The Intersection of Mental Illness and Queerness: A Quantitative Study

Jennie E. Benjamin
Georgia State University

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The Intersection of Mental Illness and Queerness: A Quantitative Study

by

Jennie Benjamin

Under the Direction of Erin Ruel, PhD

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2024
ABSTRACT

My dissertation addresses the intersection of queerness and mental illness utilizing Meyer’s minority stress theory, which argues that for sexual minorities, discrimination, stress, and internalized homophobia lead to worse mental health. Specifically, in my dissertation, I extend the minority stress theory by examining a population with two stigmatized identities, sexual minority status and diagnosed mental illness, and by testing if “coming out” or disclosure of stigmatized statuses mediates the modified minority stress theory indicators on two measures of well-being. I developed a broad-topic survey to collect the data. A majority of my sample (N=98) are white women who are bisexual with a mean age of 31.6 years who suffer from depression and anxiety. Using univariate, bivariate, and regression analyses, I argue that for my sample of queer individuals with diagnosed mental illness that (1) they suffer more from internalized mad-phobia than internalized homophobia (2) fewer came out or disclosed their mental illness compared to coming out as queer and (3) stress has the most significant impact on quality of life and psychological distress. Given my small sample size (N=98) it is hard to say if the minority stress model can handle two stigmatized identities. Future research needs to investigate the usage of the minority stress theory to see how coming out and internalized stigmas play a role.

INDEX WORDS: Mental illness, Queerness, Coming out, Quality of life, Psychological distress, Discrimination, Stress, Internalized homophobia, Internalized mad-phobia
The Interaction of Mental Illness and Queerness: A Quantitative Study

by

Jennie Benjamin

Committee Chair: Erin Ruel

Committee: Katie Acosta

Eric Wright

Electronic Version Approved:

Office of Graduate Services
College of Arts and Sciences
Georgia State University
May 2024
DEDICATION

I would like to thank my husband, Danny Benjamin, for supporting me throughout my Ph.D. journey.
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LIST OF ABBREVIATIONS

QOLS: Quality of Life Scale
QOL: Quality of Life
K6: Kessler 6
“My body does not feel like home. My body is a place where I inscribe violence – cutting and starving. Trapped in my body is someone who is chaotic – who drops from highs to lows in a matter of days. My body holds desires – for women more than men. I hate myself for feeling that way. Who am I?” This excerpt, from my private journal, highlights how my sexuality and mental health are messy. I am bi-squared, which means that I am bisexual and have been diagnosed with bipolar disorder. Growing up, both of my identities were erased. I was raised in a heteronormative house, where my desires for women were suppressed. I liked boys, and my family taught me that that was the “right” way to express my feelings. I knew my family was homophobic because my mom watched televangelists preach that being gay was a sin and I heard the slurs my father muttered under his breath. In the same way, I knew my parents were prejudiced against people with mental illnesses. My mom taught me to pray away my anxiety and my dad regularly called mentally ill people “crazy” and “insane.” Growing up in this environment, my identities were not allowed to be, and I felt ashamed.

The shame I felt manifested into a shame monster. When I was diagnosed with bipolar disorder, my mom told me, “That’s not true.” To me, finally knowing why I felt so bad was freeing, but the comments from my mom made me feel internal stigma towards myself. I internalized her words and was ashamed of my illness. In the same vein, I was romantically committed to a man, but was attracted to women. I think it is normalized to be heterosexual and feel attracted to other men, but to be attracted to other women made me also feel ashamed. For the longest time, the only two people who knew I was bisexual were my partner and therapist. It was not until I was in my late twenties that I told my parents. I was afraid to come out as bisexual because of the rejection I might experience. Coming out to my parents was really hard.
because they did not get it. They did not understand how I was married to a man but felt attraction towards women. They were concerned I was going to turn into a lesbian and leave my husband. Little did they know that that is not how being bisexual works.

While I used my own standpoint to open this paper, being queer and mentally ill affect many who share these identities making it a social problem (Mental Health America n.d.-b). 4.5% of the U.S. population identifies as gay, lesbian, or bisexual and of those people 39% reported having a mental illness in the past year, which is around 5.8 million people (Mental Health America n.d.-a). Do these approximately six million people also experience internalized stigmas? Did coming out help them deal with their erased identities and improve their quality of life? Those who are queer and experience mental illness have to deal with stigma, discrimination, prejudice, harassment, invalidation, coming out, rejection, violence, and more (Mental Health Foundation n.d.; Williams Institute n.d.). Those who are straight, able-minded usually do not struggle with these types of stressors.

In this dissertation, I focus on the population at the intersection of mental illness and queerness, an understudied and hidden population. I use “queer” as an umbrella term for anyone who is non-heteronormative and/or non-cisgender. While I personally do not claim the term “queer” when describing myself, I do understand that I fall under that category, given that I am bisexual. I realize that some “queer” people may not identify as queer (like myself), but for the sake of this project, it is useful to categorize non-heteronormativity under the umbrella term, queer. I am interested in this intersection because the intersectionality of madness and queerness has rarely been studied. The little existing research is limited to qualitative and autobiographical work. My project will use a survey design to capture a larger sample and test the minority stress theory.
I define mental illness as having received an official medical diagnosis because receiving a diagnosis is more tied to stigma and internalized stigma than self-diagnosis. Disclosing a mental illness can be seen as a synonymous process to coming out as queer, because individuals are opening up about their identity as a means to combat erasure and internal stigma while potentially increasing the risk of exposure to external discrimination.

The minority stress theory was first introduced in the 1990’s. Initially it focused entirely on sexual minorities. This theory explains that those who are queer have double the amount of stress compared to those who are not minorities (Meyer 1995, 2003). The minority stress model has three components, discrimination, expectations of discrimination (stress), and internalized homophobia (Meyer 1995). It also has three distinct features, it is unique to minorities, chronic, and structural (Meyer 2003). More recently, research has expanded the minority stress theory to test on other types of minorities such as disability and transgenderism (Lund 2021; Meza Lazaro and Bacio 2021).

My dissertation is informed by the following research questions: First I ask, following the minority stress model, how does internalized stigma, stressors, and discrimination affect quality of life and psychological distress among those who are queer and diagnosed with a mental illness? This is adding to the literature by examining a group with two minority statuses and by introducing an internalized mental illness stigma to the model. Secondly, I ask does the coming-out process, both in terms of queerness and mental health, mediate the process between the minority stress model (internalized homophobia, stressors, and discrimination) and quality of life/psychological distress outcomes? As currently presented, the minority stress theory has ignored the potential protective effect of coming out on these health outcomes. My research is
filling the gap of the intersection between mental illness and queerness, as little research has been devoted to this intersection.

