HHS Public Access

Author manuscript

Psychol Sex Orientat Gend Divers. Author manuscript; available in PMC 2019 March 01.

Published in final edited form as:

Psychol Sex Orientat Gend Divers. 2018 March ; 5(1): 1–12. doi:10.1037/sgd0000265.

Multiple Minority Stress and LGBT Community Resilience among Sexual Minority Men

Elizabeth A. McConnell[1], **Patrick Janulis**[2], **Gregory Phillips II**[2], **Roky Truong**[2], and **Michelle Birkett**[2]

[1]Department of Psychology, DePaul University, Chicago, IL

[2]Department of Medical Social Sciences, Feinberg School of Medicine, Northwestern University, Chicago, IL

Abstract

Minority stress theory has widespread research support in explaining health disparities experienced by sexual and gender minorities. However, less is known about how minority stress impacts multiply marginalized groups, such as lesbian, gay, bisexual, and transgender people of color (LGBT POC). Also, although research has documented resilience in the face of minority stress at the individual level, research is needed that examines macro-level processes such as community resilience (Meyer, 2015). In the current study, we integrate minority stress theory and intersectionality theory to examine multiple minority stress (i.e., racial/ethnic stigma in LGBT spaces and LGBT stigma in one's neighborhood) and community resilience (i.e., connection to LGBT community) among sexual minority men of different racial/ethnic groups who use a geosocial networking application for meeting sexual partners. Results showed that Black sexual minority men reported the highest levels of racial/ethnic stigma in LGBT spaces and White sexual minority men reported the lowest levels, with Asian and Hispanic/Latino men falling in between. Consistent with minority stress theory, racial/ethnic stigma in LGBT spaces and LGBT stigma in one's neighborhood were associated with greater stress for sexual minority men of all racial/ethnic groups. However, connection to LGBT community played more central role in mediating the relationship between stigma and stress for White than POC sexual minority men. Results suggest that minority stress and community resilience processes may differ for White and POC sexual minority men. Potential processes driving these differences and implications for minority stress theory are discussed.

Keywords

minority stress; stigma; connection to LGBT community; community resilience; intersectionality

Introduction

Minority stress theory posits that minority groups experience stress stemming from experiences of stigma and discrimination, which in turn places them at risk for a number of

Address correspondence to: Elizabeth McConnell, Department of Psychology, 2219 N. Kenmore Ave, Chicago, IL 60614, emcconne@depaul.edu, P: 843-696-1870, F: 773-325-7888.

negative physical and mental health outcomes. LGBT people experience forms of minority stress shared with other marginalized groups, such as discrimination, expectation of rejection, and prejudice-related life events (e.g., hate crimes), as well as unique stressors such as identity concealment and internalized homophobia (Frost, Lehavot, & Meyer, 2015; Lewis, Derlega, Griffin, & Krowinski, 2003; Meyer, 2003). However, few studies have examined the impact of minority stressors on people who live at the intersection of multiple marginalized identities. For example, LGBT people of color (POC) experience stress associated with both racism and heterosexism and thus may be at heightened risk for adverse health outcomes (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Meyer, 2003).

Intersectionality theory provides a crucial lens for understanding these experiences of multiple marginalization and their relationship to health. Intersectionality, which is rooted in Black feminist thought (e.g., Collins, 1990; Crenshaw, 1991; hooks, 1984; Lorde, 1984), articulates the understanding that social identities and the accompanying experiences of privilege and marginalization are not simply additive, but are co-constructed and interdependent (Bowleg, 2008; Purdie-Vaughns & Eibach, 2008; Williams & Fredrick, 2015). Increasingly, scholars in psychology are calling for the incorporation of intersectionality theory to holistically attend to the nuanced ways in which minority stress impacts wellbeing for members of multiple marginalized groups (Bowleg, 2008; McConnell, Todd, Odahl-Ruan, & Shattell, 2016; Purdie-Vaughns & Eibach, 2008; Remedios & Snyder, 2015; Williams & Fredrick, 2015).

In addition to examining experiences of stress related to multiple minority statuses, it is important to build knowledge about processes of resilience. Resilience refers to the ability to mitigate the adverse impact of stress and thrive in the face of adversity (Frost & Meyer, 2009; Meyer, 2015). Work on resilience has typically lagged behind work on minority stress; however, it constitutes an important strengths-based lens for examining the ability of individuals to persist and thrive in the face of significant stressors (Masten, 2001). Recent work by Ilan Meyer (2015) distinguished between two types of resilience: individual-based resilience (focused on personal agency) and community-based resilience (focused on connectedness to community and social resources). Most literature on resilience has focused on individual-level resilience, which runs the risk of creating an “expectation of individual resiliency” and deemphasizing the importance of large scale social change (Meyer, 2015). Thus, the construct of community-level resilience provides an important lens for moving beyond the individual level to understand how ecological context plays a vital role in promoting wellbeing for LGBT people and communities.

In the current study, we incorporate minority stress theory and intersectionality theory to examine experiences of stigma, stress, and LGBT community resilience. Specifically, we examine how intersectional forms of identity-based stigma (e.g., racial/ethnic stigma in LGBT spaces) are associated with stress among racially diverse sexual minority men on a geosocial networking application. Further, we extend research on variables that mediate the psychological outcome of stigma experiences (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009) by testing how connection to LGBT community may mediate the relationship between stigma and stress. By examining how these associations may differ between White sexual minority men and sexual minority men of color, we contribute to intersectional

understandings of the importance of community resilience as part of the minority stress framework (Meyer, 2015). This responds to a call in the field for intersectional research on multiple minority stress (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Bowleg, 2008; Purdie-Vaughns & Eibach, 2008; Remedios & Snyder, 2015; Williams & Fredrick, 2015), particularly quantitative research (Else-Quest & Hyde, 2016a, 2016b). We now review literature on intersectionality theory, multiple minority stress and LGBT POC, and multilevel approaches to resilience to provide background for the current study.

Intersectionality Theory and Research in Psychology

Intersectionality provides a theoretical framework for understanding how multiple social identities (e.g., race, gender, sexual orientation, socioeconomic status [SES], and disability) intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression at the macro social structural level (Bowleg, 2012). Several key features of intersectionality theory are important to highlight. First, social identities are understood in the context of their relationships to power, which are shaped by systems of privilege and oppression (Bowleg, 2008; Parent, DeBlaere, & Moradi, 2013; Warner & Shields, 2013; Williams & Fredrick, 2015). Second, intersectionality theory takes a holistic view of social identities as mutually constructed and interdependent rather than as distinct, separable aspects of experience. For example, early work on intersectionality articulated how Black women's experiences of sexism were shaped by racism, and thus were not represented by mainstream White feminist movements; similarly, their experiences of racism were shaped by sexism, and thus were not represented by male-dominated civil rights movements (Crenshaw, 1991). This is an example of "intersectional invisibility," which takes multiple forms (e.g., historical, cultural, political, and legal) and perpetuates the subordination of multiply marginalized groups by excluding their experiences from dominant discourses (Purdie-Vaughns & Eibach, 2008). Intersectionality theory reduces this invisibility by emphasizing the fundamental interconnections between systems of oppression; this emphasis is at the heart of its theoretical contribution and utility for transformative social change.

The interconnection and complexity of social identities has presented a major methodological challenge for psychologists interested in conducting intersectionality research. Qualitative methods have been useful as they permit participants to describe their experiences of in their own terms and are able to accommodate the richness and complexity of these experiences (Bowleg, 2008; Else-Quest & Hyde, 2016a, 2016b; Ghabrial, 2016; Nadal, Davidoff, Davis, Wong, Marshall, & McKenzie, 2015). Far fewer quantitative applications of intersectionality theory in psychology exist, and many of those that do suffer from methodological shortcomings (Else-Quest & Hyde, 2016a, 2016b). Quantitative approaches have historically taken an additive approach, which considers each identity separately and then sums them into an understanding of individuals' overall experiences, or a multiplicative approach, which considers how two or more identities may interact to shape experience (Bowleg, 2008; Purdie-Vaughns & Eibach, 2008; Williams & Fredrick, 2015). Both of these approaches fundamentally rely on single-axis conceptualizations of identity, frequently examining identities as predictor variables by testing main effects (additive approach) and interactions (multiplicative approach) (Parent et al., 2013; Williams &

Fredrick, 2015). By contrast, truly intersectional psychological approaches move beyond considering identities as demographic predictors to examining the unique experiences of groups with specific intersecting identities, particularly by examining experiences of within-group diversity (Parent et al., 2013).

