2 = .020 (See Table 3 for descriptive statistics). When controlling for outness, participants' reports of previous partners' gender (never had sex, own gender exclusively, mostly own gender but some with another, own and another gender equally, mostly another gender but some with own gender, and exclusively other gender) also did not have a significant effect F (5, 245) = 1.15, p = .335, η^2 = .025 (See Table 4 for descriptive statistics).

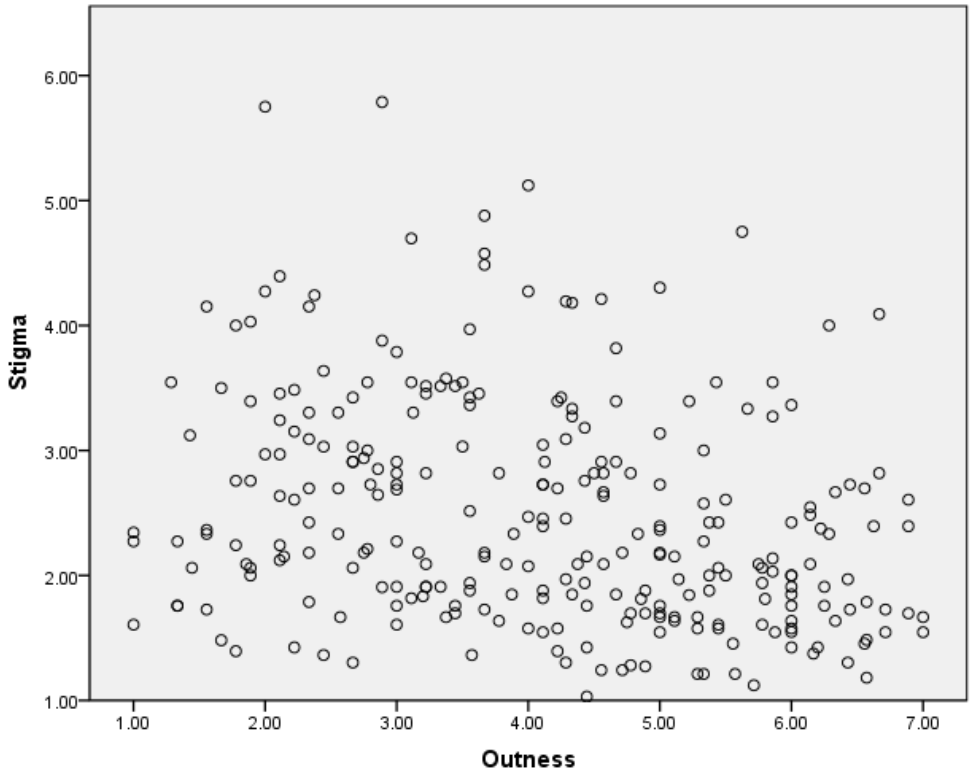

Figure 1. Correlation of Perceived Stigma Scores and Outness Inventory Scores. The average scores of self-reported stigma (on a scale from 1-6) correlated with the average Outness Inventory scores (on a scale from 1-7) r (269) = -.282, $p < .001$.

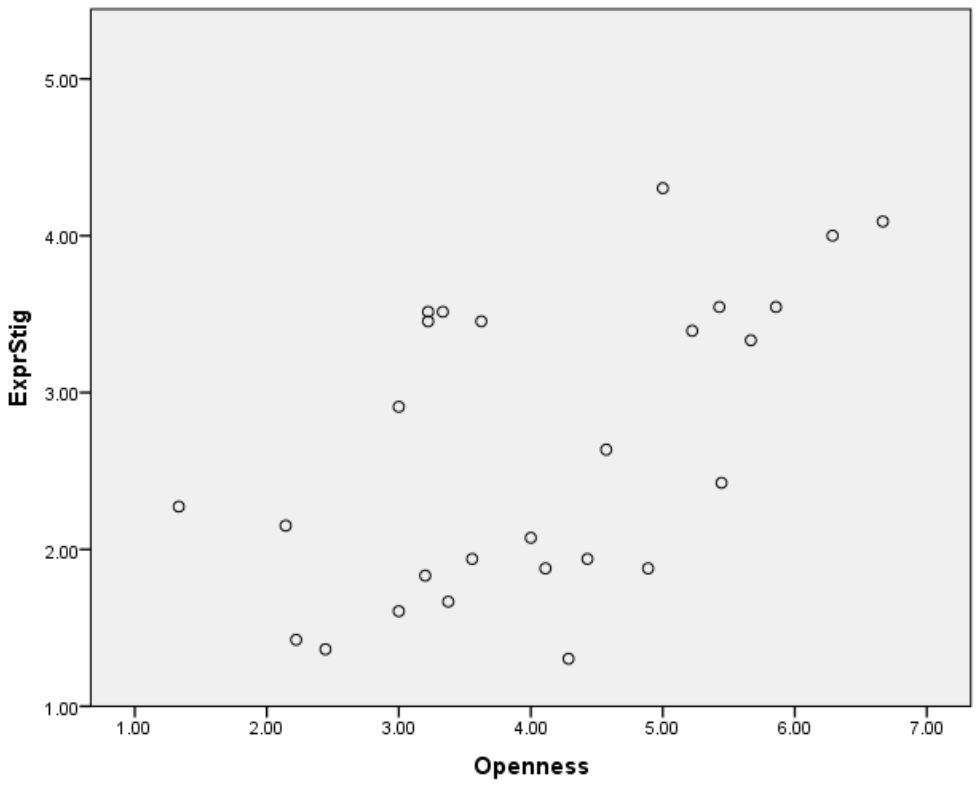

Figure 2. Correlation of Perceived Stigma Scores and Outness Inventory Scores for Participants who Reported Their Gender as "Other." The average scores of self-reported stigma (on a scale from 1-6) correlated with the average Outness Inventory scores (on a scale from 1-7) ***r* (27) = .549, *p* =.002**.

Table 3

Descriptives Controlling for Outness for Stigma Across Gender Identity and Sexual Orientation Categories

	Male				Female				Other			
			95% CI				95% CI				95% CI	
	M	SE	LL	UL	M	SE	LL	UL	M	SE	LL	UL
Homosexual	2.45	.11	2.23	2.68	2.42	.11	2.20	2.64	3.35	.33	2.70	4.00
Bisexual	2.44	.32	1.79	3.08	2.61	.15	2.30	2.91	2.60	.61	1.38	3.81
Pansexual	1.84	.87	.12	3.56	2.54	.15	2.23	2.86	2.50	.30	1.89	3.11
Heterosexual	*	*	*	*	1.37	.87	-.34	3.09	2.48	.61	1.27	3.70
Other	2.66	.35	1.96	3.36	2.51	.22	2.07	2.95	2.18	.24	1.71	2.66

*No participants reported being a male heterosexual were retained for this level of analysis.

Table 4

Descriptives Controlling for Outness for Stigma Across Gender Identity and Previous Partners' Gender Categories

	Male				Female				Other			
			95% CI				95% CI				95% CI	
	M	SE	LL	UL	M	SE	LL	UL	M	SE	LL	UL
I have never had sex	2.57	.19	2.18	2.95	2.38	.17	2.04	2.73	1.99	.24	1.51	2.48
My Own Gender Only	2.51	.14	2.22	2.79	2.33	.13	2.06	2.60	2.24	.37	1.49	2.99
My Own Gender Mostly	2.26	.24	1.77	2.74	2.56	.14	2.27	2.85	3.09	.30	2.50	3.68
Multiple Genders Equally	.977	.85	-.70	2.65	2.81	.24	2.32	3.29	3.22	.49	2.26	4.19
Other Gender Mostly	2.74	.60	1.56	3.92	2.76	.16	2.43	3.09	2.65	.42	1.81	3.48
Other Gender Only	1.94	.60	.75	3.14	1.87	.34	1.18	2.56	2.33	.85	.65	4.00

Research Question 3

My third research question explored the relationship between perceived stigma and self-reported visits to healthcare professionals. A multinomial logistic regression was conducted to determine if perceived stigma predicted non-scheduled visits to healthcare professionals (0 visits, 1 visit, 2 visits, or 3 or more visits). Nineteen participants reported 2 visits and 12 participants reported 3 or more visits, therefore these categories were combined into a "2 or more visits" category per Vittinghoff and McCulloch's (2006) suggestion of sample sizes larger than 16 per variable. Perceived stigma did not significantly predict the number of non-scheduled doctor visits (b = .25, Wald χ^2 (2, n = 250) = 1.713, p = .425) when "2 or more visits" was used as the reference category. Similarly, perceived stigma, openness, and self-reported sexual orientation were not significant predictors of non-scheduled visits to healthcare professionals (b = .16, Wald χ^2 (6, n = 245) = 7.999, p = .238) when "2 or more visits" was used as the reference category. A multinomial logistic regression was conducted to determine if perceived stigma predicted scheduled visits to healthcare professionals (0 visits, 1 visit, 2 visits, or 3 or more visits). Perceived stigma did not predict the number of visits (b = .17, Wald χ^2 (3, n = 249) = 1.998, p = .386) when "3 or more visits" was used as the reference category. Additionally, perceived stigma, openness, and self-reported sexual orientation were not significant predictors of scheduled visits to healthcare professionals (b = .20, Wald χ^2 (9, n = 244) = 11.702, p = .231) when "3 or more visits" was used as the reference category.

Research Question 4

My fourth research question further explores the relationship between perceived stigma and use of protection during sex. Participants who reported having never had sex were excluded from this analysis. Use of protection during sex was measured such that a low score indicated using protection frequently if not every single time (suggesting a low level of risky sexual behavior regarding use of protection) and high scores indicated rarely if never using protection (suggesting a high level of risky sexual behavior regarding use of protection). Perceived stigma and reported use of protection during sex were not corelated ($r(180) = -.08$, $p = .29$).

The number of sexual partners the participant reported having in the past year (0 partners, 1-3 partners, 4-6 partners, 7-9 partners, 10-12 partners, or 13 or more partners) did not have a significant effect on experienced stigma ($F(5, 242) = .98$, $p = .45$, $\eta^2 = .016$; See Table 5 for descriptive statistics).

Table 5

Descriptives for Stigma Across the Number of Sexual Partners in Past Year Categories

Number of Partners	M	SE	95% CI LL	95% CI UL
0	2.34	.36	1.92	2.44
1-3	2.51	.21	2.02	2.71
4-6	2.21	.15	1.82	2.10
7-9	1.98	.23	1.77	2.62
10-12	2.73	.6	.68	3.15
13 or more	2.11	.71	-.77	2.99

The nature of the participant's previous relationships (In a monogamous relationship, in an open relationship, casual encounters, I don't know what type of relationship it was, and does not apply because I have not had sex) did not have a significant effect on experienced stigma (F (4, 241) = 1.23, p = .25, η^2 = .024; See Table 6 for descriptive statistics).

Table 6

Descriptives for Stigma Across the Nature of Previous Relationship Categories

Previous Relationship	M	SE	95% CI LL	95% CI UL
Monogamous	2.54	.09	2.36	2.71
Open	2.43	.16	2.10	2.75
Casual encounters	2.39	.15	2.08	2.70
I don't know	2.83	.34	2.00	3.66
Never had Sex	2.44	.12	2.21	2.68

CHAPTER 4

DISCUSSION

Implications

There was not a significant difference in levels of perceived stigma observed across participants, regardless of their sexual orientation, their gender, or the genders of the participants' previous partners. It is possible that there is no significant difference in experienced stigma across genders or sexual orientations within the LGBT population. While there are documented differences in attitudes towards homosexual men compared to homosexual women (Breen & Karpinski, 2013), these attitudes were implicit in nature and therefore may not be overt enough for the person with these attitudes to behave in such a way that creates a stigmatizing experience for sexual minorities they may encounter. Additionally, negative attitudes towards bisexual men and women (Herek, 2002) could also have shifted to a more implicit nature as well.