Next, I will review the literature on quality of life and psychological distress, as well as why I chose to use the minority stress model to better understand my sample’s marginality. I will discuss internalized stigma along with coming out as queer, mentally ill, and both. I present the data and methods, including design, population, sampling, constructs, and analysis in Chapter 2. Chapters 3 and 4 will present the results of the study. Chapter 3 will focus on understand who is in this doubly marginalized population as well as unpack the nature of internalized stigma and coming out as either queer or mentally ill. Chapter 4 will test my modified minority stress theory model on individuals who are queer and mentally ill using OLS multivariable regressions on the health outcomes. Chapter 5 will end with a discussion and conclusion section. I will discuss three main takeaways and wrap up with a conclusion.
2 LITERATURE REVIEW

2.1 Minority Stress Model

Queer individuals have a higher prevalence of mental disorders compared to heterosexuals and this has led to the theory of “minority stress” (Meyer 2003). Meyer claims that prior to 1995, researchers denied that the minority stress model was real, as there were other explanations of stress, such as socioeconomic status, between white and black, men and women, and straight and gay people (Meyer 1995: 39). Meyer posits that these researchers had selection bias, thus selecting participants that do not truly show off the minority stress theory. So, Meyer re-envisioned the minority stress model in 1995 when he used the plight of gay men to help us understand how minority groups experience greater stress than nonminority groups (Meyer 1995). For example, “out” gay men have a more positive self-view than “closeted” gay men and selecting “out” gay men to participate did not show case the stress that “closeted” gay men experience (1995:40). It is interesting, that despite knowing this, coming out was never formally included in the minority stress model, but maybe it should have been.

Besides selection bias, Meyer highlighted how other research showed that when gay men were stressed, it was around areas consistent with the minority stress theory, such as “self-acceptance, alienation, and paranoid symptoms” (1995: 40). In their work, Meyer claims that the minority stress model stems from three processes: “internalized homophobia, expectations of rejection and discrimination (perceived stigma), and actual prejudice events” (1995:40). Meyer states that these three processes create a matrix of stress for gay men (1995:42). Through regression models, the three processes (internalized homophobia, stigma, and prejudice), individually and as a group predict distress in gay men (1995:51).
The importance of the minority stress model is that it lays bare how society systematically disadvantages homosexuals. The minority stress model asserts that “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems” (2003: 674). Social interactions – discrimination, prejudice, racism, sexism, and homophobia – add on to general stressors. These minority stressors influence queer people to identify as a minority, thus they are stigmatized by society. The minority stress model is influential because it recognizes how social structures contribute to stress: “it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors or biological, genetic, or other nonsocial characteristics of the person or the group” (Meyers 2003: 676).

For example, queer people have a higher prevalence of suicide and according to Durkheim, it was because of anomie, or normlessness (Durkheim 1951). Because of this normlessness, lack of social control, and alienation, queer people are isolated from society, their needs are not met, and they are more likely to commit suicide (Durkheim 1951). Risk for suicide is one way the minority stress model operates, another way is that queer people are more likely to be in conflict with societal norms and the dominant culture, which can affect their overall mental health (Merton 1968; Moss 1973). For example, the expectation to have a heterosexual marriage is in conflict with queer people’s aspirations and this type of societal stress can cause queer people to have health problems, such as anxiety and depression (Meyer 2003). Psychological wellbeing can be compromised due to minority stress.

There are three processes of the minority stress model that impact queer people (Meyer 1995). From distal to proximal they are (1) external prejudice events and discrimination (2) expectations of discrimination and vigilance and (3) internalized homophobia (Meyer 1995,
First, discrimination can be in housing, education, employment, relationships, entitlements, basic human rights all the way to anti-queer violence (Meyer 1995). Discrimination and prejudice are the most explicit of minority stress because queer people become victims of violence (1995: 41). Second, because queer people experience such high rates of discrimination, they begin to expect violence and develop vigilance to cope with discrimination (Allport 1954; Meyer 1995). This vigilance is chronic, as it is enacted every day, and requires a lot of energy and resources to maintain (1995: 41). For example, queer people may try to “pass” as heterosexual in public to avoid discrimination, but this can cause fatigue and stress. Third, “internalized homophobia refers to the direction of societal negative attitudes toward the self” (1995: 40). Internalized homophobia stems from discrimination, as the queer person begins to take on societal stigma and judgement. When queer people internalize homophobia, they take on a deviant identity which harms their psychological wellbeing (1995: 40). All three processes, (1) discrimination (2) vigilance (3) internalized homophobia, can lead to harmed health of queer people.

In addition to the three processes of the minority stress model, it also has three distinct features. One feature is that the minority stress model is unique to minorities, meaning it does not apply to non-minorities. Everyone experiences everyday stressors, but minority stressors are additive to minorities. A second feature of the minority stress model is that this minority stress is chronic. Being chronic means that the minority stress has “stable underlying social and cultural structures,” thus it effects the everyday lives of minorities (Meyer 2003: 676). The third, and last, feature of the minority stress model is that it is structural, meaning it stems from social institutions and structures, such as the government, school systems, housing market, etc.
The minority stress model has been around since the 1990s and has been recently applied to several research projects, but not limited to these (Lund 2021; Meza Lazaro and Bacio 2021; Shepler, Glaros, and Boot 2021). Emily Lund (2021) used the minority stress model to understand the higher suicide rates among people with disabilities. Lund discussed how proximal factors, such as internalized stigma (stemming from internalized homophobia) and self-concealment, and distal factors, such as discrimination and harassment, of the minority stress model, play a role in suicidality among those with disabilities. For example, those with disabilities experience victimization (distal process) throughout their life-course, including, but not limited to, abuse, denial of equipment or personal assistance, bullying, and insults. Those with disabilities also experience self-concealment (proximal) of their disability to blend in with society and prevent their disability as being seen as problematic. This concealment can work in many ways, but those with autism are known to “mask” or “camouflage” certain behaviors to come across as normative. This victimization and self-concealment lead to increased rates of suicidality among those with disabilities. Lund used the minority stress model to highlights the proximal and distal processes.