At the same time, there are virtually endless configurations of identities. This complexity, combined with the lack of established tools for conducting intersectional psychological research, can make the task of conducting truly intersectional research overwhelming (Remedios & Snyder, 2015). As intersectionality research is sorely needed, particularly given the dearth of research on multiple minority stress (Bowleg et al., 2003; Remedios & Snyder, 2015), researchers have articulated recommendations for advancing intersectional psychological research. First, they underscore the importance of incremental advances, as "we cannot reasonably expect to go from a science of single identities to a science of everything, accounting for all combinations of identities and variations within each identity category, without incremental advances in between" (Remedios & Snyder, 2015, p. 410). Thus, it may be important for researchers to intentionally focus on particular intersections of identities (Parent et al., 2013). Second, they recommend moving beyond demographic questions to examine the relationships between identities and specific constructs such as prejudice, discrimination, and stress (Bowleg, 2008; Parent et al., 2013). This acknowledges the context-dependent nature of identities given the interplay between individuals and their environments (Else-Quest & Hyde, 2016a; Williams & Fredrick, 2015) and encourages a focus on how experiences of marginalization may differ rather than attempting to sum the distinct effects of multiple marginalized identities (Parent et al., 2013; Purdie-Vaughns & Eibach, 2008). Third, they illustrate how questions can "tap the interdependence and mutuality of identities" rather than implying to participants that their identities should be considered separately or ranked in importance (Bowleg, 2008, p. 316; Else-Quest & Hyde, 2016a). In the current study, we incorporate these recommendations by: a) exploring within-group diversity among sexual minority men; b) focusing on the intersection of race and sexuality; c) comparing the experiences of White and POC participants rather than using identities as predictor variables; and d) examining identity-based forms of stigma in specific contexts and their associations with stress.

Multiple Minority Stress for LGBT POC

LGBT POC are subject to excess social stress stemming from experiences of racism, heterosexism, and/or cissexism. Although the experiences of LGBT POC may differ based on their specific racial/ethnic identity, this population shares dual minority status related to sexual orientation and race/ethnicity (Balsam et al., 2011). On one hand, LGBT POC face heterosexism and cissexism in both the larger US society as well as in their respective racial/ethnic communities (Bowleg, 2013). On the other hand, they experience racism in LGBT communities and in their dating relationships (Balsam et al., 2011; Bowleg, 2013; Rostosky, Riggle, Gary, & Hatton, 2007). LGBT POC also reported high levels of identity compartmentalization and stress related to negotiating their marginalized identities in different spaces (Ghabrial, 2016). Given minority stress theory's emphasis on the detrimental impact of cumulative stress on wellbeing, researchers have posited that these

multiple experiences of minority stress may leave LGBT POC especially vulnerable to adverse health outcomes (Balsam et al., 2011).

Intersectional invisibility has created a substantial gap in knowledge about multiple minority stress for LGBT POC. LGBT people and communities are increasingly acknowledged as a health disparity population (Institute of Medicine, 2011; National Institute on Minority Health and Health Disparities, 2016), but have historically been understudied in mainstream psychology, such as through the omission of items to capture sexual orientation in population health studies (Sell & Becker, 2001. Within this body of work, the unique experiences of LGBT POC are lost when they are aggregated into the broader umbrella of LGBT population health research. The experiences of LGBT people of color, particularly sexual minority men of color, are also understudied in intersectional psychological research (Bowleg, 2013; Parent et al., 2013). Thus, despite the existing body of research on LGBT minority stress, only a few studies have examined minority stress among LGBT POC. LGBT POC report unique forms of minority stress, including racism in LGBT communities, heterosexism in racial/ethnic communities, and racial/ethnic discrimination in dating and close relationships (Balsam et al., 2011; Bowleg, 2013; Hunter, 2010), which are missed when studies focus on single-axis conceptualizations of minority stress. Application of intersectionality theory is critical to reduce this intersectional invisibility, which ultimately provides better understanding of health disparities by illuminating the complexities of social inequities (Hankivsky & Christofferson, 2008). In the current study, we aim to reduce this intersectional invisibility by examining specific forms of stigma that may differ between White and POC LGBT people (e.g., racial/ethnic stigma in LGBT communities).

There are likely complex relationships between multiple minority stress and resilience for LGBT POC. Minority stress theory suggests that LGBT POC are at higher risk for negative mental health outcomes than White LGBT people due to overall higher levels of stress. However, research has found little evidence of these racial disparities (Balsam et al., 2015; Kertzner, Meyer, Frost, & Stirratt, 2009; Mustanski, Garofalo, & Emerson, 2010), suggesting that LGBT POC show resilience despite greater minority stress exposure. Stress-inoculation theories suggest that early experiences of racism may help LGBT POC develop resilience processes that they are later able to draw on to understand and cope with LGBT minority stress (Bowleg et al., 2003; Greene, 1994; Hatzenbuehler et al., 2009).

Researchers have found evidence for the intersectional nature of these resilience processes. For example, Ghabrial (2016) recently built on the concept of positive marginality (i.e., reframing a stigmatized identity as a positive aspect of the self that is associated with connection to a community working for social change; Unger, 2000) by identifying how LGBT POC also articulated narratives of “positive intersectionality.” Positive intersectionality refers to LGBT POC’s identification of “ways their marginalized identities support one another,” or how acceptance and empowerment around one aspect of identity can lead to acceptance and empowerment along another aspect of identity, ultimately increasing resilience and wellbeing (Ghabrial, 2016). For example, Black gay and bisexual men reported that their experiences of race-based stigma were more salient than sexuality-based stigma, but also highlighted how these experiences were a source of psychological growth, freedom from societal expectations, and resilience (Bowleg, 2013). By comparing

minority stress and resilience processes between White sexual minority men and sexual minority men of color, we aim to contribute to quantitative literature on how these processes may work in similar or different ways for these groups. To illustrate how these complex relationships may operate for LGBT POC, we now turn to recent research and theory on intersectional, multilevel approaches to resilience.

Intersectional, Multilevel Approaches to Resilience

Resilience, or the ability to mitigate the adverse impact of stress and thrive in the face of adversity, is a critical element of minority stress theory (Frost & Meyer, 2009; Meyer, 2015). In this respect, resilience is essentially a process of stress buffering. Resilience is distinct from coping in that coping refers to the effort an individual puts into adapting or responding to stress while resilience refers to successful adaptation or response to stress in a way that minimizes or avoids adverse health outcomes (Meyer, 2015).

More recently, Meyer (2015) distinguished between individual- and community-based resilience. Individual resilience describes an individual's capability to cope with stress and triumph over adversity (e.g., personal agency and locus of control; Meyer, 2015; Rotter, 1966; Turner & Roszell, 1994). Community resilience refers to a community's capacity to empower marginalized members, such as through the provision of both tangible and intangible resources that facilitate successful coping with stress (Fergus & Zimmerman, 2005; Meyer, 2015). For LGBT communities, intangible resources may include LGBT affirming social norms and values, and tangible resources may include LGBT affirming laws and policies, physical spaces such as LGBT community centers and neighborhoods, and access to LGBT affirming health services (Meyer, 2015). Meyer (2015) notes that community resilience provides a promising framework, as continued focus on the individual level obscures the impact of systems of oppression and precludes an understanding of the importance of transformative social change.

However, several factors complicate the extent to which individuals and groups benefit from community resilience. First, communities must achieve resilience in order to function as a resource for individuals. Communities that do not have access to adequate resources or are dominated by risk factors are unlikely to promote resilience in the individuals who are connected with them (Meyer, 2015). Second, individuals must identify and connect with communities in order to experience community resilience. Community members likely vary in this connection depending on a number of factors, including identity centrality and within-community stigma (Meyer, 2015). For example, bisexuality has been shown to be negatively associated with social wellbeing; this relationship was mediated by lower connection to LGB community, likely due to the prevalence of biphobia in sexual minority communities (Kertzner et al., 2009).

Experiences of racial/ethnic stigma in LGBT spaces may negatively impact the extent to which LGBT POC feel connected with these communities and have opportunities to benefit from community resilience (Balsam et al., 2011; Bowleg, 2013; Ghabrial, 2016). LGBT POC reported they experienced racism in White LGB communities (Bowleg, 2013) and primarily found community connection in intersectional LGBT POC spaces (Ghabrial, 2016), underscoring how the relative lack of LGBT POC spaces and the prevalence of racial/

ethnic stigma in the broader LGBT community may negatively impact the wellbeing of LGBT POC by decreasing a potential buffer for minority stress. At the same time, LGBT POC may receive support and learn coping skills for dealing with stigma in their racial/ethnic communities (Bowleg et al., 2003) and may demonstrate more resilience in the face of stigma due to stress-inoculation processes (Greene, 1994; Hatzenbuehler et al., 2009) and positive intersectionality narratives (Ghabrial, 2016). Also, LGBT POC may access community resilience through affiliation with multiple diverse communities, particularly given findings that POC report stronger community and familial orientations than White people (Gaines et al., 1997).