It's also possible variation of experiences of stigma within these groups is higher than the variation of experiences across groups. The potential for experiencing stigma due to one's sexual orientation is so contingent on many individual factors (such as the social and political environment in which one lives and works; degree of disclosure, not only voluntarily informing others, but through mannerisms, behaviors, clothing choices and general expression of oneself; age; marital status; and many other factors). Further, there could be variations across subgroups of the sexual orientation categories, especially based on the perceived masculinity or femininity of these sub groups (Fiske et al., 2002).

Differences across groups may also not have been found due to the nature of the participants who responded. Recruitment was directed towards established LGBT organizations which likely offered support with and perhaps some shelter from stigmatizing events. Similarly, these LGBT organizations were largely college or university organizations meaning the participants tended to be rather young (median age was 21 years old). The young age of these participants may have limited their exposure to stigmatizing events simply due a lower amount of general life experiences. Further, the participants were self-selecting, meaning it's possible the type of people who were comfortable answering this survey by their nature had experienced less stigma. The nature of the participants in this study will be discussed in further detail in the Limitations section.

When assessing stigma, participants were asked if certain things had ever happened to them, without a specific time frame attached to the question (such as "Have you ever experienced this situation?" compared to "In the past year, have you experienced this situation?"). The vague timeframe in the stigma measure was intentional so as to assess a potentially wider range of experiences. However, it is possible many negative experiences may have been forgotten, or the severity of the impact of the negative experience may have lessened, especially over time. In fact, it can be beneficial to one's mental health to forget or suppress negative experiences (Joorman, Hertel, Brozovich, & Gotlib, 2005), including experiences of perceived stigma.

I had expected a positive relationship between perceived stigma and the participant's openness because being "out of the closet" and forthcoming about one's

identity could create an easier or more visible target for others. However, these two factors had a negative relationship in which perceived experiences of stigma decreased as their outness increased. While this relationship is not causal in nature, it could be due to the nature of the self-selected sample. Many participants may have chosen to respond to the survey because they were more comfortable and open about their sexual orientation and feel less they have experienced less stigma due to their sexual orientation. Also, again, the relative youth of the sample examined may impact the relationship between experienced stigma and opennes simply through the lower amount of general life experiences (and therefore opportunities for stigmatization to occur) of the sample.

This relationship could also be due to participants becoming more comfortable with expressing and sharing their sexual orientation due to experiencing lower levels of stigma towards this identity. This finding could expand on Austin (2013) and Whitehead et al. (2016) who reported similar findings in regard to level of outness being negatively correlated with perceived stigma from healthcare providers. The measure of perceived stigma in this study examined stigma in a generalized setting across interactions in various social settings.

Participants who identified their gender as “other,” exhibited a positive correlation between levels of perceived stigma and outness. While the exact reason for this relationship was not explored in this study, it could be due to the interaction between sexual orientation and gender identity expression. The concept of gender identity and expression is just beginning to emerge in general and widespread public discussion. As such, gender non-conformance is not yet widely understood, and the level of tolerance

and acceptance is lower than that of sexual minorities. It is also possible the small sample size for this particular population resulted in a poorly powered analysis that falsely rejected the null hypothesis.

Perceived stigma did not predict the number of scheduled or non-scheduled visits to healthcare professionals. This health measure was chosen because I estimated many of the participants in this study to be young college aged adults in their early twenties, who likely would not be experiencing the degree of health problems brought on by years of chronic stress from stigmatization. However, stress does play an acute and much more immediate role in the health of the immune system. Because visits to a healthcare professional are distinct and much more easily quantifiable than colds or other illnesses, which could blend together or are easily forgotten when reflecting back later, this measure was chosen to address the potential health effects caused by differences in perceived stress levels. Possible explanations of the lack of significant results for this measurement are discussed in the limitations section.

Additionally, most participants were college aged adults and were also recruited largely through college organizations. It is possible that this young population is overly healthy when compared to the general population due to their young age. It is also possible a large portion of participants were experiencing similar life stressors associated aspects of transitioning from childhood to adulthood (such as developing independent time management skills, balancing school responsibilities, and learning how to navigate other tasks associated with being an independent adult) outside of stressors associated

with their sexual orientation, and these stressors may outweigh or dilute the effect of stress experienced due to stigmatization of their sexual orientation.

I also examined the relationship between riskiness of sexual behavior and perceived stigma. Riskiness of sexual behavior was defined as the amount of times participants reported using protection during previous sexual encounters. Neither sexual orientation or the reports of participants' previous partner's gender had a significant effect on reported use of protection during sex. Risky sexual behavior can result in people contracting and spreading sexually transmitted infections. This measure was also selected due to its relationship to depression and suicidal ideation (Schwartz, 2014; Seth et al., 2011) which could also be related to factors such as internalized homophobia due to experiences of stigma.

The increase in sexual education and safe sex education, especially in campus organizations, may have confounded the results associated with this health measure. Safe sex for non-heteronormative sexual relationships has become an increasingly open area of discussion among LGBT groups and organizations, largely in response to sparse resources available in the general public (Halloran, 2015). As information becomes more available, the topic of using protection during sex becomes less taboo, possibly resulting in the use of protection becoming more common (Alford, 2008).

Further, the number of partners participants reported having in the past year or the nature of their relationship (e. g. casual encounters or committed relationships) did not affect the reported levels of experienced stigma. This could be due to a floor effect as the average number of reported sexual partners in the past year for participants choosing to

respond to this question was 1.02. While the range of sexual partners varied from 0 to 7, only about seven percent of respondents reported having more than three sexual partners in the past year. This lack of variability in the reported number of sexual partners likely contributed to this result. A possible contribution to the low variability and high percentage of participants responding to having few sexual partners could be related to the participant's desire of providing a socially acceptable or desirable response and therefore under reporting the amount of their previous partners. While the topics of monogamy and sexual promiscuity are gradually becoming more open for discussion, leading to a higher level of acceptance there is still a degree of stigma surrounding high levels of promiscuity. Historically sexual taboos lessen in severity within groups and organizations for sexual minorities before lessening in heteronormative populations. This is largely due to the fact that sexuality is an identifying characteristic of these groups and organizations.

Stigmatization is based on the identity of the participant, which in this case requires either open and regular disclosure of the person's sexual identity or proximity to someone who is construed as a romantic partner. While the number and nature of previous relationships was not a factor contributing to experienced stigma in this study, these measures did not account for how much or what type of exposure to the general public the relationship received.

Limitations

There are several limitations to this study that should be noted. I was unable to attain the number of participants needed to generate acceptable power (β=.9) as suggested

by the a priori power analysis conducted. This means that it is unlikely that smaller effects were able to be detected. A specific example of this limitation is that only eight participants self-identified as both male and either bisexual or pansexual. This unfortunately small number greatly limited the usefulness of the statistical analyses and conclusions that can be drawn from them. The participants in this study who reported their gender as male were also significantly underrepresented (25% of participants) compared to the estimated 47% of American LGBT individuals who reported their gender as male in the 2012 Gallup poll assessing American LGBT population demographics. This negatively impacts the external validity of any examination of gender differences.

A poll conducted by Gallup suggested that a large portion of the LGBT population (about 55% of those polled) either have some college education (but did not graduate) or have a high school diploma or less. This suggests that a large portion of the greater sexual minority population would not be accessible through the recruitment technique used for this study. Further, this poll suggested that 53% of the LGBT population is women, meaning 47% of the LGBT population is men or people who fall outside the gender binary. Only 25% of the participants in this study reported their gender as being male and 13.4% of the participants in this study reported their gender as being transgender or "other" meaning it is likely the male population was under represented in this study.

Furthermore, recruitment only took place through established organizations and was aimed at individuals who were either seriously questioning or were "out" as their

sexual orientation. This selection bias tended to recruit individuals who had access to peer or professional support systems, which could have resulted in under representation of LGBT people who might not otherwise have similar buffers to the effects of perceived stigma. There is a large population of sexual minorities who may be isolated from these institutions because they are unaware of, do not have access to, or for personal reasons choose not to associate with these particular organizations. These populations can, for obvious reasons, prove challenging to access and I chose not to recruit from this subset of the larger population due to limitations of resources.

There is also the possibility that people who experience less stigma and are more open about their sexual orientation tend to be more likely to respond to survey requests. While the sample assessed in this study did exhibit a considerable degree of variance in reported openness (M = 4.09, S. D. = 1.53, range = 1.00 - 7.00), the overall average experiences of stigma were slightly below the middle of the range of scores of the questionnaire (M = 2.48, S. D. = .91, range = 1.03 – 5.79). A more generalizable and representative sample would help determine if this indicates the sample assessed has been somewhat buffered from experiences of stigma due to their sexual orientation as a result of their involvement or association with the recruited organizations.

The health outcome measures used were a further limitation to this study. While health-related indicators of stress are well researched and understood, especially for racial minorities (Armstead et al., 1989; Clark, 2000, 2003a, 2003b; Clark & Anderson, 2001; Clark et al., 1999; Fang & Myers, 2001; Harrell et al., 2003; Herbert & Cohen, 1993; Jones et al., 1996; Krieger & Sidney, 1996; McNeilly et al., 1995; Monjan, 1977; Padgett

& Glaser, 2003; Steffen et al., 2003; Sutherland & Harrell, 1986), these indicators are often seen after years of chronic exposure to stigmatization. The population in this study is both relatively young, and their stigmatizing identity is much less readily available than say a stigmatizing identity of being a racial minority. I attempted to measure more acute stress-related health outcomes due to impaired immune system functioning through self-reported visits to healthcare professionals. However, young adults typically have the highest uninsured rate in the United States (Collins et al., 2011), which negatively impacts the rate at which they seek healthcare for minor and non-urgent maladies (Collins et al., 2012). Access to healthcare, including financial means, was not assessed in this study to determine the degree to which this may have impacted healthcare professional visits. Further, the way the questions assessing scheduled and non-scheduled visits to healthcare professionals were worded limited the responses to four categories, thus limiting the variance detected, especially for participants who visited their healthcare provider 3 or more times in the previous 3 months.

Additionally, this study has limitations that are similar to all online studies. There was no face to face contact with any participants, so if there were particular items that were unclear to the participant, there was little chance for clarification before the participant needed to submit his or her answers. With online research, as well as most research relying on participants' self-reporting, there are very few ways to verify that the person participating in the survey is who they claim to be, and almost no way to verify this without collecting direct and personal identifiers.

Finally, it is possible that societal attitudes towards the identified groups in this study have shifted into neutral or even positive ideologies, which would largely reduce the perception of perceived stigma. As more and more states fight to legalize same-sex marriage (data for the current study were collected before the United States Supreme Court decision to overturn the Defense of Marriage Act; essentially paving the way for equal marriage recognition across the United States), and more awareness is brought to other sexual minority issues, the generalized uncertainty and anxiety associated with these minority groups may be decreasing, especially on most college campuses. As the general population is further exposed to more information regarding sexual minorities, it is likely the general perception is to become less negative, and subsequent prejudicial activity to reduce (Birtel & Crisp, 2012). Further research with a larger and more representative sample would be able to explore this concept in greater detail.

Future Research

Future directions in this area should continue to employ measures of the gender of participants' previous sexual partners. This measure is useful because personal sexual orientations are not necessarily easily visible at any given time. For example, someone who may personally identify as bisexual may be treated differently if he or she has a predominant history of dating individuals of their own gender verses dating individuals of another gender.