Additionally, Shepler et al. (2021) used the minority stress model to test relationship satisfaction among gay and bisexual men. Through linear regressions, four factors of the minority stress model, identity concealment (hiding one’s sexual identity), uncertainty (questioning one’s sexuality), centrality (how central one’s sexuality is to their identity), and affirmation (affirmation of one’s sexuality), explained 40% of the variance of relationship satisfaction. This means that relationship satisfaction is inversely predicted by identity concealment, uncertainty, and centrality, and positively predicted by identity affirmation. So, gay and bisexual men are more satisfied with their relationships when they do not conceal their
identity, do not question their identity, when their sexuality is not central to their identity, and when they affirm their sexuality. Shepler et al. extended the minority stress model to better understand relationship satisfaction.

Lastly, Yazmin Meza Lazaro and Guadalupe A. Bacio (2021) used the minority stress model to understand the mental health of transgender Latinas. They used distal factors (employment status, general discrimination/violence, housing discrimination, and discrimination/violence in places of public accommodation) and resilience factors (being out to family and family support) to predict the mental health of transgender Latinas (2021:1). They found that those who were discriminated against had worse mental health, including distress, substance abuse, and suicidality. They also found that those who were out to their family had better mental health, again suggesting that coming out mediates the associations between minority stress and mental health. Meza Lazaro and Bacio used the minority stress model to better understand the under-studied population of the double minority group, transgender Latinas. What these authors did not do, is examine the three aspects of minority stress in terms of being Latina and being transgender.

2.2 Minority Stress Model Components

2.2.1 Stigmatized by Society

In this next section, I discuss in-depth the processes of the minority stress model in terms of the aspects of stigma and discrimination. Stigma is a major component of the minority stress model because of its connection to discrimination, vigilance, and internalized homophobia (Meyer 1995). Stigma is when an individual feels shameful for not living up to societal expectations and fears being discredited (Goffman 1963). Mentally ill and queer people are stigmatized by society through discrimination, being ostracized, devalued, and ignored (Herek
For example, in the past, stigma around queer people has revolved around the AIDS epidemic (Herek 1999). AIDS was the “excuse” used by homophobes to be prejudice against gay men, leading gay men to be discounted, discredited, and discriminated against (1999: 1106).

While mentally ill and queer people have a “stigma,” the real problem is when society “stigmatizes” them. For example, gay men were stigmatized by heterosexual people based on their HIV status (Herek 1999). So, what happens is once mentally ill and queer people become visible, they are stigmatized, and then discriminated against. Another example is when mentally ill individuals were connected to witchcraft and the devil (Hemphill 1966). Being mentally ill has led people to be imprisoned, tortured, institutionalized, and drugged against their will. Mental illness was stigmatized and thus led those with a mental illness to be treated like sub-human (discrimination).

Like mental illness, queerness has been pathologized because homosexuality was coded in the Diagnostic Statistical Manual (DSM) from 1952 to 1968 (American Psychiatric Association 1952, 1968, 2013; Drescher 2015). The DSM coding made homosexuality into a mental illness. Even though homosexuality is no longer coded in the DSM, people still stigmatize those who are homosexual. In addition to this pathologization, society stigmatizes queer people with homophobia, transphobia, and heterosexism. Overall, mentally ill and queer people, historically and presently, are stigmatized by society; Society places the stigma on mentally ill and queer individuals labelling them as deviant (Franzese 2015).

Because of this stigmatization and discrimination, many mentally ill and queer people are vigilant, wanting to stay away from places that are stigmatized. For example, because homosexuality and transgenderism have been stigmatized, many queer people want to stay away from the mentally ill community (Vider and Byers 2015). This separation has created a siloed
effect where the queer community and the mentally ill community hardly interact with each other (Pilling et al. 2017). The queer community does not want to be associated with mental illness, while the mentally ill community does not want to be associated with queerness. Both groups are already heavily stigmatized and by avoiding the other group, they are simply dodging more stigma.

The vigilance mentally ill and queer people experience can begin to develop into internalized homophobia. Mentally ill and queer people can stigmatize themselves by taking on the negative labels that others place on them. By taking on these negative labels, mentally ill and queer people may begin to dislike or even hate themselves and not want to be associated with others who are mentally ill and queer. This process can create a lot of stress and harm their mental and physical well-being. Overall, stigma is closely associated with the three processes of the minority stress model (discrimination, vigilance, and internalized homophobia).

2.2.2 Internalized Stigma

Different from being stigmatized by society, internalized stigma is an inward process. Internalized stigma is when an individual takes in assumptions and stereotypes about a part of their identity (sexuality, mental illness, etc.) and begin to believe and apply these assumptions to their life (Drapalski et al. 2013). For example, an individual may hear assumptions about people with mental illness are “crazy” and begin to believe that they themselves are crazy. These negative self-concepts can hinder an individual’s life, achievements, and goals.

In sum, the literature on the minority stress theory focus on how stress, minority-identity based discrimination and internalized minority-identity stigma make up the additive minority stress model that leads to poor health outcomes. It has been applied to single minority group statuses originally but more recently has been applied to populations with multiple stigmas.
However, the amount and types of stigma populations with multiple stigmas may face has not been tested. Therefore, in this study, I modify the minority stress model to include, along with measures of general stress and discrimination, two forms of internalized stigma. I explicitly examine both internalized homophobia and internalized “mad-phobia”. Additionally, I test whether or not “Coming out” as queer or as mentally ill mediates the impact of “minority stress” on mental health outcomes. Below I discuss coming out.

2.3 “Coming Out”

Another hardship for mentally ill-queer folx is potentially coming out/disclosure. While not every mentally ill-queer person comes out, there is pressure to come out and disclose one’s identity. Many scholars have critiqued coming out, as it is a dated way of understanding how queer folx navigate the world. The coming out process does not encompass the nuances of disclosure or acknowledge the complexity or messiness. However, for the sake of my dissertation, I do think coming out has value in better understanding the minority stress model. In my dissertation, I will be again modifying the minority stress theory by adding a coming out element to it.