Current Study

In the current study, we contribute to incremental advances in intersectional understandings of multiple minority stress by focusing on experiences of identity-related stigma in specific contexts and their relationships to LGBT community resilience and stress in a sample of racially diverse sexual minority men. First, we examined racial/ethnic differences in experiences of racial/ethnic stigma in LGBT spaces and LGBT stigma in one's neighborhood. We hypothesized that sexual minority men of color would report greater experiences of racial/ethnic stigma in LGBT spaces than White sexual minority men; our analysis of racial/ethnic differences in LGBT stigma was exploratory. Next, we tested two models examining the role of connection to LGBT community in mediating the relationship between: a) racial/ethnic stigma in the LGBT community and stress and b) LGBT stigma in one's neighborhood and stress. We hypothesized that connection to LGBT community would mediate the relationship between stigma and stress, and that this relationship may operate differently for White sexual minority men and sexual minority men of color. Consistent with stress-inoculation positive intersectionality theories, sexual minority men of color may be more resilient to stigma than White sexual minority men. Alternatively, consistent with an additive model of multiple minority stress, sexual minority men of color may be more impacted by stigma than White sexual minority men. Given these competing theoretical explanations and the lack of research comparing these processes between White and POC sexual minority men, our analyses of racial/ethnic differences in the relationship between stigma, connection to LGBT community, and stress were exploratory.

We chose to focus on LGBT stigma in participants' neighborhoods rather than in their racial/ethnic communities because of the salience of neighborhood as an immediate, everyday context that impacts health and wellbeing for sexual minorities (Duncan & Hatzenbuehler, 2014; Duncan, Hatzenbuehler, & Johnson, 2014; Hatzenbuehler, 2014), and because our sample included White sexual minority men, who may be less likely to identify with their racial/ethnic community given their membership in the dominant racial group (Goodman, 2011; Todd & Abrams, 2011; Wong & Cho, 2005). Also, it is possible that participants who experience LGBT stigma in their neighborhood may be more likely to seek out or rely on LGBT community and spaces (Frye, Egan, Van Tie, Cerdá, Ompad, & Koblin, 2014).

The models tested in the current study differ from other models tested in minority stress research in several important ways. Although the minority stress literature often treats experiences of stigma and discrimination as forms of stress (Meyer, 2003), researchers have

identified that these experiences may or may not be perceived as stressful. For example, Hatzenbuehler and colleagues (2009) examined how individual emotion-regulation strategies mediated the relationship between stigma experiences and distress. In the current study, we examine connection to LGBT community as a mediator of the relationship between stigma experiences and perceived stress. We also focused on perceived stress as an outcome rather than mental health symptoms (e.g., depression, anxiety) given that we assessed specific forms of stigma (i.e., race/ethnicity and LGBT) in specific spaces (i.e., residential neighborhood and LGBT community). Given this limited focus, we believed it was unreasonable to expect these stigma experiences to be associated with mental health symptoms and focused on stress more generally. Given the large body of literature documenting the adverse health effects of stress (Thoits, 2010), we believe it was appropriate to examine stress as an outcome variable.

Although we were interested in the experiences of LGBT POC more broadly, in the current study we focused on cisgender men who utilized a geosocial networking application designed for sexual minority men seeking romantic and/or sexual partners. There is a range of gender identities represented in the LGBT umbrella, experiences of minority stress and connection to LGBT community are likely shaped by intersectionality related to gender identity (Babbit, 2013). Given this complexity and the importance of focusing on specific intersections of identity to contribute to incremental advances in intersectional psychological research (Remedios & Snyder, 2015), we chose to limit our sample to cisgender men. Many geosocial networking apps include user bases that encompass a diverse population across age, race/ethnicity, location, and gender. Due to the relative confidentiality of these apps compared to visiting LGBT identified venues and neighborhoods, users also likely vary in terms of outness and connection with LGBT community. Given that much research with LGBT populations has relied on participants who are recruited through LGBT venues and networks and who are comfortable enrolling in an LGBT related study (often in-person), existing research may be skewed towards participants with higher levels of outness and connection to LGBT community (Balsam et al., 2011; Williams & Fredrick, 2015). These apps provided a unique opportunity for the targeted recruitment of a diverse sample of sexual minority men in the current study.

Methods

Recruitment

Participants were recruited via banner and pop-up ads from a geospatial networking application used to meet men. Nationwide banner and pop-up ads ran from April 2015 to June 2015 and were targeted to users within the United States. Banner ads ran continuously during this time looking for individuals to join a “men’s health study.” Pop-up ads appeared on four dates spread throughout the study period and would appear to a user the first time they logged into the application during each of these dates. Participants did not receive an incentive for participation and the study protocol was approved by the [removed for blind review] Institutional Review Board as an anonymous, exempt study. Upon clicking on the ad, participants were directed to a landing page followed by a consent form and screener.

Participants

A total of 1,375 participants consented to being part of the study and met inclusion criteria of being at least 18 years old. In order to reach the final analytic sample, we excluded participants who did not provide basic demographics (i.e., race and gender; n = 148), participants who did not have complete data on all study scales (n = 544), duplicate participants (n = 24), participants who did not identify with one of the four racial/ethnic groups in our study (i.e., Black/African American, Asian, Hispanic/Latino, or White; n = 51), and participants who did not identify as cisgender men (n = 19). This resulted in our final analytic sample of 589 sexual minority men.

Participants' mean age was 36.9 years (*SD* = 12.6; *Range* 18 to 77). Of the 589 men, most identified as White (n = 419; 71.1%), followed by Hispanic/Latino (n = 111; 18.9%), Black/African American (n = 31; 5.3%), and Asian (n = 28; 4.8%). For sexual orientation, most identified as gay (n = 506; 85.9%), followed by bisexual (n = 68; 11.5%), queer (n = 10; 1.7%), questioning/unsure (n = 2; 0.3%), straight (n = 1; 0.2%), and not listed (n = 1; 0.2%). On a scale of 1 (*Not out to anyone*) to 4 (*Out to everyone*), mean level of outness was 3.06 (*SD* = 0.82; *Range* 1 to 4).

Measures

Racial/ethnic stigma in the LGBT community—Racial/ethnic stigma in the LGBT community was measured using six items adapted from work by Ramirez-Valles and colleagues (2010). This scale used the prompt, "When in LGBT spaces, how often have you…" to assess frequency of racial/ethnic stigma on a scale of one (*Never*) to four (*Many times*), with higher scores indicating higher stigma. For the full-text of all items, see Table 1. This scale demonstrated good internal consistency in the current study (α = .89).

LGBT stigma in neighborhood—The level of perceived LGBT stigma within participants' residential neighborhood was measured using three items developed for the current study. Participants indicated strength of agreement ranging from one (*Strongly Agree*) to four (*Strongly Disagree*) with a series of three statements. For the full-text of all items, see Table 1. This scale demonstrated good internal consistency in the current study (α = .83).

Connection to LGBT community—Connection to LGBT community was measured using six items based on the scale developed by Frost and Meyer (2012). Participants indicated strength of agreement ranging from one (*Strongly Agree*) to five (*Strongly Disagree*), with higher scores indicating higher connection. For the full-text of all items, see Table 1. This scale demonstrated good internal consistency in the current study (α = .91).

Stress—Stress in the past month was assessed using the Perceived Stress Scale (Cohen & Williamson, 1988). Participants rated frequency of four stress symptoms on a scale of one (*Never*) to five (*Very Often*), with higher scores indicating greater stress. Example items include, "Felt that you were unable to control the important things in your life?" and "Felt that things were going your way?" (reverse coded). This scale demonstrated good internal consistency in the current study (α = .80).

Analytic Strategy

First, we conducted a multivariate analysis of variance (MANOVA) with race/ethnicity as the independent variable, and racial/ethnic stigma in LGBT spaces and LGBT stigma in neighborhood as the dependent variables. We then conducted one-way analyses of variance (ANOVAs) separately for each scale. For each significant ANOVA, we examined pairwise differences between group means and used Tukey's multiple comparison procedure to control Type I error for these pairwise comparisons (Toothaker, 1993).