Future research should also consider using measures of general stress, depression and anxiety, especially if the research involves health and health practices of the participants. As noted above, stigma theoretically leads to an increased stress response

which in turn theoretically leads to compromised immune systems and worse health in general. Additional measures of general stress and anxiety were left out of the current study as participants were being recruited on a volunteer basis only. Because participants had only internal motivations to fully complete the study, the drop off rate towards the end of the study was a significant loss. This loss would have been higher if the length of the study was longer.

There were several participants in this study who did not identify exclusively as male or female. While this is not a requirement to be a sexual minority, gender-nonconformity offers a unique set of stigmatizing experiences. Gender-nonconformity is unique from being a sexual minority within the scope of this study in that it cannot be as easily hidden as it is, by its nature, and expression of one's self. However, gender-nonconformity is unique from racial minority stigmatizations in that gender expression and gender identity is in popular culture largely viewed as a choice, and as such, tends to draw more harsh criticism and stigmatization. While gender-nonconforming population is smaller and in many ways more secluded than the sexual minority population, it could offer a unique perspective on the interaction between gender identity, sexual orientation, and perceived stigma.

Future research should also look to increase power by enhancing recruitment practices. One possible improvement would be to offer compensation or a lottery for participation in the survey. Additionally, recruitment should branch out into community based organizations and consider a targeted advertising campaign to the general public.

By expanding the search for participants, it will be more likely to broaden the variability of participants and their experiences, making the findings more generalizable.

Amazon.com's Mechanical Turk (mTurk) offers a unique pool of potential participants which can be relatively easily and affordably accessed. Participants or "workers" in mTurk were comprised of roughly half a million workers from over 190 countries, though workers are predominantly residents of the United States and India (Paolacci & Chandler, 2014). Workers can be easily screened based on previous "work" performance (was the work entirely completed, was the work completed to the standards requested, was the work completed in a timely manner) to ensure more successful completion of entire surveys (combatting participation fatigue). It should be noted that mTurk workers were not typically representative of larger populations (Berinsky, Huber, & Lenz, 2012; Paolacci, Chandler, & Ipeirotis, 2010; Shapiro, Chandler & Mueller, 2013). Further, mTurk workers tend to disproportionately report being less healthy compared to the general population (Mortensen, Alcalá, French, & Hu, 2018). However, mTurk workers are more representative of larger populations than student or community samples drawn from campus towns (Krupnikov & Levine, 2014; Stewart, Chandler & Paolacci, 2017). The mTurk platform might also be particularly useful in reaching certain target demographics such as people who are underemployed, married, parents, or even people who identify as LGBT (Chandler & Shapiro, 2016).

To experience stigma, one must possess an attribute that results in a "spoiled social identity" (Goffman, 1963). Bisexuality and pansexuality are seen as a violation of not only the heterosexual social identity, but the mononormative identity as well,

resulting in experienced stigma from the heterosexual and homosexual populations. However, the more open men and women are regarding their sexual orientation, the less stigma they report experiencing. While it may seem counter-intuitive due to the openness allowing for a greater potential target, the freedom from suppressing behaviors viewed as violating societal norms could result in less of these behaviors being displayed. These violations of societal norms are placed on the target by others based on the perception of the target. As such, the importance of what the target personally identifies their orientation to be is less than how they are perceived by others. To better understand experienced stigma in sexual minorities, researchers must consider measurements designed to assess the potential perception of the targets' behavior.

REFERENCES

Alaire, M. & Gaudet, S. (2013). "I don't know if she is bisexual or if she just wants to get attention": Analyzing the various mechanisms through which emerging adults invisibilize bisexuality. *Journal of Bisexuality, 13*, 191-214. https://doi.org/10.1080/15299716.2013.780004

Alencar, G. A., Garcia, C. L., Quirino, G. S., Alves, M. J. H., Belem, J. M., Santos Figueiredo, F. W., … Adami, F., (2016). Access to health services by lesbian, gay, bisexual, and transgender persons: Systemic literature review. *BioMed Central International Health and Human Rights, 16*, doi: 10.1186/s12914-015-0072-9

Alford, S. (2008). *Science and Success, 2nd Edition: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections*. Washington, DC: Advocates for Youth

Allison, K. W. (1998). Stress and oppressed category membership. In J. K. Swim and C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 145-170). San Diego, CA: Academic.

Antoni, M. H., Carrico, A. W., Duran, R. E., Spitzer, S., Penedo, F., Ironson, G., … Schneiderman, N., (2006). Randomized clinical trial of cognitive behavioral stress management on human immunodeficiency virus viral load in gay men treated with highly active antiretroviral therapy. *Psychosomatic Medicine, 68,* 143-51. doi: 10.1097/01.psy.0000195749.60049.63

Armstead, C. A., Lawler, K. A., Gordon, G., Cross, J., & Gibbons, J. (1989). Relationship of racial stressors to blood pressure responses and anger expression in Black college students. *Health Psychology, 8,* 541-556.

Assemblies of God: Homosexuality, Marriage, and Sexual Identity (2017). Retrieved from https://ag.org/Beliefs/Topics-Index/Homosexuality-Marriage-and-Sexual-Identity

Associated Press. (2003, June 26). Supreme Court Strikes Down Texas Law Banning Sodomy. *New York Times,* Retrieved January 15, 2013, from http://www.nytimes.com/2003/06/26/politics/26WIRE-SODO.html.

Austin, E. L. (2013) Sexual orientation disclosure to health care providers among urban and non-urban southern lesbians. *Women and Health, 53,* 41–55. doi: 10.1080/03630242.2012.743497

Baldwin, A., Dodge, B., Schick, V., Herbenick, D., Sanders, S. A., Dhoot, R. & Fortenberry, J. D. (2016). Health and identity-related interactions between lesbian, bisexual, queer, and pansexual women and their healthcare providers. *Culture, Health and Sexuality, 19,* 1181-1196. doi: 10.1080/13691058.2017.1298844

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology, 71,* 230-244. doi:10.1037/0022-3514.71.2.230

Barker, M., Bowes-Catton, H., Iantaffi, A, Cassidy, A, & Brewer, L (2008). British bisexuality: A snapshot of bisexual identities in the United Kingdom. *Journal of Bisexuality, 8*, 141–162.

Bennett, M. E., Weyant, R. J., & Simon, M. (1993). Predictors of dental students' belief in the right to refuse treatment to HIV-positive patients. *Journal of Dental Education, 57,* 673-679.

Bergeron, S., & Senn, C. Y. (2003). Health care utilization in a sample of Canadian lesbian women: Predictors of risk and resilience. *Women & Health, 37,* 19–35.

Berinsky, A. J., Huber, G. A., & Lenz, G. S. (2012). Evaluating online labor markets for experimental research: Amazon.com's Mechanical Turk. *Political Analysis, 20,* 351-368. doi: 10.1093/pan/mpr057

Birtel, M. D., & Crisp, R. J. (2012). "Treating" prejudice: An exposure-therapy approach to reducing negative reactions toward stigmatized groups. *Psychological Science, 23,* 1379-86. doi: 10.1177/0956797612443838

Blackburn, J. (2012) *Jessie J's 100% gay ... but bi is more trendy.* http://www.thesun.co.uk/sol/homepage/showbiz/tv/thevoice/4265487/Voice-coach-JessieJs-100-gay-but-bi-is-more-trendy.html#ixzz2aWieLST5. Accessed September 5, 2016.

Bos, A. E. R., Pryor, J. B., Reer, G. D. & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology, 35,* 1-9. doi:10.1080/01973533.2012.746147

Braine, N. (2014). Sexual minority women who use drugs: Prejudice, poverty, and access to care. *Sexuality Research and Social Policy, 11,* 199-210. doi: 10.1007/s13178-014-0155-8

Braithwaite, J. (1989). *Crime, shame and reintegration.* Cambridge, MA: Cambridge University Press.

Breen, A. B., & Karpinski, A. (2013). Implicit and explicit attitudes toward gay males and lesbians among heterosexual males and females. *The Journal of Social Psychology, 153,* 351-374. doi: http://dx.doi.org/10.1080/00224545.2012.739581

Brondolo, E., Rieppi, R., Kelly, K. P., & Gerin, W. (2003). Perceived racism and blood pressure: A review of the literature and conceptual and methodological critique. *Annals of Behavioral Medicine, 25,* 55-65. https://doi.org/10.1207/S15324796ABM2501_08

Buchmueller T., & Carpenter C. S. (2010) Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000–2007. *American Journal of Public Health, 10,* 485–495. doi: 10.2105/AJPH.2009.160804.

Burke, S. E., Dovideo, J. F., LaFrance, M., Przedworski, J. M., Perry, S. P., Phelan, S. M., … van Ryn, M., (2017). Beyond generalized sexual prejudice: Need for closure predicts negative attitudes toward bisexual people relative to gay/lesbian people. *Journal of Experimental Social Psychology, 71,* 145-150. doi: 10.1016/j.jesp.2017.02.003

Chandler, J. & Shapiro, D. (2016). Conducting clinical research using crowdsourced convenience samples. *Annual Review of Clinical Psychology, 12,* 53-81. https://doi.org/10.1146/annurev-clinpsy-021815-093623

Clark, R. (2000). Perceptions of interethnic group racism predict increased vascular reactivity to a laboratory challenge in college women. *Annals of Behavioral Medicine, 22,* 214 –222.

Clark, R. (2003a). Parental history of hypertension and coping responses predict blood pressure changes in Black college volunteers undergoing a speaking task about perceptions of racism. *Psychosomatic Medicine, 65,* 1012–1019.

Clark, R. (2003b). Self-reported racism and social support predict blood pressure reactivity in Blacks. *Annals of Behavioral Medicine, 25,* 214 – 222.

Clark, R., & Anderson, N. B. (2001). Efficacy of racism-specific coping styles as predictors of cardiovascular functioning. *Ethnicity and Disease, 11,*286 –295.

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

Clarke, A. E. (1993). Barriers to general practitioners caring for patients with HIV/AIDS. *Family Practice, 10,* 8-13. doi:10.1093/fampra/10.1.8

Clausell, E., & Fiske, S. T. (2005). When do subgroup parts add up to the stereotypic whole? Mixed stereotype content for gay male subgroups explains overall ratings. *Social Cognition, 23,* 161-181. doi: 10.1521/soco.23.2.161.65626

Cleary, P. D., & Jette, A. M. (1984). The validity of self-reported physician utilization measures. *Medical Care, 22,* 96-803.

Cohen, S., & Herbert, T. B. (1996). Health psychology: Psychological factors and physical disease from the perspective of human psychoneuroimmunology. *Annual Review of Psychology, 47,* 113-142.

Collins, S. R., Garber, T., & Robertson, R. (2011). Realizing health reform's potential: How the Affordable Care Act is helping young adults stay covered. *The Commonwealth Fund, 5,* 1-26

Collins, S. R., Robertson, R., Garber, T. & Doty, M. M. (2012). Young, uninsured, and in debt: Why young adults lack health insurance and how the Affordable Care Act is helping. *The Commonwealth Fund, 14,* 1-24.

Crandall, C. S. (1991). Do heavy-weight students have more difficulty paying for college? *Personality and Social Psychology Bulletin, 17,* 606 – 611. doi:10.1177/0146167291176002

Crandall, C. S., D'Anello, S., Sakalli, N., Lazarus, E., Nejtardt, G. W., & Feather, N. T. (2001). An attribution-value model of prejudice: Anti-fat attitudes in six nations. *Personality and Social Psychology Bulletin, 27,* 30-37. doi: 10.1177/0416167201271003

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review, 96,* 608-630. doi: 10.1037/0033-295X.96.4.608

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504–553). Boston, MA: McGraw-Hill.