2.3.1 Coming Out as Queer

The coming out narrative is problematic because the inside/outside rhetoric argues that those of us who are “out” are simultaneously “inside” (Fuss 1991). “…To be out is really to be in – inside the realm of the visible, the speakable, the culturally intelligent” (1991:4). In other words, value is placed on queer folx coming out by making them visible to the queer and straight communities. Additionally, the inside/outside rhetoric mirrors the binary oppositions of heter/homo and male/female, thus the binary of inside/outside is not useful to the queer community. Coming out is not useful because coming out creates “the closet” (Butler 1991).
“Being ‘out’ must produce the closet again and again in order to maintain itself as ‘out.’ …outness can only produce a new opacity; and the closet produces the promise of disclosure that can, by definition, never come” (1991:16). Once queers are out of the closet, what then? What spatiality do they occupy – a room, house, university, bar? (1991:16). Coming out is a production of values and to come out means that queerness is laden with stigma.

Furthermore, the linear process of coming out can be problematic because of the value placed on disclosure (Klein et al. 2015). First, individuals who are out are considered to be “healthy and well adjusted” (2015:297). Second, many scholars think that coming out will reduce homophobia – heterosexuals will hold more positive attitudes about queer people if they personally know a queer person. Coming out in this sense, is political activism and a personal duty; This justification for coming out places the burden on queer people instead of homophobes. Third, stage models are rigid and lack dynamics; These models ignore situational variables and power dynamics that contribute to the negotiation of identity. These models also assume a final subject, which ignores intersectional theory. Coming out is valued and critiqued, but the lived experience differs among the queer community.

Overall, coming out is a process that is heavily debated among scholars, but what matters is if coming out if useful to participants or not. Coming out does mean more visibility, which might lead to more discrimination or support. Coming out may reduce homophobia or increase it. These variables really depend on the participant, which is why my dissertation is investigating the effects of coming out on the quality of life and psychological distress.

2.3.2 Coming Out as Mentally Ill

In addition to the pressure of coming out as queer, many individuals also deal with coming out as mentally ill. Revealing one’s mental health status is not called coming out, but
instead called “disclosure.” Most literature about mental health disclosure use the Disclosure Decision-Making Model (DD-MM) (Greene 2009). According to this model, if someone is considering disclosing their medical status they consider five components: “stigma, preparation, prognosis, symptoms, and relevance” (2009:229). If a mentally ill individual thinks they will be stigmatized, their intentions to disclose decrease (233-35). However, if a mentally ill individual feels more prepared, has visible symptoms, and perceives their diagnosis as relevant, their intention to disclose increases. Next, the mentally ill individual will assess the receiver by considering the relational quality and the anticipated reaction. On the one hand, better relational quality and positive anticipated response increases the mentally ill individual’s intent to disclose. On the other hand, negative anticipated response, gossip, or unsolicited third-party disclosure decreases their intent to disclose. After assessing the receiver, the mentally ill individual will evaluate their disclosure efficacy - - confidence, risk assessment, and impression management. If the mentally ill individual feel confidence about disclosing an assesses little risk, they will more than likely go through with disclosing. The DD-MM model provides a framework to better understand mental health disclosure on a personal, interactional level. However, this model does not apply to public disclosure.

2.3.3 Coming Out as Queer and Mentally Ill

On top of that, having to come out twice, as queer and mentally ill, is a process that has not been academically mapped before. However, I found a blogger who mapped out his experience of coming out twice. The first step to coming out twice is he had to figure himself out (Soak 2018). He said it took him four years to realize he was gay and two years to realize he struggled with depression. The internal fight and struggle were the longest part because he had to come to terms with who he was. After he figured himself out, the blogger said the next stage is
acceptance (Soak 2018). The blogger said that mentally ill and queer people not only have to accept their sexuality, but their mental disorder. For this blogger, accepting his sexuality was easier because he surrounded himself with other queer people, who were supportive. Accepting his depression was harder because he did not have peers to help him. He eventually accepted his depression, because if he did not, he would have failed college.

After acceptance, the blogger said it is “time to go to war with your environment” (Soak 2018). The blogger discusses how society is set up for straight and mentally-well people, and that society is still prejudice against those who are queer and experience mental illness. Having to deal with stigma and prejudice is a huge component of minority stress that we have already discussed. The blogger was terrified of telling his parents that he was gay because he feared abandonment and exile. While his family accepted him, the fear was a stressful experience. The blogger said that he did not have to come out twice to his mother, because his mother already knew her son was depressed. The blogger’s mother knew he was depressed because his father had just died. What was the hardest part of disclosing his depression to others was when other people invalidated his depression or ignored it.

The last stage, according to this blogger, is selectively coming out (Soak 2018). Selectively coming out means deciding whether to come out to new people you meet throughout your life-course. This blogger constantly has to decide to bring up the lessons or struggles of his depression or the fact that he is attracted to men. This decision comes up with every person he will meet and that is a life-long stressor. The pressure of coming out or staying silent can take a real toll on his mental and physical well-being.

After these stages, the blogger left a little nugget of wisdom; he said that his mental health and his sexuality impact each other (Soak 2018). Coming out as gay contributed to him
being more depressed (stress of people finding out he was gay, fear of people judging him, anxiety of people attacking him, etc.). Just like his depression kept him from enjoying his sexuality (finding a group of queer peers, dating men sooner, discovering bisexual tendencies, etc.). This blogger has showed us that coming out twice is at least double the amount of stress, if not an exponential amount, compared to coming out once. Coming out twice is even more stressful when compared to straight, mentally well people, who do not have to worry about these processes at all.

There are not many studies that address coming out as both queer and mentally ill, but I did find a study by Miller et al. (Miller, Wynn, and Webb 2019) where they interviewed 31 queer students with disabilities. “Students described processes of (a) disclosing identities for self/others, (b) disclosing identities indirectly, and (c) passing for privileged identities” (2019: 311). Each student said their disability was “invisible,” most indicating they had a mental illness (310). Some students discussed how they would come out if it benefited themselves or others. For example, one student came out in college so he could avoid having a “shitty time at college” (311). Other students discussed coming out indirectly through signifiers, such as appearance or wedding rings. Lastly, students discussed passing as a privileged identity, such as non-disabled, heterosexual, and cisgender. Students claimed that passing had pros and cons; pros being able to save energy and resources, cons not being able to be oneself. Overall, coming out twice is an overwhelming experience that requires time and energy.

2.4 Social Relationships

Social relationships can mitigate the negative effects of minority stress (Meyer 2003:677). Social relationships can offer support to those who are a minority and help them deal with stigma and discrimination through acceptance. I will investigate three areas of social
relationships – family, friends, and work life– to understand their mitigating or toxic effects on the quality of life and psychological distress of mentally ill and queer individuals.