Next, we tested separate mediation models for White participants (n=419; Figure 2) and participants of color (n=170; Figure 3). We followed recommendations in the literature to examine indirect effects using bootstrap resampling procedures (Mallinckrodt, Abraham, Wei, & Russell, 2006). This approach creates empirical distributions of the variability in a sample rather than assuming that indirect effects are normally distributed (Mallinckrodt et al., 2006; Preacher & Hayes, 2008). Methodologists have endorsed bootstrapping methods and found in simulation studies that they outperformed the traditional normal theory approach (Mallinckrodt et al., 2006). We tested racial/ethnic stigma and LGBT stigma in separate models using the INDIRECT macro (Preacher & Hayes, 2008) in SAS v9.4 (Cary, NC). For interested readers, we also report other paths often used to establish mediation (Baron & Kenney, 1986).

Results

Racial Differences in Stigma

The MANOVA examining racial/ethnic differences in the two types of stigma (i.e., racial/ethnic stigma in LGBT spaces and LGBT stigma in neighborhood) was significant, $\Lambda = 0.77$, $F(6, 1168) = 26.66$, $p < .01$, indicating mean differences between racial/ethnic groups on at least one type of stigma. We then conducted one-way ANOVAs separately for each stigma scale. The ANOVA for racial/ethnic stigma in LGBT spaces was significant, $F(3,585) = 55.48$, $p < .01$, while the ANOVA for LGBT stigma in neighborhood was not, $F(3, 585) = 1.48$, *ns*. Examination of R^2 indicated that 22% of the variance in racial/ethnic stigma in LGBT spaces and 1% of the variance in LGBT stigma in neighborhood was explained by racial/ethnic group membership.

Tukey multiple comparison procedures showed Black participants reported significantly higher racial/ethnic stigma in LGBT spaces than any other racial/ethnic group ($M = 2.69$, $SD = 0.69$). Asian ($M = 2.19$, $SD = 0.65$) and Hispanic/Latino ($M = 2.02$, $SD = 0.86$) participants reported lower racial/ethnic stigma than Black participants, but higher stigma than White participants, who reported the lowest levels of racial/ethnic stigma ($M = 1.45$, $SD = 0.61$). Results are depicted in Figure 1.

Stigma, Connection to LGBT Community, and Stress

Intercorrelations between variables in the mediation models are presented in Table 2. First, we tested whether connection to LGBT community mediated the relationship between experiences of racial/ethnic stigma in LGBT spaces and stress. In order to examine experiences of multiple minority stress, separate models were run for participants of color

(Figure 2) and White participants (Figure 3). For POC participants, R^2= 0.07, indicating that 7% of the variance in stress in our sample of POC participants was accounted for by racial/ethnic stigma in LGBT spaces and connection to LGBT community. Racial/ethnic stigma in LGBT spaces was positively associated with stress, while connection to LGBT community was negatively associated with stress. However, there was not a significant indirect effect (*IE* = Indirect Effect) of racial/ethnic stigma on stress through connection to LGBT community: *IE* = 0.00, *SE* = 0.02, 95% CI [−0.03, 0.05].

White participants showed a slightly different pattern. In this model, R^2= 0.12, indicating that 12% of the variance in stress in our sample of White participants was accounted for by racial/ethnic stigma in LGBT spaces and connection to LGBT community. Experiencing racial/ethnic stigma in LGBT spaces was positively associated with stress for White participants, and there was an indirect effect of racial/ethnic stigma on stress through connection to LGBT community: *IE* = 0.05, *SE* = 0.02, 95% CI [0.01, 0.10].

Next, we tested whether connection to LGBT community mediated the relationship between experiences of LGBT stigma in one's neighborhood and stress. For POC participants, R^2 = 0.07, indicating that 7% of the variance in stress in our sample of POC participants was accounted for by LGBT stigma in one's neighborhood and connection to LGBT community. For POC participants (Figure 2), experiencing LGBT stigma in one's neighborhood was positively associated with stress, and this relationship operated in part through an indirect effect through connection to LGBT community: *IE* = 0.05, *SE* = 0.03, 95% CI [0.00, 0.13].

White participants showed a similar pattern, but with some slight differences. In the model for White participants, R^2= 0.09, indicating that 9% of the variance in stress in our sample of White participants was accounted for by LGBT stigma in one's neighborhood and connection to LGBT community. Experiencing LGBT stigma in one's neighborhood was positively associated with stress for White participants (Figure 3), and this relationship was fully mediated by an indirect effect of racial/ethnic stigma on stress through connection to LGBT community: *IE* = 0.13, *SE* = 0.03, 95% CI [0.07, 0.19].

Discussion

Stigma, Connection to LGBT Community, and Stress

Study findings highlight the extent to which sexual minority men of color have different experiences of stigma than White sexual minority men. Although White and sexual minority men of color reported similar experiences of LGBT stigma in their neighborhoods, sexual minority men of color reported higher racial/ethnic stigma in LGBT community. Also, the indirect effects of stigma on stress through connection to LGBT community were stronger for White participants than POC participants. In other words, connection to LGBT community appears to play a more important role in mediating the relationship between stigma and stress for White sexual minority men than for sexual minority men of color.

LGBT stigma in neighborhood—For sexual minority men of all racial/ethnic groups, experiencing LGBT stigma in their neighborhoods was positively associated with stress through an indirect effect on connection to LGBT community (although the association was

weaker for sexual minority men of color). Several mechanisms may explain this association. Previous research has found a positive association between experiences of discrimination and internalized homonegativity among sexual minority participants (Feinstein, Goldfried, & Davila, 2012). Research has also found that experiences of stigma and discrimination may lead to increased isolation and decreased social support among sexual minorities, as individuals seek to avoid the possibility of future experiences of stigma or rejection (Hatzenbuehler et al., 2009). Thus, it is possible that experiences of LGBT stigma lead to more negative internalized beliefs about sexual minority groups, which in turn lead to decreased connection to LGBT community. Alternatively, sexual minority men who are well-connected to LGBT community may have access to resources, support, and spaces that make them less vulnerable to experiencing stigma. Longitudinal research is needed to examine these potential pathways. Regardless of the specific mechanism at play, findings suggest that sexual minority men who experience LGBT stigma are important targets for intervention, as they are less likely to benefit from LGBT community resilience.

Racial/ethnic stigma in LGBT spaces—For racial/ethnic stigma in LGBT spaces, Black participants reported the highest levels and White participants reported the lowest levels, with Hispanic/Latino and Asian participants falling in between. This is consistent with previous research, which has found that Black sexual minority men experience the highest levels of racial stigma and White sexual minority men experience the lowest levels of racial stigma in LGBT spaces (Bowleg, 2013; Raymond & McFarland, 2009), including geosocial networking apps (Paul, Ayala, & Choi, 2010; Phillips, Birkett, Hammond, & Mustanski, 2016). Findings illustrate how LGBT spaces, contexts that promote community resilience in response to LGBT stigma, are also a source of racial/ethnic stigma for LGBT POC.

Mediating role of connection to LGBT community—Consistent with minority stress theory, racial/ethnic stigma in LGBT spaces and LGBT stigma in one's neighborhood were associated with greater stress for sexual minority men of all racial/ethnic groups. However, connection to LGBT community played a slightly different role in mediating the relationship between stigma and stress for White and POC sexual minority men. LGBT stigma in one's neighborhood showed a stronger negative association with connection to LGBT community among White participants than POC participants; also, connection to LGBT community fully mediated the relationship between LGBT stigma and stress for White sexual minority men but only partially mediated this relationship for sexual minority men of color. For White participants, racial/ethnic stigma in LGBT spaces was indirectly associated with stress through decreased connection with LGBT community. Surprisingly, for POC participants there was no association between racial/ethnic stigma in LGBT spaces and connection to LGBT community, and connection to LGBT community did not explain any of the variance in the relationship between racial/ethnic stigma in LGBT spaces and stress.

There are several potential interpretations of these findings. First, sexual minority men of color may be more resilient in their connection to LGBT community than White sexual minority men. Although some research has argued that racial/ethnic stigma in LGBT spaces may have a negative impact on connection to LGBT community for LGBT POC (Balsam et

al., 2011; Ghabrial, 2016), other research has argued that LGBT POC are likely accustomed to experiencing racial/ethnic stigma in a variety of contexts, of which LGBT spaces are only one (Bowleg, 2013). Perhaps due to the ubiquitous nature of these experiences, sexual minority men of color do not feel any less connected to LGBT community when they experience racial/ethnic stigma in these spaces. This explanation is consistent with stress-inoculation theories, which suggest that LGBT POC demonstrate greater resilience even in the face of multiple forms of minority stress, potentially due to the development of coping mechanisms for racial/ethnic stigma earlier in the lifespan (Bowleg et al., 2003; Greene, 1994; Hatzenbuehler et al., 2009), such as personal narratives that support a positive view of having multiple minority identities (Bowleg, 2013; Ghabrial, 2016).