Cuddy, A. J. C., & Fiske, S. T. (2002). Doddering, but dear: Process, content, and function in stereotyping of older persons. (T. D. Nelson, Ed.), *Ageism*, pp. 3–26. Cambridge, MA: MIT Press.

Cuddy, A. J. C., Fiske, S. T., & Glick, P. (2004). When professionals become mothers, warmth doesn't cut the ice. *Journal of Social Issues, 60,* 701-718. doi: 10.1111/j.0022-4537.2004.00381.x

Cuddy, A. J. C. Fiske S. T., & Glick, P. (2007). The BIAS map: Behaviors from intergroup affect and stereotypes. *Journal of Personality and Social Psychology, 92,* 631-648. doi: 10.1037/0022-3514.92.4.631

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

Darley, J. M., & Fazio, R. H. (1980). Expectancy confirmation processes arising in the social interaction sequence. *American Psychologist, 35,* 867-881. doi: 10.1037/0003-066X.35.10.867

Deaux, K., & Major, B. (1987). Putting gender into context: An interactive model of gender-related behavior. *Psychological Review, 94,* 369-389. doi: 10.1037/0033-295X.94.3.369

Deihl, M., & Ochs, R. (2000). Biphobia. in M. Adams, W. J. Blumenfeld, R. Castaneda, H. w. Hacman, M. L. Peters, & X. Zuniga (Eds.), *Readings for diversity and social justice: An anthology on racism, anti-Semitism, sexism, heterosexism, ableism, and classism* (pp. 276-280). New York, NY: Routledge.

Dhabhar, F. S. (2014). Effects of stress on immune function: The good, the bad, and the beautiful. *Immunologic Research, 58,* 193-210. doi:10.1007/s12026-014-8517-0

Diamond, L. M. (2003).Was it a phase? Young women's relinquishment of lesbian/bisexual identities over a 5-year period. *Journal of Personality and Social Psychology, 84,* 352-364.

Diamond, L. M. (2005) 'I'm straight, but I kissed a girl': The trouble with American media representations of female-female sexuality. *Feminism & Psychology, 15,* 104-110.

Dietrich, S., Matschinger, H., & Angermeyer, M. C. (2006). The relationship between biogenetic causal explanations and social distance toward people with mental disorders: Results from a population survey in Germany. *International Journal of Social Psychiatry, 52,* 166-174. doi: 10.1177/0020764006061246

Dijksterhuis, A., Aarts, H., Bargh, J. A., & van Knippenberg, A. (2000). On the relation between associative strength and automatic behavior. *Journal of Experimental Social Psychology, 36,* 531-544. doi: 10.1006/jesp.2000.1427

Does the Bible Comment on Same-Sex Marriages? (2017). Retrieved from https://www.jw.org/en/bible-teachings/questions/same-sex-marriage-bible-view/

Doll, L. S., & Beeker, C. (1996). Male bisexual behavior and HIV risk in the United States: Synthesis of research with implications for behavioral interventions. *AIDS Education and Prevention, 8,* 205-225.

Drescher, J, & Zucker, K. J. (2013). *Ex-Gay Research: Analyzing the Spitzer Study and its Relation to Science, Religion, Politics, and Culture.* London, England: Routledge.

Dunlap, M. C. (1989). AIDS and discrimination in the United States: Reflections on the nature of prejudice in a virus. *Villanova University School of Law Digital Repository, 34.* 909-932.

Ekstrand, M. L., Coates, T. J., Guydish, J. R., Hauck, W. W., Collette, L. & Hulley, S. B. (1994). Bisexual men in San Fransisco are not a commo vector for spreading HIV infection to women: The San Francisco Men's Health Study. *American Journal of Public Health, 84,* 915-919.

Eliason, M. J., & Schope, R. (2001). Does "don't ask don't tell" apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers. *Journal of the Gay and Lesbian Medical Association, 5,* 125–134.

Fahs, B. (2009). Compulsory bisexuality?: The challenges of modern sexual fluidity. *Journal of Bisexuality, 9,* 431-449.

Fang, C. Y., & Myers, H. F. (2001). The effects of racial stressors and hostility on cardiovascular reactivity in African American and Caucasian men. *Health Psychology, 20,* 64 –70.

Fairyington, S. (2008). Kinsey, bisexuality, and the case against dualism. *Journal of Bisexuality, 8* (3/4), 267-272.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. (2009). Statistical power analysis using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41,*1149-60. doi: 10.3758/BRM.41.4.1149

Fiske, S. T. (1980). Attention and weight in person perception: The impact of negative and extreme behavior. *Journal of Personality and Social Psychology 38,* 889–906. doi:0.1111/j.0022-4537.2004.00381.x

Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology, 82,* 878-902. doi:10.1037//0022-3514.82.6.878

Flanders, C. E., LeBreton, M. E., Robinson, M., Bian, J., & Caravaca-Morera, J. A. (2016). Defining bisexuality: Young bisexual and pansexual people's voices. *Journal of Bisexuality, 17,* 39-57. doi: 10.1080/15299716.2016.1227016

Flanders, C. E., Robinson, M., Legge, M. M., & Tarasoff, L. A. (2016). Negative identity experiences of bisexual and other non-monosexual people: A qualitative report. *Journal of Gay and Lesbian Mental Health, 20,* 152-172. doi: 10.1080/19359705.2015.1108257

Folkman, S., Chesney, M., Pollack, L., & Coates, T. (1993). Stress, control, coping, and depressive mode in human immunodeficiency virus-positive and –negative gay men in San Francisco. *Journal of Nervous and Mental Disease, 181,* 54-62.

Ford, J. G. (2002). Healing homosexuals: A psychologist's journey through the Ex-Gay movement and the pseudo-science of reparative therapy. *Journal of Gay and Lesbian Psychotherapy, 5,* 69-86. doi: 10.1300/J236v05n03_06

Fox, R. C. (1995). Bisexual identities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities over the lifespan* (pp. 48-86). Oxford, England: Oxford University Press.

Friedman, R. M., Dodge, B., Schick, V., Herbenick, D., Hubach, R., D., Bowling, J., … Reece, M., (2014). From bias to bisexual health disparities: Attitudes toward bisexual men and women in the United States. *LGBT Health, 4,* 309-318. doi: 10.1089/lgbt.2014.0005

Gates, G. J. & Newport, F. (2012, October 18). Special report: 3.4% of U.S. adults identify as LGBT. Retrieved from http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx on September 6, 2016.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York, NY: Prentice Hall.

Goldsen, K. I. F, Kim, H. J., Barkan, S. E., Muraco, A., & Ellis, C. P. (2013). Health disparities among lesbian, gay, bisexual and older adults: Results of a population-based study. *American Journal of Public Health, 103,* 1802–9. doi:10.2105/AJPH.2012.301110.

Hall, J. M. F., Cruser, D., Podawiltz, A., Mummert, D. I., Jones, H., & Mummert, M. E. (2012). Psychological stress and the cutaneous immune response: Roles of the HPA axis and the sympathetic nervous system in atopic dermatitis and psoriasis. *Dermatology Research and Practice, 2012,* 1-11. doi: http://dx.doi.org/10.1155/2012/403908

Halloran, L. (2015). *Call to Action: Lack of Comprehensive Sex Education Putting LGBTQ Youth at Risk.* Retrieved from: https://www.hrc.org/blog/call-to-action-lack-of-comprehensive-sex-education-putting-lgbtq-youth-at-r

Hamilton, M. C. (1991). Masculine bias in the attribution of personhood: People = male, male = people. *Psychology of Women Quarterly, 15,* 393-402. doi: 10.111/j.1471-6402.1991.tb00415.x

Harrell, J. P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. *American Journal of Public Health, 93,* 243-248. doi: 10.2105/AJPH.93.2.243.

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103,* 813-21. doi: 10.2105/AJPH.2012.301069.

Heck, J., Randall, V., & Gorin, S. S. (2013) Health care access among individuals involved in same-sex relationships. *American Journal of Public Health, 96*, 1111–8. doi: 10.2105/AJPH.2005.062661.

Herbert, T. B., & Cohen, S. (1993). Stress and immunity in humans: A meta-analytic review. *Psychosomatic Medicine, 55,* 364-379.

Herek, G. M. (1991). Stigma, prejudice, and violence against lesbians and gay men. In John C. Gonsioek & James D. Weinrich (Eds.) *Homosexuality: Research implications for public policy* (pp. 60-80). Newbury Park, CA: Sage.

Herek, G. M. (1994). Assessing heterosexuals' attitudes toward lesbians and gay men: A review of empirical research with the ATLG scale. In B. Greene & G. M Herek (Eds.), *Lesbian and gay psychology: Theory, research and clinical applications* (pp. 206-228). Thousand Oaks, CA: Sage.

Herek, G. M. (2002). Heterosexuals' attitudes toward bisexual men and women in the United States. *Journal of Sex Research, 39,* 264-274. doi: 10.1080/00224490209552150

Herek, G. M., & Capitanio, J. P. (1999). AIDS stigma and sexual prejudice. *American Behavioral Scientist, 42,* 1126-1143.

Herek, G. M. & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3,* 353-375. https://doi.org/10.1146/annurev.clinpsy.3.022806.091510

Herek, G. M., Gillis, J. R., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67,* 945-951. doi:10.1037/0022-006X.67.6.945

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56,* 32-43. doi: 10.1037/a0014672

Herrick L. A., Stall R., Chmiel J. S., Guadamuz T. S., Penniman T., Shoptaw S., … Plankey, M. W. (2013). It gets better: Resolution of internalized homophobia over time and associations with positive health. *Aids Behavior, 17,*1423–30. doi:10.1007/s10461-012-0392-x.

Higgins, M. (2014, March 21). *I stayed in the closet so I could benefit from straight privilege.* Retrieved from https://www.xojane.com/sex/i-stayed-in-the-closet-so-i-could-benefit-from-straight-privilege

Hoaglin, D. C., & Iglewicz, B. (1987). Fine-tuning some resistant rules for outlier labeling. *Journal of the American Statistical Association, 82,* 1147-1149. doi: 10.1080/01621459.1987.10478551

Hoffman N. D., Freeman K., & Swann S. (2009). Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *Journal of Adolescent Health, 45,* 222–9. doi:10.1016/j.jadohealth.2009.01.009.

Homophobia, Biphoia & Transphobia (n. d.) Retrieved on March 10, 2017, from https://www.pct.edu/campuslife/studentactivities/GLBTServices/Homophobia

Homosexual to fight denial of car license. (1970, November 2). *The Day, 90,* 24

Huebner, D. M., & Davis, M. C. (2007). Perceived antigay discrimination and physical health outcomes. *Health Psychology, 26,* 627-634. doi: 10.1037/0278-6133.26.5.627

Jones, D. R., Harrell, J. P., Morris-Prather, C. E., Thomas, J., & Omowale, N. (1996). Affective and physiological responses to racism: The roles of Afrocentrism and mode of presentation. *Ethnicity and Disease, 6,* 109 – 122.

Joormann, J., Hertel, P. T., Brozovic, F., & Gotlib, I. H. (2005). Remembering the good, forgetting the bad: Intentional forgetting of emotional material in depression. *Journal of Abnormal Psychology, 114,* 640-648. doi:10.1037/0021-843X.114.4.640

Jost, J. T., & Banaji, M. R. (1994). The role of stereotyping in system-justification and the production of false consciousness. *British Journal of Social Psychology, 33,* 1-27.