2.4.1 Family

Many queer or mentally ill individuals do not have their family’s support. Because queerness and mental illness are heavily stigmatized and misunderstood, many queer or mentally ill individuals have been disowned, rejected, abused, neglected, bullied, and unsupported by their families. Due to family rejection, many queer youth run away from home to find a more accepting living situation (Gambon and Gewirtz O’Brien 2020). Many mentally ill individuals are also estranged from their families; Those who are involved with their family usually must be in active treatment (to prove they are “getting better”). Family support has been shown to reduce negative mental health outcomes, but this reality can be difficult to achieve. Lack of family support can lead queer or mentally ill individuals to look to other sources of support, such as romance, friends, and community.

2.4.2 Friends

Unlike families, friendships or families of choice can be sources of support and sources of pain. Mentally ill individuals have expressed the importance of friendships to their stability and recovery. “Friendship impacts (mental) illness as (mental) illness impacts friendship” (Boydell, Gladstone, and Crawford 2002:126). This means that supportive friendships can provide emotional support, acceptance, and reciprocal interactions while symptoms can cause limitations. If the friendship is not of quality, symptom flare-ups can cause rejection, stigma, and failed friendships. Additionally, having friends with mental illnesses can be a double-edged sword – mentally ill individuals can feel comradery, but also might be weighed down by others’ pessimistic attitudes. Similarly, having able-minded friends can provide a positive, “normal”
environment, but disclosing can risk the friendship stability. Overall, mentally ill individuals usually have a small social network system due to these structural barriers.

Likewise, queer people also expressed that families of choice were essential to their well-being. Many queer individuals have experienced the conditional support, absence of care, or rejection from their origin family, thus they tend to create a new family compromised of friends (Revanche 2018). Additionally, while cisgender, heterosexual adults usually invest all their time into a romantic relationship, queer adults tend to invest more time in families of choice, as they can be longer-lasting and more reliable. Queer kinship is a social process (rather than biological) that can be extended to push up “against the conventions of family, couplehood, and sexual exclusivity” in a meaningful way (Dumortier 2016:iv; Freeman 2007). Families of choice can provide a sense of belonging, safety, and community in ways that origin families have failed.

2.4.3 Work Life

In addition to family and friendships, many mentally ill or queer individuals face workplace discrimination. Whether they are openly mentally ill or queer or outed in the workplace, one hostile co-worker can lead to discrimination. Currently, queer individuals are not protected by federal law to prevent workplace discrimination (DeFillippis 2016; McDermott 2014). Thus, many queer individuals are more likely to be unemployed, in-between jobs, not financially stable, or homeless (DeFillippis 2016). Mentally ill individuals have some federal protection - if they file with the American Disabilities Act (ADA) – but workplace discrimination can be hard to prove (Selmi 2000). Therefore, mentally ill or queer individuals have little protection against workplace discrimination (Nelson and Probst 2004).

For example, if transmen in the workplace can “pass” as men, they experience less workplace discrimination and thus less minority stress (Schilt 2010). If transmen were seen as
male, they gained workplace authority (coworkers listening to them), perceived competency (stereotypically seen as aggressive, technologically smart, having sound judgment), rewards and recognition for hard work (rewarded for doing less work, fight less to get what they want, less sexual harassment), and more economic opportunities (rising through the ranks quickly, being promoted more) (2010:70-81). If transmen were not perceived as truly male, they experienced more workplace discrimination such as coworkers challenging their gender identity, loss of pay, loss of clients, employers/coworkers not using preferred pronouns/name, etc. (2010:89).

Ultimately, transmen who are welcomed as “one of the guys” benefit on an individual level but maintain the gender status-quo, thus do not have to deal with as much stress.

Furthermore, mentally ill people may disclose their mental illness in the workplace. Many mentally ill individuals disclose their mental illness to their employers instead of their coworkers, as they fear social rejection (Jones 2011). They may disclose to their employer because they want to build a supportive work environment. Men, those without disability benefits, the elderly, white workers, and those with more visible symptoms are most likely to disclose their mental illness in the workplace (Jones 2011). These groups of people are probably not discriminated against as much, and thus feel more comfortable coming out, thus experience less stress and more aid. Most mentally ill people disclose their mental illness early in job development while they are still receiving ongoing support, verses latter on in their career. They might disclose later if they are diagnosed after the job acquisition or are hospitalized.

Mentally ill folx usually disclose their mental illness because they need support at work, they need to negotiate their accommodations, or they need help addressing how their symptoms operate within the job framework (Jones 2011). After disclosing, mentally ill folx may be rewarded or may have put themselves more at risk. Disclosure can lead to more positive,
supportive relationships between the mentally ill worker and their employer, or it could lead to a worse relationship. Similarly, disclosure could lead to positive, supportive co-worker relationships, or negative, problematic relationships. When it comes to job tenure, disclosing can provide accommodations which lead to holding the job longer, but disclosure can also lead to being fired or quitting (Jones 2011). Overall, coming out in the workplace, as either mentally ill or queer or both, can have positive or negative consequences and thus can be a difficult decision to make. This decision then becomes a stressor, thus making it a more difficult position to be in.

Instead of using the DD-MM model, I ask participants about coming out in terms of family, friends, and work. I used the same measures, for both queer and mental illness, to assess how similar these processes are. I used coming out in terms of family, friends, and work, because coming out is nuanced and different for different social aspects of life. Coming out is not just one event, like most think. In addition to asking participants about coming out as queer and mentally ill, I also ask them about internalize mad-phobia, which is asking about internalized stigma around their mental illness.

2.5 Outcomes

2.5.1 Quality of Life

Quality of life (QoL) is a theoretical way of measuring one’s personal well-being and satisfaction with life (Miriane Lucindo Zucoloto and Edson Zangiacomi Martinez 2019). The Quality of Life Scale (QoLS) was developed in the 1970’s by Flanagan (1978). The importance of QoL began in the 1960’s during President Eisenhower’s era, as the U.S. was trying to understand how social and environmental factors impacted individuals. In the 1970’s, a research study was conducted to better understand QoL and surveyed 6,500 Americans that represented a large range of socioeconomic statuses. The study found 15 factors that influenced QoL,
including areas such as physical and material well-being, relations with other people, social activities, personal development, and recreation (Flanagan 1978). This study, and created scale, are important because this was one of the first ways of measuring QoL in an empirical manner.