From a social contextual perspective, these differences may be the result of different community affiliations between White and sexual minority men of color. Although predominantly White urban centers are often viewed as the prototypical LGBT community, there are a plurality of LGBT communities that vary in racial/ethnic composition and a number of other variables (Bowleg, 2013). It is possible that sexual minority men of color are more connected to LGBT POC spaces, and thus their sense of connection to LGBT community is not impacted by experiences of racial/ethnic stigma. Sexual minority men of color may also be more likely to be connected with multiple diverse communities (e.g., on the basis of race/ethnicity, religious affiliation, or family networks), which may provide multiple forms of community support for coping with experiences of stigma (Bowleg, 2013). This may explain why connection to LGBT community explained less of the variance in stress among sexual minority men of color than White sexual minority men: if sexual minority men of color draw on multiple communities for coping with stress, connection to LGBT community may play a less central role in their experiences of community resilience.

White perceptions of racial/ethnic stigma—It is important to contextualize study findings in terms of how experiences of stigma may differ for White and sexual minority men of color. Definitionally, minority stress refers to the excess stress experienced by members of stigmatized groups (Meyer, 2003). As White sexual minority men are members of a privileged racial group, it is inaccurate to conceptualize their experiences of racial/ethnic stigma as a form of minority stress. It is possible that White participants reported experiences of racial/ethnic stigma based on situations in which they did not constitute the racial/ethnic majority (e.g., attending a predominantly African-American venue). However, such experiences are atypical for members of privileged groups and are qualitatively different from experiences of stigma and discrimination among marginalized group members (Goodman, 2011).

Research also suggests that members of privileged groups are more likely to exaggerate experiences of stigma, while members of marginalized groups are more likely to minimize these experiences. A large body of social psychological research on attributions to prejudice (i.e., interpreting one’s experience as stigma or discrimination) has found that members of privileged groups tend to report less severe, stable, and impactful instances of discrimination than members of disadvantaged groups (Schmitt & Branscombe, 2002). Additionally, attributions to prejudice were more psychologically costly for members of disadvantaged groups as they reminded group members of their disadvantaged status within society,

resulting in lower self-worth and perceptions of control. By contrast, attributions to prejudice were not harmful to perceptions of self-worth and control and were often protective of self-evaluations among members of privileged groups (Schmitt & Branscombe, 2002). It is also likely that members of disadvantaged groups become accustomed to experiences of stigma and discrimination, viewing them simply as “life as usual” (Bowleg, 2013; Warner & Shields, 2013). Taken together, these studies suggest that privileged group members are motivated to exaggerate the possibility of discrimination and disadvantaged groups are motivated to minimize the possibility of discrimination (Schmitt & Branscombe, 2002). Thus, White participants are likely to over-report racial/ethnic stigma and participants of color are likely to under-report such experiences.

Even given this probable bias, White sexual minority men in our study reported the lowest levels of racial/ethnic stigma of all racial/ethnic groups. However, these experiences had a stronger negative association with connection to LGBT community for White participants than participants of color, who reported no association. There may be several explanations for these findings. From a social psychological perspective, these differences may be the result of cognitive processes on the individual level related to group membership on the societal level. For example, in addition to being more highly motivated to perceive racial/ethnic discrimination, White sexual minority men may be more highly motivated to perceive these experiences as impactful. Thus, White participants who perceived racial/ethnic stigma in LGBT spaces may also be more likely to report feeling less connected to LGBT community. Also, research has found that members of disadvantaged groups who experience discrimination perceive less control, while there is no association between discrimination and perceived control for members of privileged groups (Schmitt & Branscombe, 2002). Thus, it is possible that distancing themselves from the LGBT community is a way in which White sexual minority men perceive control over their experiences in response to stigma.

Strengths and Limitations

This study integrates minority stress theory and intersectionality theory to examine how processes of stigma, stress, and community resilience are similar and different for White and POC sexual minority men. Given the lack of research on both community resilience and intersectional minority stress processes, as well as the overall lack of quantitative intersectional research (Bowleg, 2008), this study provides an important contribution to the literature. However, these contributions should be considered in light of several limitations.

First, this study was cross-sectional, and longitudinal work is needed to establish a causal relationship between stigma, connection to LGBT community, and stress. Longitudinal research can also examine patterns of stress and resilience over time. Second, our models explained a relatively small amount of the variance in stress (7–12%), particularly for sexual minority men of color, which may be due to the limited scope of our stigma experience measures. Although our examination of identity-based stigma in specific contexts is consistent with recommendations for quantitative intersectional research (e.g., Bowleg, 2008; Parent et al., 2013), other experiences (e.g., victimization) may explain more of the variance in stress. Third, consistent with other researchers (e.g., Hatzenbuehler et al., 2009), we examined processes that may mediate the outcome of stigma experiences. However, our

use of stress as an outcome variable diverges from much of minority stress literature, which conceptualizes stigma experiences as a specific form of stress that impact health and wellbeing. Although research documents the relationship between stress and health (Thoits, 2010), we do not directly test mental health outcomes in the current study.

Finally, the current study focused on cisgender sexual minority men. Given the importance of intersectionality related to gender identity, findings may not generalize to cisgender women or gender minority individuals (Babbit, 2013). Although the use of a geosocial networking application for sexual minority men allowed us to recruit a diverse sample with respect to geographic location, this recruitment strategy also resulted in a predominantly White sample. Due to the lower proportion of sexual minority men of color in our sample, we conducted mediation analyses with all sexual minority men of color pooled together rather than separately by racial group. However, experiences of racial/ethnic stigma likely vary substantially for Black, Asian, and Hispanic/Latino men.

Implications for Research and Practice

Research—Findings underscore the importance of taking an intersectional approach to understanding minority stress and resilience among LGBT populations. Although an extensive body of research documents the relationships between minority stress and health among LGBT people and communities (Frost et al., 2013; Institute of Medicine, 2011; Meyer, 2003), this research largely takes a single-axis approach. As findings from the current study illustrate, LGBT POC experience unique forms of minority stress (e.g., racial/ethnic stigma in LGBT spaces) that this research does not capture (Balsam et al., 2011). Further, our finding that the associations between stigma, connection to LGBT community, and stress differed for White versus POC sexual minority men underscores how processes of stress and resilience may operate differently for LGBT people with diverse intersectional identities. Future research should explore potential mechanisms that may drive these differences, such as stress-inoculation processes or more diverse community affiliations for sexual minority men of color. Given the relatively small amount of variance in stress explained by our models, particularly for sexual minority men of color, future research should also investigate other factors that may contribute to stress (e.g., victimization, financial strain, daily hassles) and resilience (e.g., individual coping skills, social support, connection to other sources of community resilience) for LGBT people. Research would also benefit from more specific conceptualizations of community affiliation, such as the use of network and geospatial methods to examine affiliations with specific groups, venues, and neighborhoods that may reflect racial/ethnic, LGBT, and other communities.

A major limitation of the current study is its cross-sectional design, which limits our ability to draw causal inferences. Longitudinal research is needed to further verify these patterns of associations and to test different stress-buffering models, such as suppressor and moderator effect models (Meyer, 2015; Wheaton, 1985). Although the current study contributes to knowledge about White versus POC sexual minority men, research is needed that examines these processes for LGBT people with other diverse intersecting identities.

Study findings contribute to an important gap in quantitative intersectional research, but it is difficult to interpret study findings without a deeper understanding of participants lived

experiences of stigma, connection to LGBT community, and stress (Bowleg, 2013; Warner & Shields, 2013). In particular, although we asked participants about their connection to LGBT community more generally, participants are likely affiliated with a diverse range of LGBT communities that differ in a number of important ways (Bowleg, 2013). Also, it is difficult to interpret the meaning that racial/ethnic stigma holds for White participants, given their privileged racial group membership. Qualitative and mixed-methods approaches provide researchers with rich tools to explore these complex experiences.

Practice—For practitioners working with sexual and gender minorities, findings underscore the importance of considering how clients' intersectional identities may shape their experiences of stigma, stress, and community connectedness. Sexual minority men of color in our study, particularly Black men, reported higher levels of racial/ethnic stigma in LGBT spaces; thus, practitioners should be aware of these potential experiences of multiple marginalization. Although this awareness of risk is important, practitioners should also explore positive aspects and strengths LGBT POC may find in living in the intersection of multiple minority statuses (e.g., Bowleg, 2013; Ghabrial, 2016). Connection to LGBT community may play a less central role in mediating the relationship between stigma and stress for sexual minority men of color, potentially due to greater coping skills for dealing with stigma or affiliation with more diverse sources of community resilience. Thus, practitioners may benefit from thinking holistically with sexual minority men of color about their sources of community support, and should be careful to avoid assumptions about the centrality of connection to LGBT community for these clients.