Jussim, L., Palumbo, P., Chatman, C., Madon, S., & Smith, A. (2000). Stigma and self-fulfilling prophecies. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 374-418). New York, NY: Guilford Press.

Juster, R., Hatzenbuehler, M. L., Mendrek, A., Pfaus, J. G., Smith, N. G., Johnson, P. J., … Pruessner, J. C., (2015). Sexual orientation modulates endocrine stress reactivity. *Biological Psychiatry, 77,* 668-676. doi: 10.1016/j.biopsych.2014.08.013

Kiecolt-Glaser, J. K., Glaser, R., Gravenstein, S., Malarkey, W. B., & Sheridan, J. (1996). Chronic stress alters the immune response to influenza virus vaccine in older adults. *Proceedings of the National Academy of Sciences of the United States of America, 93,* 3043-47.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., Weich, S., & Serfaty, M. (2007). The stigma scale: Development of a standardized measure of the stigma of mental illness. *British Journal of Psychiatry, 190,* 248-254. doi:10.1192/bjp.bp.106.024638

Kite, M. E., & Whitley, B. E. Jr. (1996). Sex differences in attitudes toward homosexual persons, behaviors and civil rights a meta-analysis. *Personality and Social Psychology Bulletin, 22,* 336-353. doi: 10.1177/0146167296224002

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). The 2011 national school climate survey: *The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* Retrieved from https://eric.ed.gov/?id=ED535177

Kosciw, J. G., Palmer, N. A., & Kull, R. M. (2015). Reflecting resiliency: Openness about sexual orientation and/or gender identity and its relationship to well-being and educational outcomes for LGBT students. *American Journal of Community Psychology, 55,* 167-178. doi: 10.1007/s10464-014-9642-6

Krieger, N., & Sidney, S. (1996). Racial discrimination and blood pressure: the CARDIA study of young black and white adults. *American Journal of Public Health, 86,* 1370-1378. doi: 10.2105/AJPH.86.10.1370

Krupnikov, Y., & Levine, A. S. (2014). Cross-sample comparisons and external validity. *Journal of Experimental Political Science, 1,* 59-80. doi:10.1017/xps.2014.7

Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin, 127,* 187-208. doi:10.1037/0033-2909.127.2.187

Lee, A. A., Laurent, S. M., Wykes, T. L., Kitchen Andren, K. A., Bourassa, K. A., & McKibbin, C. L. (2014). Genetic attributions and mental illness diagnosis: Effects on perceptions of danger, social distance, and real helping decisions. *Social Psychiatry and Psychiatric Epidemiology, 49,* 781-9. doi: 10.1007/s00127-013-0764-1

Lehavot, K., & Lambert, A. J. (2007). Toward a greater understanding of antigay prejudice: On the role of sexual orientation and gender role violation. *Basic and Applied Social Psychology, 29,* 279–292. doi:10.1080/01973530701503390

Leserman, J., Petitto, J. M., Perkins, D. O., Folds, J. D., Golden, R. N., & Evans, D. L. (1997). Severe stress, depressive symptoms, and changes in lymphocyte subsets in human immunodeficiency virus – infected men. *Archive of General Psychiatry, 53,* 279-85. doi:10.1001/archpsyc.1997.01830150105015

Lewis, R. J., Derlega, V. J., Griffin, J. L., & Krowinski, A. C. (2003). Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. *Journal of Social and Clinical Psychology, 22,* 716-729. https://doi.org/10.1521/jscp.22.6.716.22932

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and pshycial health among sexual minorities. *Perspectives on Psychological Science, 8,* 521-548. doi: 10.1177/1745691613497965.

Lin, M. H., Kwan, V. S. Y., Cheung, A., & Fiske, S. T. (2005). Stereotype content model explains prejudice for an envied outgroup: Scale of anti-Asian American stereotypes. *Personality and Social Psychology Bulletin, 31*, 34-47. doi: 10.1177/0146167204271320

Lindhorst, T. (1997). Lesbians and gay men in the country: Implications for rural social workers. In J. D. Smith & R. J. Mancoske (Eds.), *Rural gays and lesbians: Building on the strengths of communities* (pp. 1-11). New York, NY: Haworth Press.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. (1987). The social rejection of ex-mental patients: Understanding why labels matter. *American Journal of Sociology, 92*, 1461-1500.

MacDowall, L. (2009). Historicising contemporary bisexuality. *Journal of Bisexuality, 9,* 3-15. doi: 10.1080/15299710802659989

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56,* 393-421. doi: 10.1146/annurev.psych.56.091103.070137

Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology*. New York, NY: Wiley.

Martin, M. (2010, July 7) 'Take my Job!' campaign markets agricultural labor. Retrieved from http://www.npr.org/templates/story/story.php?storyId=128358334

Marx, K. & Engels, F. (1976). *The German ideology.* (3rd revised ed.). Moscow, Russia: Progress Publishers.

Mays, V. M. & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91,* 1869-1876. doi:10.2105/AJPH.91.11.1869

McNeilly, M. D., Robinson, E. L., Anderson, N. B., Pieper, C. F., Shah, A., Toth, P. S., … Gerin, W., (1995). Effects of racist provocation and social support on cardiovascular reactivity in African-American women. *International Journal of Behavioral Medicine, 2,* 321–338. doi: 10.1207/s15327558ijbm0204_3

Merritt, M. M., Benett, G. G., Jr., Williams, R. B., Edwards, C. L., & Soller, J. J., III. (2006). Perceived racism and cardiovascular reactivity and recovery to personally relevant stress. *Health Psychology, 25,* 364-369. doi: 10.1037/0278-6133.25.3.364

Merritt, R. D., & Kok, C. J. (1995). Attribution of gender to a gender-unspecified individual: An evaluation of the people = male hypothesis. *Sex Roles, 33,* 145-157 doi: 10.1007/BF01544608

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674-697. doi:10.1037/0033-2909.129.5.674

Meyer I. H, & Dean L. (1998) Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek GM, editor. *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals.* (pp. 160–186) Thousand Oaks, CA: Sage..

Mitchell, R. C., Davis, K. S., & Galupo, M. P. (2014). Comparing perceived experiences of prejudice among self-identified plurisexual individuals. *Psychology and Sexuality, 6,* 245-257. doi: 10.1080/19419899.2014.940372

Mohr, J., & Fassiger R. (2000). Measuring dimensions of lesbian and gay male experience. *Measurement & Evaluation in Counseling & Development, 33,* 66-91.

Monjan, A. A. (1977). Stress-induced modulation of the immune response. *Science, 196,* 307-308. doi: 10.1126/science.557841

Mor, Z., Davidovich, U., McFarlane, M., & Feldstein, G. (2008). Gay men who engage in substance use and sexual risk behaviour: A dual-risk group with unique characteristics. *International Journal of STD & AIDS, 19*, 698–703.

Morone, J. A. (1997). Enemies of the people: The moral dimension to public health. *Journal of Health Politics, Policy and Law, 22,* 993-1020.

Morrison, T. G., Harrington, R. & McDermott, D. T. (2010). Bi now, gay later: Implicit and explicit binegativity among Irish university students. *Journal of Bisexuality, 10,* 211-232.

Morse, E. V., Simon, P. M., Osofsky, P. M., Balson, P. M., & Gaumer, H. R. (1991). The male street prostitute: A vector for transmission of HIV infection into the heterosexual world. *Social Science and Medicine, 32,* 535-539. https://doi.org/10.1016/0277-9536(91)90287-M

Mortensen, K., Alcalá, M. G., French, M. T., & Hu, T. (2018). Self-reported health status differs for Amazon's Mechanical Turk respondents compared with nationally representative surveys. *Medical Care, 56,* 211-215. doi: 10.1097/MLR.0000000000000871

Mulick, P. S., & Wright, L. W. Jr. (2002). Examining the existence of biphobia in the heterosexual and homosexual populations. *Journal of Bisexuality, 2,* 45-64. doi: 10.1300/J159v02n04_03

Mulvihill, E. (2012). *Jessie J: I'm really bi, though "boring untrue story" says I'm full on lesbian'*. http://www.queerty.com/jessie-j-im-really-bi-though-boring-untrue-story-says-im-full-on-lesbian-20120419/#ixzz2aWggRf1L. Accessed September 5, 2016.

Neuberg, S. L., Smith, D. M., & Asher, T. (2000). Why people stigmatize: Toward a biocultural framework. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G Hull (Eds.), *The social psychology of stigma* (pp. 31-61). New York, NY: Guilford Press.

Newman, D. A. (2014). Missing data: Five practical guidelines. *Organizational Research Methods, 17,* 372-411. doi: 10.1177/1094428114548590

Ochs, R. (1996). Biphobia: It goes more than two ways. In B. A. Firestein (Ed.), *Bisexuality: The psychology and politics of an invisible minority* (pp. 217-239). Thousand Oaks, CA: Sage.

Official Statements (2017). Retrieved from http://www.adventist.org/en/information/official-statements/

Olafsdottir, S. (2011). Medicalization and Mental Health: The Critique of Medical Expansion, and a Consideration of How National States, Markets, and Citizens Matter. In Pilgrim, D., Rogers, A., Pescosolido, B. A. (Eds.) *The Sage Handbook of Mental Health and Illness* (pp. 239–60). London, England: Sage Ltd.

O'Leary A., Jones K. T. (2006). Bisexual men and heterosexual women: How big is the bridge? How can we know? *Sexual Transmission of Disease, 33,* 594–595. doi: 10.1097/01.olq.0000225280.44538.f6

Otatti, V., Bodenhausen, G. V., & Newman, L. S. (2005). Social Psychological Models of Mental Illness Stigma. In Gorrigan, P. W. (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (99-128). Washington, DC: American Psychological Association.

Padgett, D. A., & Glaser, R. (2003). How stress influences the immune response. *Trends in Immunology, 24,* 444-448. doi: http://dx.doi.org/10.1016/S1471-4906(03)00173-X

Paolacci, G., & Chandler, J. (2014). Inside the turk: Understanding Mechanical Turk as a participant pool. *Current Directions in Psychological Science, 23,*184-188. doi: 10.1177/0963721414531598

Paolacci, G., Chandler, J., & Ipeirotis, P. G. (2010). Running experiments on Amazon Mechanical Turk. *Judgement and Decision Making, 5,* 411-419.

Petroll, A. E., & Mosack, K. E. (2011). Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. *Sexually Transmitted Diseases, 38,* 63–67.

Phelan, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363-385.

Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: The case of mental illness. *Journal of Health and Social Behavior, 46,* 307-322. doi: http://www.jstor.org/stable/4147660

Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: One animal or two? *Social Science and Medicine, 67,* 358-367.

Phelan, J. C., Link B. G, Stueve, A., & Pescosolido, B. A. (2000). Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to Be Feared? *Journal of Health and Social Behavior, 41,* 188–207.

Preston, D. B., D'augelli, A. R., Kassab, C. D., Cain, R. E., Schulze, F. W., & Starks, M. T. (2004). The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention, 16,* 291-303. doi:10.1521/aeap.16.4.291.40401

Preston, D. B., D'Augelli, A. R., Kassab, C. D., & Starks, M. T. (2007). The relationship of stigma to the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention, 19,* 218-230. http://search.proquest.com/docview/198021385?accountid=14691

Pryor, J. B., & Bos, A. E. R. (2016). *Social Psychological Perspectives on Stigma*. New York, NY: Routledge.