Zucoloto and Martinez (2019) tested the QoLS against a large, heterogenous population to see if it matched Flanagan’s original theory. 1,054 primary care users in Brazil were surveyed. After psychometric testing, most of the item correlations were moderate to low. After factor analysis, they discovered that Flanagan’s original model, of five components, fit well, but different items loaded onto each construct. Overall, Zucoloto and Martinez found that Flanagan’s QoLS somewhat fit with their heterogenous population, but results were not straight forward, but rather complicated. They discuss how the QoLS fit their population, but may not be suited for all populations, given different contexts. They think that the QoLS should be tested against other populations, cultures, and contexts to better understand how the scale works.

Let’s look at few different studies to see how well the QoLS performed. Burckhardt et al. (Burckhardt and Anderson 2003) did an overview of how the QoLS performs with chronically ill patients. They found that the QoLS stood up to be a useful measure for patients. Additionally, Neto and Corrente (2018) tested the QOLS on 741 elderly people in Manaus. After factor analysis, they found the same five components as Flanagan. Ras et al. (2005) used the QOLS on 124 post-surgical cardiac patients. They only ran descriptive statistics and did not run a factor analysis. They were looking for the items with highest ratings to predict quality of life. They found for post-surgical cardiac patients that quality of life was most predicted by having and raising children and relationships with friends. Quality of life was least predicted by participating in recreation activities.
Catrone and Koch (2021) used a modified version of the QoLS, since the QoLS can be subjective and relative, called the General Capabilities Scale (GCS). This includes the following questions: “(1) independently get what they want (food, clothes, etc.)? (2) form close relationships (friendships, partners, etc.)? (3) help others (volunteer, give advice, etc.)? (4) understand their strengths and weaknesses? And (5) participate in social activities (sports, concerts, etc.)?” (2021, p. 44). They found the GCS to be useful and less fatiguing on their participants.

Given the lack of research of the QoLS on sexual minorities and those with a mental illness, I used the full QoLS items and later determined which set of items works best for the sample I obtained.

2.5.2 Kessler 6

The Kessler Screening Scale for Psychological Distress (Kessler 6 or K6) is a widely known questionnaire screener in the social science realm. Developed by Kessler et al. (2002), the scale was modified after the previous 10-item screener, the K10 (NovoPsych 2021), to be used to better understand non-specific psychological distress in the everyday population. Psychological distress is defined as emotional suffering including symptoms of depression, anxiety, and somatic experiences (Belay et al. 2021). Psychological distress can lead to impairment in function and behavioral issues (Belay et al. 2021). Psychological distress is usually a temporary occurrence in reaction to a stressor or stressors. Once the stress is resolved, the psychological distress usually goes away. The K6 is the most common research tool for capturing psychological distress, which is why I choose to use it.

Since my sample is a marginalized group, of queer and mentally ill individuals, I will use the minority stress model to assess their marginality. I will use the QoL scale and the Kessler 6
scale to address outcomes. QoL and K6 are good outcomes to test because they are in opposition to one another. QoL is measuring well-being and satisfaction, while K6 is measuring emotional suffering. These two outcomes are important in conjunction with the minority stress model, because minority stress is a stressor that influences both quality of life and psychological distress.

2.6 Overview and Hypotheses

Earlier work has discussed coming out in relation to the minority stress model, but I will actually be incorporating it into the model. I will also be modifying the model by including internalized mad-phobia (in addition to internalized homophobia) since my sample is both queer and mentally ill. Then I will look at the outcomes of quality of life and psychological distress as ways of better understanding how minority stress impacts my sample.

During this literature review, I switch back between talking about queer people and mentally ill people, but I expect to find the experiences of being queer or mentally ill will apply to those who are both mentally ill and queer. Overall, coming out in family, friendships, and work life can be complicated processes. Mentally ill and queer individuals may come out to some people and not to others, depending on how safe the situation feels. Below are my hypotheses for this dissertation:

1. As stressors increase, quality of life will decrease.
2. As stressors increase, psychological distress will increase.
3. As internalized homophobia increases, quality of life decreases.
4. As internalized homophobia increases, psychological distress will increase.
5. As internalized mad-phobia increases, quality of life decreases.
6. As internalized mad-phobia increases, psychological distress will increase.
7. As discrimination increases, quality of life decreases.
8. As discrimination increases, psychological distress will increase.
9. As a person comes out in terms of their sexuality and mental illness, their quality of life will improve.
10. As a person comes out in terms of their sexuality and mental illness, their psychological distress will decrease.
11. As a person comes out in terms of their sexuality and mental illness, their internalized homophobia will decrease.
12. As a person comes out in terms of their sexuality and mental illness, their internalized mad-phobia will decrease.
3 METHODS

3.1 Design

To answer my research questions of: (1) Following the minority stress model, how does internalized homophobia, stressors, and discrimination affect quality of life and psychological distress for those who are queer and also are diagnosed with a mental illness? (2) How does coming-out as queer and/or mentally ill impact the minority stress model, that is, how does it affect the associations between internalized homophobia, stressors, discrimination, and the health outcomes of quality of life and psychological distress?

I collected data using a survey design. This was a cross-sectional, self-administered survey with the option to have an interviewer-administered survey if the participant had issues with the self-administration. I chose survey methodology because: “surveys offer the most effective means of social description; they can provide extraordinary detailed and precise information” (Singleton and Strait 2010, p. 270). My survey addressed a large range of topics, including sexuality, mental health diagnoses, stress, discrimination, internalized stigmas, and “coming out” in terms of sexual orientation and mental health. The survey took about thirty minutes to complete. Since my population has rarely been studied, using a survey allowed me to collect a wealth of data to “yield unanticipated findings or lead to new hypotheses” (2010, p. 270).

3.1.1 Population and Sampling

3.1.1.1 Population

Eligibility was restricted to participants eighteen years or older, self-identified as queer (as I defined queer earlier as non-heteronormative and/or non-cisgender), and had been professionally diagnosed with at least one mental illness. Participants may have multiple queer
identities and multiple diagnoses. I recruited participants who have been professionally diagnosed with a mental illness (versus self-diagnosed) because I am interested in understanding labelling and stigma effects. This is considered a hidden population because being queer and experiencing mental illness are not visible characteristics. This is also a very small, marginalized pollution as they are subsets of all persons with mental illnesses as well as a subset of all individuals who identify as queer.