Connection to LGBT community played a stronger role in mediating the relationship between stigma and stress for White sexual minority men. Although these participants reported the lowest levels of racial/ethnic stigma in LGBT spaces, findings showed that they also perceived these experiences as impactful. Given the inaccuracy of conceptualizing racial/ethnic stigma as a form of minority stress for White people, White sexual minority men may benefit from psychoeducation to increase awareness of racism in LGBT communities, decrease resistance to learning about racial privilege, and build skills for acting as racial justice allies for sexual minority men of color (Goodman, 2011).

Conclusion

In this study, we integrated intersectionality theory and minority stress theory to examine experiences of identity-based stigma and community resilience among racially diverse sexual minority men. Findings underscore unique forms of stigma that sexual minority men of color are more likely to experience, such as racial/ethnic stigma in LGBT spaces, and highlight how minority stress and resilience processes may operate differently for White and POC sexual minority men. Although intersectional and multilevel approaches introduce new complexity into psychological research, we agree with others that these approaches are crucial for advancing meaningful understanding of the relationships between stigma, stress, and health.

References

Babbitt LG. An intersectional approach to Black/White interracial interactions: The roles of gender and sexual orientation. Sex Roles. 2013; 68:791–802. DOI: 10.1007/s11199-011-0104-4

Balsam KF, Molina Y, Beadnell B, Simoni J, Walters K. Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. Cultural Diversity and Ethnic Minority Psychology. 2011; 17:163–174. DOI: 10.1037/a0023244 [PubMed: 21604840]

Balsam KF, Molina Y, Blayney JA, Dillworth T, Zimmerman L, Kaysen D. Racial/ethnic differences in identity and mental health outcomes among young sexual minority women. Cultural Diversity and Ethnic Minority Psychology. 2015; 21:380–390. DOI: 10.1037/a0038680 [PubMed: 25642782]

Baron RM, Kenny DA. The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. Journal of Personality and Social Psychology. 1986; 51(6):1173–1182. DOI: 10.1037/0022-3514.51.6.1173 [PubMed: 3806354]

Bowleg L. “Once you’ve blended the cake, you can’t take the parts back to the main ingredients”: Black gay and bisexual men’s descriptions and experiences of intersectionality. Sex Roles. 2013; 68:754–767. DOI: 10.1007/s11199-012-0152-4

Bowleg L. The problem with the phrase women and minorities: Intersectionality - an important theoretical framework for public health. American Journal of Public Health. 2012; 102:1267–1273. DOI: 10.2105/AJPH.2012.300750 [PubMed: 22594719]

Bowleg L. When Black + lesbian + woman ≠ Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. Sex Roles. 2008; 59:312–325. DOI: 10.1007/s11199-008-9400-z

Bowleg L, Huang J, Brooks K, Black A, Burkholder G. Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. Journal of Lesbian Studies. 2003; 7:87–108. doi:0.1300/J155v07n04_06. [PubMed: 24831386]

Cohen, S., Williamson, G. Perceived stress in a probability sample of the US. In: Spacapam, S., Oskamp, S., editors. The social psychology of health: Claremont symposium on applied social psychology. New York: SAGE Publications; 1988. p. 31-67.

Collins, PH. Black feminist thought: Knowledge, consciousness and the politics of empowerment. New York: Routledge, Chapman, and Hall; 1990.

Crenshaw K. Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford Law Review. 1991; 43:1241–1299. DOI: 10.2307/1229039

Duncan DT, Hatzenbuehler ML. Lesbian, gay, bisexual, and transgender hate crimes and suicidality among a population-based sample of sexual-minority adolescents in Boston. American Journal of Public Health. 2014; 104:272–278. DOI: 10.2105/AJPH.2013.301424 [PubMed: 24328619]

Duncan DT, Hatzenbuehler ML, Johnson RM. Neighborhood-level LGBT hate crimes and current illicit drug use among sexual minority youth. Drug and Alcohol Dependence. 2014; 135:65–70. DOI: 10.1016/j.drugalcdep.2013.11.001 [PubMed: 24326203]

Else-Quest NM, Hyde JS. Intersectionality in quantitative psychological research I: Theoretical and epistemological issues. Psychology of Women Quarterly. 2016a; 40:155–170. DOI: 10.1177/0361684316629797

Else-Quest NM, Hyde JS. Intersectionality in quantitative psychological research II: Methods and techniques. Psychology of Women Quarterly. 2016b; 40:319–336. DOI: 10.1177/0361684316647953

Feinstein BA, Goldfried MR, Davila J. The relationship between experiences of discrimination and mental health among lesbians and gay men: An examination of internalized homonegativity and rejection sensitivity as potential mechanisms. Journal of Consulting and Clinical Psychology. 2012; 80:917–927. DOI: 10.1037/a0029425 [PubMed: 22823860]

Fergus S, Zimmerman MA. Adolescent resilience: A framework for understanding healthy development in the face of risk. Annual Review of Public Health. 2005; 26:399–419. DOI: 10.1146/annurev.publhealth.26.021304.144357

Frost DM, Lehavot K, Meyer IH. Minority stress and physical health among sexual minority individuals. Journal of Behavioral Medicine. 2015; 38:1–8. DOI: 10.1007/s10865-013-9523-8 [PubMed: 23864353]

Frost DM, Meyer IH. Measuring community connectedness among diverse sexual minority populations. Journal of Sex Research. 2012; 49:36–49. DOI: 10.1080/00224499.2011.565427 [PubMed: 21512945]

Frost DM, Meyer IH. Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. Journal of Counseling Psychology. 2009; 56:97–109. DOI: 10.1037/a0012844 [PubMed: 20047016]

Frye V, Egan JE, Van Tieu H, Cerdá M, Ompad D, Koblin BA. I didn't think I could get out of the fucking park." Gay men's retrospective accounts of neighborhood space, emerging sexuality and migrations. Social Science & Medicine. 2014; 104:6–14. DOI: 10.1016/j.socscimed.2013.12.002 [PubMed: 24581056]

Gaines SO Jr, Marelich WD, Bledsoe KL, Steers WN, Henderson MC, Granrose CS, … Yum N. Links between race/ethnicity and cultural values as mediated by racial/ethnic identity and moderated by gender. Journal of Personality and Social Psychology. 1997; 72(6):1460–1476. DOI: 10.1037/0022-3514.72.6.1460 [PubMed: 9177025]

Ghabrial MA. "Trying to figure out where we belong": Narratives of racialized sexual minorities on community, identity, discrimination, and health. Sexuality Research and Social Policy. 2016; 14:42–55. DOI: 10.1007/s13178-016-0229-x

Goodman, DJ. Promoting diversity and social justice: Educating people from privileged groups. New York: Routledge; 2011.

Greene B. Ethnic-minority lesbians and gay men: Mental health and treatment issues. Journal of Consulting and Clinical Psychology. 1994; 62(2):243–251. DOI: 10.1037/0022-006X.62.2.243 [PubMed: 8201060]

Hanhardt, CB. Safe space: gay neighborhood history and the politics of violence. Durham, NC: Duke University Press; 2013.

Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: A Canadian perspective. Critical Public Health. 2008; 18:271–283. DOI: 10.1080/09581590802294296

Hatzenbuehler ML, Nolen-Hoeksema S, Dovidio J. How does sexual minority stigma "get under the skin"? A psychological mediation framework. Psychological Bulletin. 2009; 135:707–730. DOI: 10.1037/a0016441 [PubMed: 19702379]

Hatzenbuehler ML. Structural stigma and the health of lesbian, gay, and bisexual populations. Current Directions in Psychological Science. 2014; 23:127–132. DOI: 10.1177/0963721414523775

hooks, b. Feminist theory: From margin to center. Cambridge, MA: South End Press; 1984.

Hunter MA. All the gays are White and all the Blacks are straight: Black gay men, identity, and community. Sexuality Research and Social Policy. 2010; 7:81–92. DOI: 10.1007/s13178-010-0011-4

Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press; 2011.