Pryor, J. B., & Reeder, G. D. (2011). HIV-related stigma. In J. C. Hall, B. J. Hall, & C. J. Cockerell (Eds.), *HIV/Aids in the Post-HAART Era: Manifestations, treatment, and epidemiology* (pp. 790-806). Shelton, CT: PMPH-USA Ltd.

Puhl, R. M., & King, K. M. (2013). Weight discrimination and bullying. *Clinical Endocrinology & Metabolism, 27,* 117-27. doi: http://dx.doi.org/10.1016/j.beem.2012.12.002.

Rawson, H. E., & Bloomer, K. (1994). Stress, anxiety, depression, and physical illness in college students. *Journal of Genetic Psychology, 155,* 321-330.

Reijneveld, S. A., & Stronks, K. (2001). The validity of self-reported use of health care across socioeconomic strata: a comparison of survey and registration data. *International Journal of Epidemiology, 30,* 1407-1414. https://doi.org/10.1093/ije/30.6.1407

Reiss, I. L. (1986). A sociological journey into sexuality. *Journal of Marriage and Family, 48,* 233-242.

Rice, K. (2015). Pansexuality. In *The International Encyclopedia of Human Sexuality.* Hoboken, NJ: John Wiley & Sons, Ltd. doi: 10.1002/9781118896877.wbiehs328

Ritter, P. L., Stewart, A. L., Kaymanz, H., Sobel, D. S., Block, D. A., & Lorig, K. R. (2001). Self-reports of health care utilization compared to provider records. *Journal of Clinical Epidemiology, 54,* 136-141. https://doi.org/10.1016/S0895-4356(00)00261-4

Robin, L., & Hammer, K. (2000). Bisexuality: Identities and community. In V. A. Wall & N. J. Evans (Eds.), *Toward acceptance: Sexual orientation issues on campus* (pp. 245-259). Lanharm, MD: University Press of America

Rosenberg, M., Schooler, C., Schoenbach, C., & Rosenberg, F. (1995). Global self-esteem and specific self-esteem: Different concepts, different outcomes. *American Sociological Review, 60,* 141-156.

Ruggiero, K. M., & Taylor, D. M. (1997). Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control. *Journal of Personality and Social Psychology, 72,* 373-389.

Rusch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. *Psychiatry Research, 179,* 328-32. doi: 10.1016/j.psychres.2009.09.010

Rust, P. C. (1995). *Bisexuality and the challenge to lesbian politics: Sex, loyalty, and revolution.* New York, NY: New York University Press.

Rust, P. C. (2002). Bisexuality: The state of the union. *Annual Review of Sex Research, 13,* 180-240 doi: 10.1080/10532528.2002.10559805

Sakalli, N. (2002). Application of the attribution-value model of prejudice to homosexuality. *The Journal of Social Psychology, 142,* 264-71.

Schnabel, L. (2016). Gender and homosexuality attitudes across religious groups from the 1970s to 2014: Similarity, distinction, and adaptation. *Social Science Research, 55,* 31-47. doi: 10.1016/j.ssresearch.2015.09.012

Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social Science and Medicine, 67,* 1370-1381. doi: 10.1016/j.socscimed.2008.07.007

Schomerus, G., Matschinger, H., Angermeyer, M. C. (2013) Causal beliefs of the public and social acceptance of persons with mental illness: a comparative analysis of schizophrenia, depression and alcohol dependence. *Psychological Medicine, 44,* 1–12. doi:10.1017/S003329171300072X

Schueler, L. A., Hoffman, J. A., & Peterson, E. (2009). Fostering safe, engaging campuses for lesbian, gay, bisexual, transgender, and questioning students. In S. R. Harper & S. J. Quaye (Eds.), *Students engagement in higher education: Theoretical perspective and practical approaches for diverse populations* (pp.61-79). New York, NY: Routledge.

Schwanberg, S. L. (1996). Health care professionals' attitudes towards lesbian women and gay men. *Journal of Homosexuality, 31,*71-83. http://dx.doi.org/10.1300/J082v31n03_05

Schwartz, M. R. (2014). Depression, suicidal ideation, and risky sexual behavior among U. S. adolescents (Master's Thesis). University of Washington, Seattle, WA, United States

Seth, P., Patel, S. N., Sales, J. M., DiClemente, R. J., Wingood, G. M., & Rose, E. S. (2011). The impact of depressive symptomatology on risky sexual behavior and sexual communication among African American female adolescents. *Psychological Health Medicine, 16,* doi10.1080/135485506.2011.554562

Shapiro, D. N., Chandler, J., & Mueller, P. A. (2013). Using Mechanical Turk to study clinical populations. *Clinical Psychological Science, 1,* 213-220. https://doi.org/10.1177/2167702612469015

Shilo, M., & Mor, Z. (2014). The impact of minority stressors on the mental and physical health of lesbian, gay and bisexual youths and adults. *Health Social Work, 39,* 161-171. doi: 10.1093/hsw/hlu023

Spalding, L. R., & Peplau, L. A. (1997). The unfaithful lover: Heterosexuals' perceptions of bisexuals and their relationships. *Psychology of Women Quarterly, 23,* 41-46.

Spitzer, L. (1981). The diagnostic status of homosexuality in DSM-III: A reformulation of the issues. *American Journal of Psychiatry, 138,* 210-215.

Steffen, P. R., McNeilly, M., Anderson, N., & Sherwood, A. (2003). Effects of perceived racism and anger inhibition on ambulatory blood pressure in African Americans. *Psychosomatic Medicine, 65,* 746 –750.

Stangor, C. (2015). The study of stereotyping, prejudice, and discrimination within social psychology: A quick history of theory and research. In Nelson, T. D. (Ed.),

Handbook of prejudice, stereotyping, and discrimination (3-28). New York, NY: Psychology Press.

Stein, G. L., & Bonuck, K. A. (2001). Physician-patient relationships among the lesbian and gay community. *Journal of the Gay and Lesbian Medical Association, 5,* 87–93.

Stewart, N., Chandler, J., & Paolacci, G. (2017). Crowdsourcing samples in cognitive science. *Trends in Cognitive Sciences, 21,* 736-748. https://doi.org/10.1016/j.tics.2017.06.007

Stockard, J. & Johnson, M. M. (1979). The social origins of male dominance. *Sex Roles, 5,* 199-218. doi:10.1007/BF00287931

Storr, M (1999) Postmodern bisexuality. *Sexualities, 2,* 309-325

Sutherland, M. E., & Harrell, J. P. (1986). Individual differences in physiological responses to fearful, racially noxious, and neutral imagery. *Imagination, Cognition, and Personality, 6,* 133–150.

Swank, E., Fahs, B., & Frost, D. M. (2013). Region, social identities, and disclosure practices as predictors of heterosexist discrimination against sexual minorities in the United States. *Sociological Inquiry, 83,* 238-258. doi: 10.1111/soin.12004

Thompson, E. M. (2006). Girl friend or girlfriend?: Same-sex friendship and bisexual images as a context for flexible sexual identity among young women. *Journal of Bisexuality, 6,* 47-67.

Tranby, E., & Zulkowski, S. E. (2012). Religion as Cultural Power: The Role of Religion in Influencing Americans' Symbolic Boundaries around Gender and Sexuality. *Sociology Compass, 6,* 870-882. doi: 10.1111/j.1751-9020.2012.00495.x

Vittinghoff, E., & McCulloch, C. E. (2006). Relaxing the rule of ten events per variable in logistic and Cox regression. *American Journal of Epidemiology, 165,* 710-18. doi: 10.1093/aje/kwk052

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1995) *Dual attraction: Understanding Bisexuality.* Oxford, England: Oxford University Press.

Weiss, J. T. (2004). The archaeology of biphobia and transphobia within the U. S. gay and lesbian community. *Journal of Bisexuality, 3,* 25-55. doi: 10.1300/J159v03n03_02

Weissman, J. S., Levin, K., Chasan-Taber, S., Massagli, M. P., Seage, G. R., & Scampini, L. (1996). The validity of self-reported health-care utilization by AIDS patients. *AIDS, 10,* 775-83.

Westwood, S. (2016). LGBT* ageing in the UK: Spatial inequalities in older age housing/care provision. *Policy Press, 14,* 63-76. doi: http://dx.doi.org/10.1332/175982716X14538098308249

Whitehead, J., Shaver, J., & Stephenson, R. (2016) Outness, stigma, and primary health care utilization among rural LGBT populations. *PLoS ONE, 11,* doi:10.1371/journal.pone.0146139

Willging, C. E., Salvador, M., & Kano, M. (2006). Brief reports: Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57,* 867-870. doi: 10.1176/appi.ps.57.6.867

Williams, D. R. (1997). Race and health: Basic questions, emerging directions. *Annals of Epidemiology, 7,* 322-333. doi: 10.1016/S1047-2797(97)00051-3

Yoshimo, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52,* 353-461. doi: 10.2307/1229482

Yost, M. R., & Gilmore, S. (2011). Assessing LGBTQ campus climate and creating change. *Journal of Homosexuality, 58,* 1330-1354.

Yost, M. R., & Thomas, G. D. (2012). Gender and binegativity: Men's and women's attitudes toward male and female bisexuals. *Archives of Sexual Behavior, 41,* 691-702. doi:10.1007/s10508-011-9767-8

Zane, Z. (2016a). *8 subtle biphobic phrases gay folks say all the time.* Retrieved from https://www.pride.com/bisexual/2016/7/19/8-subtle-biphobic-phrases-gay-folks-say-all-time

Zane, Z. (2016b, March 6). *Bisexuals, passing, and straight privilege: A deeper look.* Retrieved from https://www.huffingtonpost.com/zachary-zane/bisexuals-passing-and-straight-privilege_b_9374272.html

APPENDIX A

LIST OF UNIVERSITY AND COLLEGE CENTERS AND STUDENT ORGANIZATIONS CONTACTED

This list was obtained from

http://preview.hrc.org/issues/youth_and_campus_activism/4926.htm

School	Name of Organization
U. Alabama (Tuscaloosa)	Spectrum
U. A. B.	Alliance
U. Alabama (Huntsville)	PRISM
Auburn U.	Spectrum
Jacksonville State U.	JSU Students for Equality
U. of Montevallo	Spectrum
U. of S. Alabama	USA Spectrum
Troy University	Troy Gay Straight Alliance
U. of Alaska Anchorage	The Family
U. of Arizona	Pride Alliance
Arizona State	LGBTQA Coalition
Northern Arizona U.	Prism NAU
Arkansas State	Gay-Straight Alliance
U. of Central Arkansas	UCA Prism
Auburn U. @ Montgomery	GSA
U. of Alasksa Fairbanks	LGBT & Allies

Henderson State U.	Queer-straight Alliance
Northwest Arkansas C. C.	Gay-Straight Alliance
U. of Arkansas Fayettesville	PRIDE
U. of Arkansas Monticello	Gay-Straight Alliance
California Polytechnic State University (San Luis Obispo)	Spectrum
California State Polytechnic University (Pomona)	Pride Center
	Queer People of Color
	Queer students and allies for Equality
Cal. St. Bakersfield	Gay Lesbian Straight Student Network
Cal. St. Long Beach	LGBT Student resource center
Cal. St. San Bernardino	The Pride Center
Cerritos College	Queer-straight Alliance
Fullerton College	Lambda Society
Las Positas College	Gay-Straight Alliance
Loyola Marymount University	Gay-Straight Alliance
Palomar C. C.	Gay-Straight Alliance
Pomona College	The Queer Resource Center
San Diego Mesa College	LGBT Student Union
San Jose State	LGBT and Women's Resource Center
Stanford	Queer Straight Alliance