3.1.1.2 Sample

Because this is a hidden population, I used convenience sampling procedures to collect the sample including a modified respondent-driven sampling (RDS) technique, which works well with hard-to-reach populations (Heckathorn 2011). RDS is similar to snowball sampling, but instead of asking each node to recruit other participants, I would ask my participants to pass along my flyer to anyone they thought might be eligible. This is also modified because though I used nodes, I did not limit recruitment to a few nodes only, therefore, there is no way to track how many participants came from each node.

My whole sample was voluntary. A criticism of RDS is the self-selecting of volunteer participants. I minimized this by recruiting participants through a variety of different methods including email, flyers, social media, and in-person events. My original survey had 283 clicks and 139 eligible participants. Of the 139 eligible participants, 41 completed less than 50% of the survey. After removing item nonresponse (N=41) the analysis data set had a final sample size of 98 participants or 71% of the eligible participants.

To recruit participants, I sent out my flyer (see flyer in appendix) via email and social media. My flyer has information about the survey on it, including a link and a QR code. I recruited participants from a variety of places and gatekeepers (listed as follows). I utilized local
and national sociology, psychology, and women’s studies Listserv’s (ASA, SSSP, Georgia State University, Emory, University of Georgia, Mercer, Berry College, Georgia Southern, University of North Carolina, California State University, Berkeley, Princeton, University of Michigan, Stanford, Northwestern, University of Chicago, University of Wisconsin, Columbia, University of Texas, Duke, etc.), social media (Facebook, Instagram, Facebook Groups, LinkedIn, Twitter, etc.), flyers in public places (university campuses, coffee shops, etc.), gatekeepers (NAMI of Georgia, The Trevor Project, NIMH, SAMHSA, GLSEN, PFLAG, etc.), and handed out flyers at events (GSU’s Pride in the Plaza and Atlanta’s Pride Festival).

My first round of emails was sent on June 6, 2022. I received several “no’s” from gatekeeper organizations because (1) they were offended by my use of the word “mad” and (2) they did not support outside research. In regards to the word “mad,” I originally used it as a reclamation of the slur it once was, much like “Black” and “crip.” However, many gatekeepers were offended by this term because it has not been accepted as a reclamation in the United States, like in other countries. Since the use of “mad” reduced participation from gatekeepers from passing along my survey, it is safe to assume that potential participants may also have been offended by the word, thus preventing them from taking the survey at all. Moving forward, I will not be using the term “mad” in my dissertation, only when referring to Internalized Mad-Phobia.

I received several “yes’s” from local and national Listserv’s. But mostly I did not hear back from those who I emailed. Then, later on in the month, I hung flyers in Georgia State University’s library and in a local coffee shop, Blume Organics. Then on June 29, 2022, I went to Georgia State’s University’s “Pride in the Plaza” event, where I sat at a table and handed out flyers from 11:30am to 1:30pm. I handed out about 50 flyers. My second round of emails went out on September 16, 2022. I selected this date as it was after the fall semester had started for
most schools. I hardly heard back from most people. Then on October 8, 2022, I went to Atlanta’s Pride Festival. I volunteered with the American Foundation for Suicide Prevention booth and as I was volunteering, I handed out flyers. I was there from 3pm-5pm and handed out around 40 flyers.

At this point in time, I had not received enough participants, so I copied my original survey, and created a new survey that did not have eligibility requirements (being mentally ill and queer), except for being 18 years of age. The purpose of removing the eligibility requirements, was to get more people into the bulk of the survey, while also attracting comparison groups, such as people who are just mentally ill or just queer (instead of both). I created a new flyer (see in appendix) with a new link and QR code on it. Then on October 31, 2022, I sent out the new flyer to local university Listserv’s, without much traction. Then in December 2022, I asked one of my committee members to share my flyer on ASA Connect’s mental health section, which they did. I received some traction from this move.

Part of RDS is once I have gotten a participant to fill out the survey, I then ask them to share it with another person. So, when I was handing out flyers in person, I would say, “Do you know anyone who would be willing to take my survey?” as I showed them my flyer. For those who took the online survey, the end page stated, “Thank you for taking my survey! I appreciate your time! This is really going to help me and others. Please share the link with a friend if you think they would be interested!” When I shared my flyer on social media, I would ask others to reshare.

In my dissertation proposal, I proposed that I would get three hundred participants, but I only ended up with 98. It is hard to know why I did not get three hundred participants. It could have been the use of the word “mad” was offense to large gatekeepers as well as participants. It
could have been that the survey was too lengthy, and participants started the survey and did not finish it. It could have been because the survey was too confusing to be filled out on a mobile phone or computer verses paper. It could have been that the survey asked too personal or controversial topics. It could have been that I needed to recruit my participants in a different way than what I did.

3.1.2 Eligibility

To ascertain eligibility, the survey asked several YES/NO questions. To be eligible a respondent needed to answer NO to being exclusively heterosexual, YES to having a diagnosed mental illness, and YES to being 18 years or older. If a participant does not meet eligibility, they were sent to a page thanking them for their time, but explaining they are not eligible to take the survey.

In the survey, I obtained anonymous consent by having participants check a box that they know participating is voluntary and they can stop at any time. The survey was obtained anonymously and only I.P. addresses were gathered (to make sure participants only take the survey once). To address questions about the survey, I set up a Google phone number and used my current email address so participants could reach me. Only a handful of participants emailed me, mostly about eligibility requirements.

3.1.3 Human Subjects

First, IRB approved my protocol. The IRB number is H22579 and the reference number is 369943. Next, I obtained informed consent after eligibility was determined. In the survey, I had a page explaining how the survey is anonymous, voluntary, and can be stopped at any time. Before the participant started the survey they had to check a box on the consent page to move forward. Confidentiality was maintained by only obtaining IP addresses, maintaining anonymity.
There are minimal risks in taking my survey. There will be some questions that discuss taboo topics or may elicit an emotional reaction. To prepare for an emotional reaction, I listed the Georgia Crisis phone number in the consent section, so participants have a resource to talk about their emotions if need be. There is technically no benefit to the participant for participating in the survey. I did my best to minimize harm. The participants did not receive any incentive or compensation.