Kertzner RM, Meyer IH, Frost DM, Stirratt MJ. Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. American Journal of Orthopsychiatry. 2009; 79:500–510. DOI: 10.1037/a0016848 [PubMed: 20099941]

Lewis RJ, Derlega VJ, Griffin JL, Krowinski AC. Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. Journal of Social and Clinical Psychology. 2003; 22:716–729. DOI: 10.1521/jscp.22.6.716.22932

Lorde, A. Sister outsider. Berkeley, CA: The Crossing Press; 1984.

Major B, O'Brien LT. The social psychology of stigma. Annual Review of Psychology. 2005; 56:393–421. DOI: 10.1146/annurev.psych.56.091103.070137

Mallinckrodt B, Abraham WT, Wei M, Russell DW. Advances in testing the statistical significance of mediation effects. Journal of Counseling Psychology. 2006; 53:372–378. DOI: 10.1037/0022-0167.53.3.372

Masten AS. Ordinary magic: Resilience processes in development. American Psychologist. 2001; 56(3):227–238. DOI: 10.1037/0003-066X.56.3.227 [PubMed: 11315249]

McConnell EA, Todd NR, Odahl-Ruan C, Shattell M. Complicating counterspaces: Intersectionality and the Michigan Womyn's Music Festival. American Journal of Community Psychology. 2016; 57:473–488. DOI: 10.1002/ajcp.12051 [PubMed: 27216853]

Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin. 2003; 129:674–697. DOI: 10.1037/0033-2909.129.5.674 [PubMed: 12956539]

Meyer IH. Resilience in the study of minority stress and health of sexual and gender minorities. Psychology of Sexual Orientation and Gender Diversity. 2015; 2(3):209–212. DOI: 10.1037/sgd0000132

Mustanski BS, Garofalo R, Emerson EM. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. American Journal of Public Health. 2010; 100:2426–2432. DOI: 10.2105/AJPH.2009.178319 [PubMed: 20966378]

Nadal KL, Davidoff KC, Davis LS, Wong Y, Marshall D, McKenzie V. A qualitative approach to intersectional microaggressions: Understanding influences of race, ethnicity, gender, sexuality, and religion. Qualitative Psychology. 2015; 2:147–163. DOI: 10.1037/qup0000026

National Institute on Minority Health and Health Disparities. Sexual and gender minorities formally designated as a health disparity population for research purposes. 2016 Oct 6. Retrieved from: http://www.nimhd.nih.gov/about/directors-corner/message.html

Parent MC, DeBlaere C, Moradi B. Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. Sex Roles. 2013; 68(11–12):639–645. DOI: 10.1007/s11199-013-0283-2

Paul JP, Ayala G, Choi KH. Internet sex ads for MSM and partner selection criteria: The potency of race/ethnicity online. Journal of Sex Research. 2010; 47:528–538. DOI: 10.1080/00224490903244575 [PubMed: 21322176]

Phillips G, Birkett M, Hammond S, Mustanski B. Partner preference among men who have sex with men: Potential contribution to spread of HIV within minority populations. LGBT Health. 2016; 3:225–232. DOI: 10.1089/lgbt.2015.0122 [PubMed: 26907954]

Phillips G, Turner B, Salamanca P, Birkett M, Hatzenbuehler ML, Newcomb M, Marro R, Mustanski B. Victimization as a mediator of alcohol use disparities between sexual minority subgroups and sexual majority youth using the 2015 National Youth Risk Behavior Survey. Drug and Alcohol Dependence. 2017; 178:355–362. DOI: 10.1016/j.drugalcdep.2017.05.040 [PubMed: 28692946]

Preacher KJ, Hayes AF. Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. Behavior Research Methods. 2008; 40:879–891. DOI: 10.3758/BRM.40.3.879 [PubMed: 18697684]

Purdie-Vaughns V, Eibach RP. Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities. Sex Roles. 2008; 59:377–391. DOI: 10.1007/s11199-008-9424-4

Ramirez-Valles J, Kuhns LM, Cambell RT, Diaz RM. Social integration and health: Community involvement, stigmatized identities, and sexual risk in Latino sexual minorities. Journal of Health and Social Behavior. 2010; 51:30–47. DOI: 10.1177/0022146509361176 [PubMed: 20420293]

Raymond HF, McFarland W. Racial mixing and HIV risk among men who have sex with men. AIDS and Behavior. 2009; 13:630–637. DOI: 10.1007/s10461-009-9574-6 [PubMed: 19479369]

Remedios JD, Snyder SH. How women of color detect and respond to multiple forms of prejudice. Sex Roles. 2015; 73:371–383. DOI: 10.1007/s11199-015-0453-5

Rostosky S, Riggle E, Gray B, Hatton R. Minority stress experiences in committed same-sex couple relationships. Professional Psychology: Research & Practice. 2007; 38:392–400. DOI: 10.1037/0735-7028.38.4.392

Rotter JB. Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs: General and Applied. 1966; 80:1–28. DOI: 10.1037/h0092976

Schmitt MT, Branscombe NR. The meaning and consequences of perceived discrimination in disadvantaged and privileged social groups. European Review of Social Psychology. 2002; 12:167–199. DOI: 10.1080/14792772143000058

Sell RL, Becker JB. Sexual orientation data collection and progress toward Healthy People 2010. American Journal of Public Health. 2001; 91:876–882. DOI: 10.2105/ajph.91.6.876 [PubMed: 11392926]

Thoits PA. Stress and health major findings and policy implications. Journal of Health and Social Behavior. 2010; 51(1 suppl):S41–S53. DOI: 10.1177/0022146510383499 [PubMed: 20943582]

Todd NR, Abrams EM. White dialectics: A new framework for theory, research, and practice with White students. The Counseling Psychologist. 2010; 39:353–395. DOI: 10.1177/0011000010377665

Toothaker, LE. Multiple comparison procedures. New York: SAGE Publications; 1993.

Turner, RJ., Roszell, P. Psychosocial resources and the stress process. In: Avison, WR., Gotlib, IH., editors. Stress and mental health. New York: Plenum; 1994. p. 179-210.

Unger RK. The 1999 SPSSI Presidential Address: Outsiders inside: Positive marginality and social change. Journal of Social Issues. 2000; 56:163–179. DOI: 10.1111/0022-4537.00158

Warner LR, Shields SA. The intersections of sexuality, gender, and race: Identity research at the crossroads. Sex Roles. 2013; 68:803–810. DOI: 10.1007/s11199-013-0281-4

Wheaton B. Models for the stress-buffering functions of coping resources. Journal of Health and Social Behavior. 1985; 26:352–364. DOI: 10.2307/2136658 [PubMed: 4086758]

Williams SL, Fredrick EG. One size may not fit all: The need for a more inclusive and intersectional psychological science on stigma. Sex Roles. 2015; 73:384–390. DOI: 10.1007/s11199-015-0491-z

Wong C, Cho GE. Two-headed coins or Kandinskys: White racial identification. Political Psychology. 2005; 26:699–720. DOI: 10.1111/j.1467-9221.2005.00440.x

Public Significance Statement

This study integrates minority stress theory and intersectionality theory to examine how connection to LGBT community may mediate the relationship between stigma and stress among racially diverse sexual minority men. Results suggest that minority stress and community resilience processes may differ for White and POC sexual minority men.