U. Cal. at Berkeley	Gender Equality resource center
	LavenderCal
	Sigma Epsilon Omega Fraternity
UC Davis	Asian Pacific Island Queers
	Davis Dykes
	La Familia
UC Irvine	LGBT resource center
UCLA	LGBT resource center
	La Joteria de UCLA
	Mishpacha
	Pan Asian Queers
	Queer Alliance
	QueerxGirl
	Student Coalition for Marriage Equality
UC Riverside	LGBT resource center
UC San Diego	LGBTQI Association
	Queer People of Color
UC San Francisco	LGBT Resources
	Resource Center for Sexual and Gender
UC Santa Barbara	Diversity
UC Santa Cruz	GLBTI Network
U. of Redlands	Pride Center

USC	Gay Lesbian Bisexual Transgender Assembly
Colorado College	Queer-straight Alliance
Colorado School of Mines	Sigma Lambda
Colorado State U.	Student Organization for GLBT
Metropolitan State College of Denver	Auraria Genders & Sexualities Alliance
U. of Colorado (Boulder)	Student Alliance of Gay Engineers
	GATHER
	Gay-Straight Alliance
U. of Colorado (Colorado Springs)	Spectrum
U. of Nothern Colorado	GLBT Resource Office
Central Connecticut State U.	PRIDE
Connecticut College	LGBTQ Resource Center
	Ally and Queer Undergrad Association,
U. Conn	Rainbow Center
Yale	LGBT Co-op at Yale
U. of Deleware	LGBT community Office
Widener U. - School of Law	OUTLaw
American University	AU Queers and Allies
	GLBT Resource Center
	Lambda Grad Student Group
	Lambda law Society

George Washington U.	Allied in Pride
Georgetown	GU Pride
Howard U.	BLAGOSAH
Broward county C. C.	Gay-Straight Alliance
Edison State College	Gay-Straight Alliance
Embry-Riddle Aeronautical University	Gay-Straight Alliance
Florida Atlantic	Lambda United
Florida Atlantic - Jupiter Campus	Spectrum
Florida Institute of Technology	UNITE
	Office of Multicultural Programs and Services
Florida International	-LGBTQ Initiatives
Florida State	LGBT Student Union
Tallahassee community College	Pride
U. of Central Florida	GLB Student Union
U. of Florida	LGBT Affairs
	Outlaw
	Pride Student Union
	Gator GSA
U. of Miami (FL)	Spectrum
U. of N. Florida	Pride
U. of S. Florida	PRIDE Alliance

U. of W. Florida	Gay-Straight Alliance
Augusta State U.	Lambda Alliance
Clayton State U.	Gay-Straight Alliance
Emory University	Office of LGBT Life
Georgia Institute of Tech	Pride Alliance
Georgia Southern	Gay-Straight Alliance
Georgia State College	Gay-Straight Alliance
Geogia State U.	Alliance for Sexual and Gender Diversity, Black OUT
Kennesaw State	PRIDE Alliance
Oglethorpe U.	OUTlet
Savannah College of Art and Design	Queers and Allies
U. of Georgia	LGBT resource center
U. of West Georgia	Lambda
Valdosta State U.	Gay-Straight Alliance
U. of Hawaii Hilo	Pride Hilo
U. of Hawaii Manoa	The Queer Student Union
Idaho State	LGBTSA
U. of Idaho	Gay-Straight Alliance
Eastern Illinois	EIU Pride
Illinois State	PRIDE
Illinois Wesleyan University	Pride Alliance

Lake Forest College	PRIDE Lake Forest
Northern Illinois U.	LGBT resource center
Northwestern University	Rainbow
Southern Illinois U.	GLBT Resource Center
U. of Chicago	LGBTQ Resource Center
U. of Illinois Chicago	PRIDE @ UIC
U. of Illinois Urbana	Office of LGBT Resources
Ball State U.	Spectrum
Butler University	Alliance
Earlham College	Spectrum
Indiana State	Advocates for Equality
Indiana U.	OUT
Indiana U. South Bend	Gay-Straight Alliance
Indiana U. South East	Gay-Straight Alliance
Purdue U.	Ally Association, Queer Student Union
St. Mary's College	SAGA
U. of Evansville	PRIDE
U. of Southern Indiana	Spectrum
Wabash College	SHOUT
Coe College	Coe Alliance
Drake U.	Rainbow Union
Grinnell college	Coming Out Group, StoneCo

Iowa State U.	LGBT Ally Alliance
Luther College	Pride
U. of Iowa	GLBT Allied Union
U. of Northern Iowa	PROUD
Wartburg College	Alliance
Bethany College	Bethany College Ally Group
Kansas State	LGBTQ and More
Pittsburg State U.	Queer-straight Alliance
U. of Kansas	Queers and Allies
Murray State University	Murray State Alliance
U. of Kentucky	Gay-Straight Alliance
U. of Louisville	Office of LGBT Services
Western Kentucky U.	Student Identity Outreach
Louisiana State	Spectrum
McNeese State	The Alliance
Tulane U.	Office of LGBT student life
Bowdoin College	Bowdoin Queer Straight Alliance
Colby College	The Bridge
U. of Maine	GLBT Services
U. of New England	GLBTQ Students Advisor
U. of South Maine	Center for Sexualities and Gender Diversity
Johns Hopkins U.	Diverse Sexuality and Gender Alliance

Loyola College	Spectrum
Maryland Institute College of Art	Queer Alliance
McDaniel College	Allies
Towson University	Queer Student Union
U. of Maryland - Baltimore County	Freedom Alliance
U. of Maryland - College Park	Graduate Lambda Coalition
	Office of LGBT Equity
	Pride Alliance
Boston college	Allies of Boston College
Boston University	Spectrum
Brandeis University	Triskelion
Bridgewater State College	GLBT Pride Center
Clark University	GLBT Alliance
Endicott College	Gay-Straight Alliance
Framingham State College	10% Alliance and Allies
Hampshire College	Queer Community Alliance Center
	Gay and Lesbian Caucus, Queer Students and
Harvard	Allies
MIT	GLBTs and Friends
	LGBT Services
	Undergrad LGBT Community
Northeastern University	NUBiLaGA

Simmons College	Alliance
Suffolk University	Rainbow Alliance
Tufts University	The Queer Straight Alliance
U. of Mass	Pride Alliance
Wellesley College	Spectrum
Worcester Polytechnic Institute	Gay-Straight Alliance
College for Creative Studies	Gay-Straight Alliance
Eastern Michigan U.	Queer Unity for Eastern Students
Grand Valley State U.	Out 'n' About
Kalamazoo College	Kaleidoscope
Kalamazoo Valley C. C.	Gay-Straight Alliance
Kettering U.	Kettering Allies
Michigan State U.	The Alliance of LGBTA Students
Michigan Tech U.	Keweenaw Pride
Mott Community College	Gay-Straight Alliance
Nothern Michigan U.	OUTLook
Saginaw Valley State U.	Gay-Straight Alliance
U. of Michigan - Ann Arbor	East Quad Spectrum
	LGBT Commission, Gender Explorers
	LambdaGrads
	Lavendar Info and Library Association
	OutLaws

	Spectrum Center
U. of Michigan - Dearborn	Lambda Alliance
U. of Michigan - Flint	LGBT Center
Wayne State U.	BGLAS
Western Michigan U.	LGBT Student Services, OUTSpoken
Art Institutes International Minnesota	Ai Alliance LGBTQA
Augsburg College	LGBTQIA Support Services
Carleton College	Carleton In and Out
Concordia College at Moorhead	Straight and Gay Alliance
Macalester College	Macalester Out and Proud Community
	Queer Union
Metropolitan Staet University	GLBT resource center
Minnesota State Mankato	Sexuality and Gender Equality
	LGBT Center
Minnesota State Moorhead	Ten Percent Society
Riverland C. C.	Gay-Straight Alliance
Rochester Community and Technical College	Circle of Friends
Southwest Minnesota State	GLBTA
St. Cloud State University	GLBT Alliance
U. of Minnesota - Duluth	Queer Student Union

U. of Minnesota - Twin Cities	GLBTA Programs Office
	Queer Student Cultural Center
	Queer Grad Student and Professional Association
U. of St. Thomas	Allies
Northwest Miss C. C.	Gay-Straight Alliance
U. of Southern Mississippi	Gay-Straight Alliance
Drury U.	Allies
Missouri State	BiGALA
Missouri Western State	Pride Alliance
Northwest Missouri State	common Ground
St. Louis U.	Rainbow Alliance
Truman State U.	Prism
Mizzou	Gamma Rho Lambda
U. of Missouri - Columbia	LGBT Resource Center
U. of Missouri - Kansas City	Queers and Allies
U. of Missouri - St. Louis	GLBT & Allies Resource Center
Westminster college	The Alliance
U. of Montana	Lambda Alliance
Nebraska Wesleyan U.	Plains Pride
U. of Nebraska - Lincoln	Queer Student Alliance
U. of Nebraska - Kearney	Queer Straight Alliance

U. of Nevada - Las Vegas	Spectrum
U. of Nevada - Reno	Queer Student Union
Dartmouth College	CGLBTC
	DGALA
	Gay-Straight Alliance
	Green Lambda
	Rainbow Alliance
Dartmouth Med School	qMD
Franklin Pierce Law Center	Lambda Law
Keene State College	KSC Pride
New England College	SOUP
Plymoth State U.	ALSO
Southern New Hampshire U.	SOAR
Tuck School of Business at Dartmouth	Tuck Gay-Straight Alliance
U. of New Hampshire	UNH Alliance
County College of Morris	Gay-Straight Alliance
Drew University	Drew Alliance
Princeton U.	Pride Alliance
Rutgers University - New Brunswick	BGL Alliance of Rutgers
The College of New Jersey	Prism

New Mexico State U.	Stonewall QSA
New Mexico Tech.	Queer Association of Socorro Area Residents
U of New Mexio	Queer Straight Alliance
Adelphi University	LGBTSSA
CUNY Queens College	GLASA
Colgate U.	Rainbow Alliance and Advocates
Cornell U.	LGBT Resource Center
Fordham U.	Pride Alliance
Hofstra U.	The Pride Network
	The Center for LGBT Ed, Outreach and
Ithaca College	Services
New York U.	Queer Union
Pace U.	LGBTQA Task Force
Rochester Institute of Tech	RIT Gay Alliance
SUNY Canton College of Tech.	SPECTRUM
SUNY College at Oswego	Rainbow Alliance
SUNY Plattsburgh	SOUL
Sarah Lawrence College	QVC
SUNY Purchase College	GLBT Union
Syracuse	LGBT Resource Center
	Open Doors
	Pride Union

The College of Sait Rose	Identity
SUNY Albany	Pride Alliance
U. of Rochester	Pride Network
Vassar College	Queer Coalition of Vassar College
Appalachian State U.	Sexuality and Gender Alliance
Duke U.	Center for LGBT Life
Guilford College	PRIDE
North Carolina State U.	Center for GLBT Programs and Services
	GLBT CommUNITY Alliance
UNC Chapel Hill	GLBT Straight Alliance
	LGBTQ Center
UNC Charlotte	PRIDE
UNC Wilmington	PRIDE
U. of North Dakota	Ten Percent Society
Baldwin-Wallace College	Allies
Bowling Green State U.	LGBTA-Q Resource Center
	Vision
Case Western Reserve University	Spectrum
Cleveland State U.	GLS Alliance
Denison University	Outlook
Kent State	PRIDE!Kent
Kenyon College	Allied Sexual orientations

Marietta College	Rainbow Alliance
Miami (Ohio) U.	Spectrum
Oberlin College	Lambda Union
	Queers and Allies of Faith
Ohio Northern University	Open Doors
Ohio U.	Ally
	LGBT Center
	Open Doors
Ohio Wesleyan U.	PRIDE
Shawnee State U.	Gay-Straight Alliance
Ohio State	GLBT Student Services
U. of Akron	LGBT Union
U. of Dayton	Student Allies
U. of Toledo	Spectrum UT
Oklahoma State U.	Sexual Orientation Diversity Association
Rose State College	Spectrum Alliance
U. of Oklahoma	GLBT and Friends
U. of Science and Arts of Oklahoma	USAO Gay Straight alliance
U. of Tulsa	BGLTA
Eastern Oregon University	GSA Sexuality Resource Center
Lane CC	Queer Straight Alliance
Lewis & Clark College	United Sexualities

Lewis & Clark School of Law	OutLaw
Oregon State	LGBT Outreach Services
	Rainbow Continuum
Portland State U.	Queer Resource Center
	Queers and Allies
Reed College	Queer Alliance
Southern Oregon U.	Queer Resource Center
U. of Oregon	LGBTQA
Western Oregon U.	Triangle Alliance
Willamette U.	Angles
California U. of Pennsylvania	Rainbow Alliance
Carlow College	PRIDE
Carnegie Mellon U.	Allies
Dickinson College	Spectrum
Elizabethtown college	Allies
Marywood University	Ally Group
Penn State	LGBTA Student Resource Center
	LGBTQA Student Alliance
	oSTEM
Temple U.	Common Ground
U. of Pittsburgh	Rainbow Alliance
U. of Pennsylvania	LGBT Center

	Queer Student Alliance
Villanova U.	BGLOV
	Gay-Straight Coalition
Brown U.	LGBTQ Resource Center
Rhode Island College	Rainbow Alliance
U. of Rhode Island	GLBT Center
	OutURI
Clemson U.	Safe Zone Program
U. South Carolina	BGLSA
Winthrop U.	GLoBAL
Northern State U.	10 % Society
U. of South Dakota	10% Society
Maryville college	Gay-Straight Alliance
Tennessee Technological U.	TTU Lambda Association
Vanderbilt U.	Office of LGBTQI Life
Central Texas College	Gay Straight Alliance of C. Texas
Houston C. C.	OUT Students and Allies
Rice	GATHER
Saint Edwards U.	GLBTS Alliance
Sam Houston U.	Stonewall Kats
Schreiner U.	Allied Advance
South Plains College	Gay-Straight Alliance

Stephen F. Austin State U.	Pride NAC
Texas A&M U.	GLBT Resource Center
	GLBT Aggies
Texas Christian University	Gay Straight Alliance
Texas Tech U.	Gay-Straight Alliance
Texas Woman's U.	Pride
U. of Houston	GLOBAL
U. of North Texas	Gay and Lesbian Association of Denton
U. of Texas Arlington	Safe Zone
U. of Texas Brownsville	CHANGE
U. of Texas Austin	GLBTQA Business Students
	Gender and Sexuality Center
Southern Utah U.	Queer Straight Alliance
U. of Utah	LGBT Resource Center
	Queer Student Union
Utah State U.	GLBTA Services
Green Mountain College	Pride
Marlboro College	Marlboro Pride
Middlebury College	Middlebury Open Queer Alliance
U. of Vermont	Free to Be
College of William and Mary	Lambda Alliance
George Mason U.	Pride Alliance

Hollins U.	OUTloud
Radford U.	Spectrum
Roanoke College	Lambda Alliance
U. of Mary Washington	PRISM
U. of Richmond	Student Alliance for Sexual Diversity
U. of Virginia	Greek Mens Club
	LGBT Resource Center
	Queer Grads
	Uva Pride
Virginia Commonwealth U.	Queer Action
Virginia Tech	LGBT Alliance
Evergreen State College	Evergreen Queer Alliance
Gonzaga U.	HERO
Pacific Lutheran U.	Harmony
Seattle U.	Gay-Straight Alliance
U. of Puget Sound	Gay-Straight Alliance
U. of Washington	GLBT Student Commission
	Q Center
U. of Washington - Tacoma	Queer-straight Alliance
Washington State U.	GLBTA Committee
Whitman College	GLBTQ Student Organization
Marshall U.	LGBT Outreach

	Lambda Society
Shepherd U.	Allies
West Virginia U.	BIGLTM
Alverno College	LGBT Rainbow Alliance
Beloit College	Alliance
Cardinal Stritch U.	Gay-Straight Alliance
Carthage College	10% Society
	Ally
Edgewood College	Friends Like Us
Lawrence U.	GLOW
Marquette U.	Gay Straight Alliance
Milwaukee School of Engineering	SAGA
Northland College	Alliance
St. Norbert College	Rainbow Alliance
U. of Wisconsin Green Bay	SAGA
U. of Wisconsin La Crosse	The Pride Center
U. Wisconsin Law Scool	Q Law
U. Wisconsin Madison	LGBT Campus Center
	LGBT Social Work/Welfare Group
	Out for Business
	Q-Grads
	Queer People of Color

	Sex Out Loud
	Students for Equality
	Ten Percent Society
U. of Wisconsin Milwaukee	Rainbow Alliance
U. of Wisconsin Platteville	The Alliance
U. of Wisconsin Richland	Gay-Straight Alliance
U. of Wisconsin River Falls	Gay-Straight Alliance
U. of Wisconsin Rock county	The Alliance
U. of Wisconsin Stevens Point	Gay-Straight Alliance
U. of Wisconsin Stout	Out at Stout
U. of Wyoming	Spectrum

APPENDIX B

OUTNESS INVENTORY

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

1 = person *definitely does not know* about your sexual orientation status.

2 = person *might know* about your sexual orientation status, but it is *never talked about.*

3 = person *probably knows* about your sexual orientation status, but it is *never talked about.*

4 = person *probably knows* about your sexual orientation status, but it is *rarely talked about.*

5 = person *definitely knows* about your sexual orientation status, but it is *rarely talked about.*

6 = person *definitely knows* about your sexual orientation status, and it is *sometimes talked about*.

7 = person *definitely knows* about your sexual orientation status, and it is *openly talked about.*

1----------7

1. mother

2. father

3. siblings (sisters, brothers)

4. extended family/relatives

5. new straight friends

6. work peers

7. work supervisors

8. members of your religious community (e.g., church, temple)

9. leaders of your religious community (e.g., minister, rabbi)

10. strangers, new acquaintances

APPENDIX C

EXPERIENCES OF DISCRIMINATION SCALE

Please rate how often the experience reflected in each of the following items has happened to you personally. I am interested in your personal experiences as a lesbian, gay, or bisexual individual and realize that each experience may or may not have happened to you.

0 Indicates that you do not think that this has ever happened and 6 Indicates that you think this almost always happens.

1. People have acted as if my sexual orientation is “just a phase” I am going through.
2. I find it hard telling people about my sexual orientation.
3. People have acted as if my sexual orientation means that I cannot be loyal in relationships.
4. I feel the need to hide my sexual orientation from my friends.
5. People have not wanted to be my friend because of my sexual orientation.
6. I feel embarrassed about my sexual orientation.
7. People have acted as if my sexual orientation is only a sexual curiosity, not a stable sexual orientation.
8. People have insulted me because of my sexual orientation.
9. I have been discriminated against in the work place because of my sexual orientation.
10. Others have acted uncomfortable around me because of my sexual orientation.
11. People have avoided me because of my sexual orientation.
12. People have tried to discredit my sexual orientation.

13. I have been discriminated against by health professionals because of my sexual orientation.
14. People have assumed that I will cheat in a relationship because of my sexual orientation.
15. I have been discriminated against by potential employers because of my sexual orientation.
16. I have had rude comments or gestures made towards me because of my sexual orientation.
17. I have been alienated because of my sexual orientation.
18. I closely monitor who knows about my sexual orientation.
19. People have treated me as if I am likely to have an STI/HIV because of my sexual orientation.
20. People's reactions to me because of my sexual orientation make me keep to myself.
21. People have treated me as if I am obsessed with sex because of my sexual orientation.
22. I worry about people who live in my neighborhood or nearby finding out about my sexual orientation.
23. People have stereotyped me as having many sexual partners without emotional commitments.
24. I am scared of how other people will react if they find out about my sexual orientation.
25. Others have treated me negatively because of my sexual orientation
26. Very often I feel alone because of my sexual orientation.

27. People have said that my sexual orientation is a temporary or transient sexual orientation
28. I have been excluded from social networks because of my sexual orientation.
29. I have felt talked down to because of my sexual orientation.
30. I worry about telling people about my sexual orientation.
31. I have been discriminated against by police because of my sexual orientation.

APPENDIX D

MEDICAL HISTORY QUESTIONNAIRE

1. In the last three months, approximately how many times have you visited a doctor, nurse practitioner, or nurse for a non-scheduled appointment (e. g. walked in, or scheduled less than 3 days in advance)?

_____ 0 times

_____ 1 time

_____ 2 times

_____ 3 or more times

2. In the last three months, approximately how many times have you visited a doctor, nurse practitioner, or nurse for a scheduled appointment (e. g. routine check-up, referred to specialist, etc.)

_____ 0 times

_____ 1 time

_____ 2 times

_____ 3 or more times

3. In the last year, approximately how many times have you been screened for an STI?

_____ 0 because I am not sexually active

_____ 0 because I am in a monogamous relationship

_____ 0 because I cannot afford a screening

_____ 0 for other reasons

_____ 1 time

_____ 2 times

_____ 3 or more times

4. Approximately how many sexual partners have you had in the last year? (For the purpose of this study, a sexual partner is anyone that you have had oral sex, anal sex, or intercourse with.)

_____ 0

_____ 1-3

_____ 4-6

_____ 7-9

_____ 10-12

_____ 13 or more

Please think about the last 3 or 4 (or less depending on your situation) sexual partners that you have had for the next set of questions.

5. Were you in a relationship with these partners?

_____ Yes, and generally they were monogamous (you and your partner were committed only to each other) relationships

_____ Yes, and generally they were open (you or your partner, or both of you were in a relationship, but it was not exclusively monogamous) relationships.

_____ No, they were generally casual encounters.

_____ I don't know.

_____ Does not apply to me because I have never had sex.

6. How often did you use protection when having sex?

_____ Every single time that I had sex.

_____ Almost all the times that I had sex.

_____ Most of the times that I had sex.

_____ Some of the times that I had sex.

_____ Almost none of the times that I had sex.

_____ Absolutely none of the times that I had sex.

_____ Does not apply to me because I have never had sex.

APPENDIX E

DEMOGRAPHICS QUESTIONNAIRE

Please tell a little about yourself. This information will be used only to describe the sample as a group.

Age: _____

Gender: _____Male _____Female ____Transgender: ____M-to-F ____ F-to-M

Your current relationship status (please select the best descriptor):

____Single ____Married/Partnered ____Dating, long term ____Dating, casual

If you are in a relationship, what is the gender of your partner?

_____Male _____Female ____Transgender: ____M-to-F ____ F-to-M

Race/ethnicity (Please check one)

_____ African American/Black

_____ Asian American/Pacific Islander

_____ American Indian/Native American

_____ Hispanic/Latino/a

_____ Multi-racial, please specify: _____

_____ White/Caucasian

_____ Other, please specify: _____

Your sexual orientation (please check the one best descriptor):

_____ Homosexual

_____ Bisexual/Pansexual

_____ Heterosexual

_____ Other

Have you had sex with persons of your own gender, the other gender, or both genders?

___ Never had sex

___ My own gender only

___ My own gender mostly, but some with other gender

___ Both genders equally

___ Mostly other gender, but some with my own gender

___ Other gender only