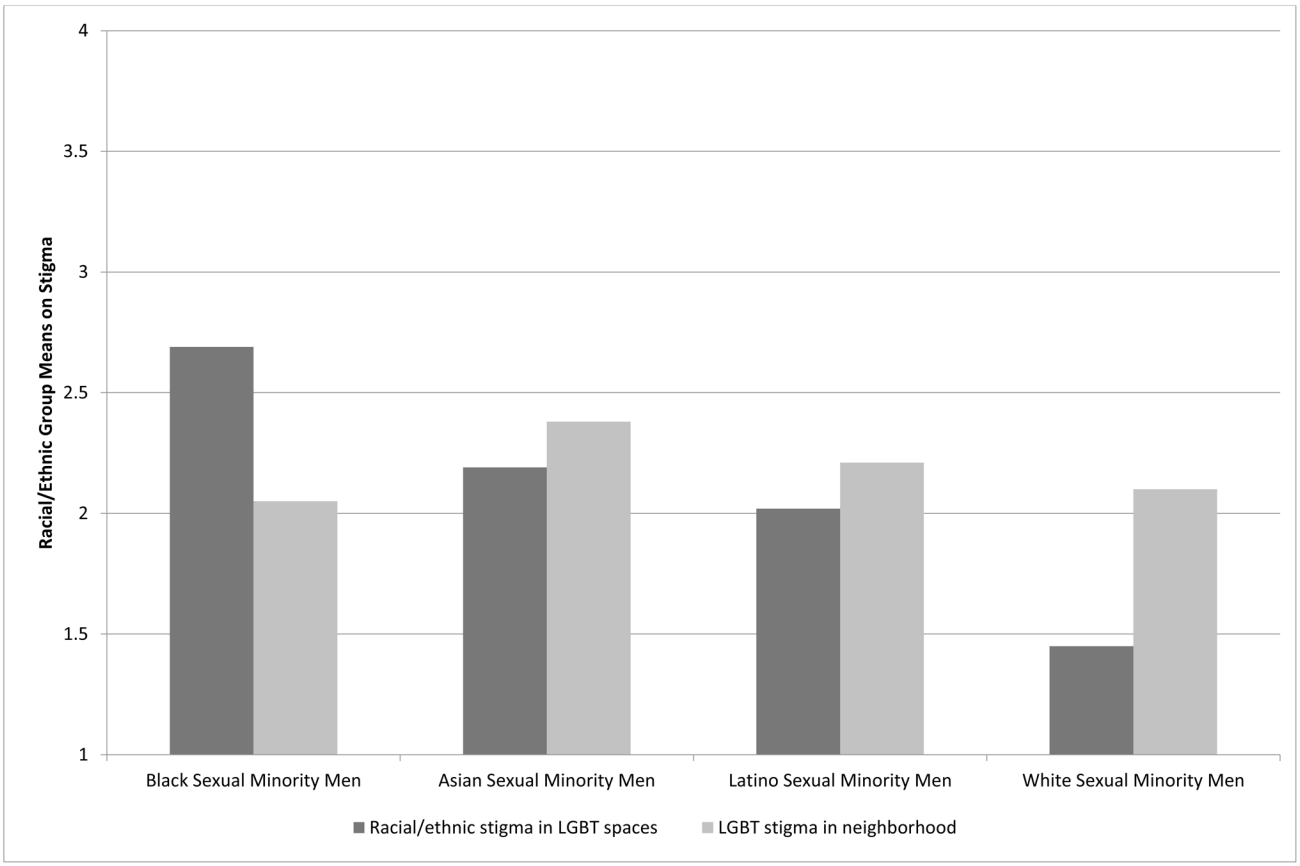

Figure 1.
Mean level of racial/ethnic stigma in LGBT spaces and LGBT stigma in neighborhood by racial/ethnic group.

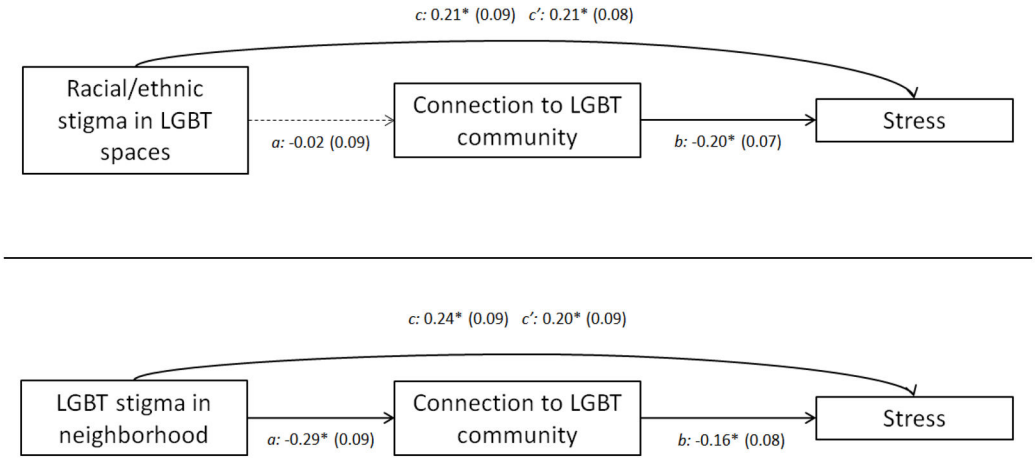

Figure 2.

Models examining connection to LGBT community mediating the relationship between racial/ethnic stigma and stress and LGBT stigma and stress for POC participants. The *c* path indicates the direct effect of the independent variable (IV) on the dependent variable (DV). The *a* path indicates the direct effect of the IV on the mediator. The *b* path indicates the direct effect of the mediator on the DV. The c' path indicates the effect of the IV on the DV after accounting for the mediator. *$p < .05$.

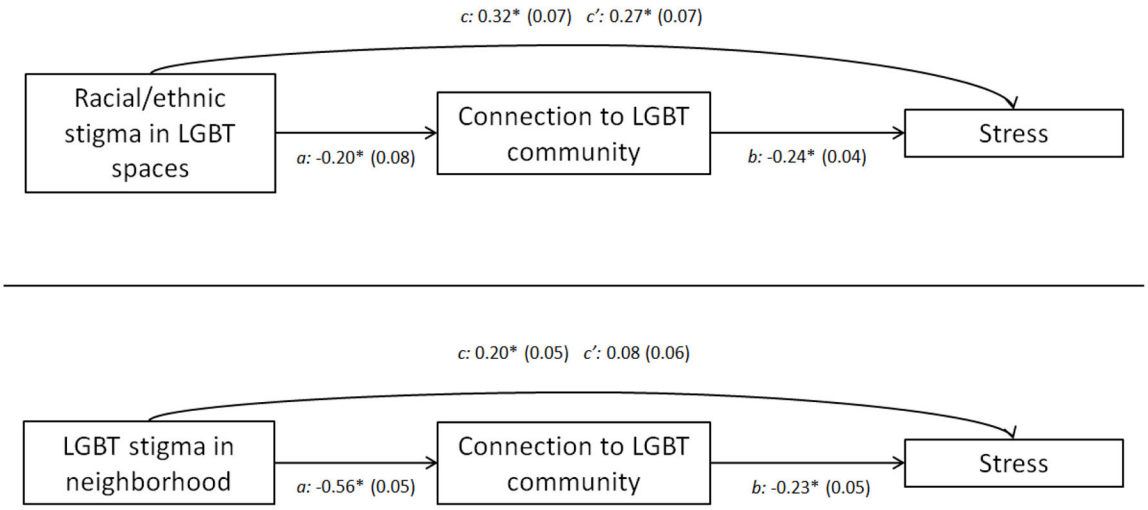

Figure 3.

Models examining connection to LGBT community mediating the relationship between racial/ethnic stigma and stress and LGBT stigma and stress for White participants. The *c* path indicates the direct effect of the independent variable (IV) on the dependent variable (DV). The *a* path indicates the direct effect of the IV on the mediator. The *b* path indicates the direct effect of the mediator on the DV. The c' path indicates the effect of the IV on the DV after accounting for the mediator. *$p < .05$.

Table 1

Items Measuring Racial/Ethnic Discrimination in LGBT Spaces, LGBT Stigma in Neighborhood, and Connection to LGBT Community

Racial/Ethnic Stigma in LGBT Spaces	
When in LGBT spaces, how often:	
1	have you been ignored or treated with less respect than others because of your race/ethnicity?
2	have others looked at you suspiciously because of your race/ethnicity?
3	have you been treated poorly because of the way you speak English or because of the way you talk?
4	have you been mistaken for a salesperson, waiter, or other service help because of your race/ethnicity?
5	have you felt that you are not accepted because of your race/ethnicity?
6	have you felt unwelcome because of your race/ethnicity?
LGBT Stigma in Neighborhood	
Please tell us about your neighborhood.	
1	I feel comfortable with my neighbors knowing my sexual orientation.
2	In my neighborhood, I would feel comfortable going to an LGBT-identified space.
3	In my neighborhood, I feel comfortable holding my partner’s hand in public.
Connection to LGBT Community	
We’re interested in understanding your relationship with the LGBT community.	
1	I feel comfortable going to gay bars and dance clubs.
2	I feel welcome in most LGBT spaces.
3	I feel I’m a part of the LGBT community.
4	Participating in the LGBT community is a positive thing for me.
5	I feel a bond with the LGBT community.
6	I am proud of the LGBT community.

Table 2

Intercorrelations of Study Variables for POC and White Participants

Measure	1	2	3	4
1. LGBT stigma in neighborhood	–	−0.01	−0.25*	0.21*
2. Racial/ethnic stigma in LGBT spaces	0.04	–	−0.02	0.19*
3. Connection to LGBT community	−0.47*	−0.12*	–	−0.20*
4. Stress	0.20*	0.22*	−0.29*	–

Note.

*$p < .05$.

Intercorrelations for POC participants are presented above the diagonal, and intercorrelations for White participants are presented below the diagonal.

Psychol Sex Orientat Gend Divers. Author manuscript; available in PMC 2019 March 01.