3.2 Constructs

3.2.1 Dependent Variables

The two dependent variables for this study are quality of life and the Kessler 6, a measure of psychological distress. Quality of life was measured using the Quality of Life Scale (QOLS) (Flanagan 1982) which has 16 questions about varying aspects of life. Table 1 presents all 16 items along with the factor loadings on the five factors derived through principal components factor analysis. These questions are answered with “Delighted” (7), “Pleased” (6), “Mostly Satisfied” (5), “Mixed” (4), “Mostly Dissatisfied” (3), “Unhappy” (2), “Terrible” (1). Flanagan used a range of 16 (terrible quality of life) to 112 (great quality of life), using all 16 items in one scale. However, Flanagan did not do a factor analysis.

Since Flanagan did not use factor analysis to validate his theoretical construct, I am following the guide of (Miriane Lucindo Zucoloto and Edson Zangiacomi Martinez 2019). Zucoloto and Martinez validated Flanagan’s quality of life scale and found five latent aspects: (1) physical/material well-being; (2) relations; (3) social/community activities; (4) personal development fulfillment; and (5) recreation. In running exploratory factor analysis on my sample, I too derived five factors but they did not directly match Zucoloto and Martinez’s factors.
Given that I wanted to use a single measure of quality of life, I followed Catrone and Koch’s (2021) general capabilities scale as this seemed to best capture the quality of life aspect most pertinent to my study. Catrone and Koch took the most highly correlated items from Zucoloto and Martinez’s validation (2019) to create their version of the quality of life scale to reduce task burden on respondents. My version of the general capabilities scale left out items involving close relationships included in Catrone and Koch because they did not correlate well with the other set of items. My version of the general capabilities scale includes: independently getting what they want, (#16); helping others (#7); participating in social activities (#8, 13,14,15); and understanding own strengths and weaknesses (#10). See the Table 1 provides the confirmatory factor analysis.

For the quality of life scale (general capabilities), the cronbach’s alpha of 0.801 indicates the scale is reliable. Next I ran a factor analysis. The KMO had a value of 0.779 which is considered excellent and the test of sphericity is significant which tells us that these variables do hang together and that factor analysis is appropriate. It has one eigenvector greater than one that explains 46.020% of the variance.

The general capabilities quality of life scale is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater or more positive quality of life.

<table>
<thead>
<tr>
<th>Table 1: Quality of Life Scale Confirmatory Factor Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer the following with Delighted (0), Pleased (1), Mostly Satisfied (2), Mixed (3), Mostly Dissatisfied (4), Unhappy (5), Terrible (6)</td>
</tr>
<tr>
<td>Helping and encouraging others, volunteering, giving advice</td>
</tr>
<tr>
<td>Participating in organizations and public affairs</td>
</tr>
<tr>
<td>Understanding yourself-knowing your assets and limitations- knowing what life is about</td>
</tr>
<tr>
<td>Socializing- meeting other people, doing things, parties, etc.</td>
</tr>
<tr>
<td>Reading, listening to music, or observing entertainment</td>
</tr>
<tr>
<td>Participating in active recreation</td>
</tr>
<tr>
<td>Independent, doing for yourself</td>
</tr>
</tbody>
</table>
My second dependent variable was the Kessler 6 Scale (K6). K6 is composed of six likert scale items that asked in the past thirty days did the participant feel “nervous, hopeless, restless or fidgety, depressed, that everything was an effort, and worthless.” The responses were None of the time (1), A little of the time (2), Some of the time (3), Most of the time (4), All of the time (5). The K6 is a known scale with known reliability and validity (Ferro 2019). My factor analysis confirmed a single factor. Results are shown in Table 2. The Cronbach’s Alpha of 0.812 indicates the scale is reliable. Next I ran a factor analysis. The KMO had a value of 0.820 which is considered excellent and the test of sphericity is significant which tells us that these variables do hang together and that factor analysis is appropriate. It has one eigenvector above the value of 1.0 that explains 52.307% of the total variance. The psychological distress scale (K6) is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater distress or a worse health outcome.

**Table 2: Kessler 6 Confirmatory Factor Analysis**

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous</td>
<td>0.585</td>
</tr>
<tr>
<td>Hopeless</td>
<td>0.768</td>
</tr>
<tr>
<td>Restless or Fidgety</td>
<td>0.413</td>
</tr>
<tr>
<td>Depressed</td>
<td>0.726</td>
</tr>
<tr>
<td>That everything was an effort</td>
<td>0.644</td>
</tr>
<tr>
<td>Worthless</td>
<td>0.757</td>
</tr>
<tr>
<td>EigenValue</td>
<td>3.138</td>
</tr>
<tr>
<td>% of Variance Explained</td>
<td>52.307</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Eigenvalues</th>
<th>3.221</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Variance Explained</td>
<td>46.020</td>
</tr>
<tr>
<td>Cronbach’s Alpha</td>
<td>0.801</td>
</tr>
<tr>
<td>KMO</td>
<td>0.779</td>
</tr>
<tr>
<td>Bartlett’s Test of Sphericity</td>
<td>Chi-Square: 179.855</td>
</tr>
<tr>
<td></td>
<td>df: 21</td>
</tr>
<tr>
<td></td>
<td>Sig: &lt;0.001</td>
</tr>
</tbody>
</table>
3.2.2 Independent Variables

My independent variables (I.V.) stem from the minority stress theory. The first I.V. is internalized homophobia. I used the Internalized Homophobia Scale (Martin and Dean 1992), which is a measure of six yes/no Likert scale questions asking about internalized homophobia (see Table 3). For example, “I wish I weren’t queer.” Answering “yes” to any of the questions indicates internalized homophobia. The final scale ranged from zero (no internalized homophobia) to a nine (highest internalized homophobia). Martin and Dean did not use a cutoff score; they simply said the higher the score, the higher the internalized homophobia. Internalized Homophobia is a scale of 6 questions. Each question ranges from 1 (Strongly Disagree) to 5 (Strongly Agree). The internalized homophobia scale is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater homophobia or a worse health outcome.

The six items are reliable. The Cronbach’s Alpha is 0.808, indicating the scale is reliable. Next I ran confirmatory factor analysis and confirmed a single factor. The KMO had a value of 0.722 which is considered excellent and the test of sphericity is significant which tells us that these variables do hang together and that factor analysis is appropriate. It has one eigenvector greater than 1.0 that explains 62.951% of the total variance.

<table>
<thead>
<tr>
<th>Cronbach’s Alpha</th>
<th>0.812</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMO</td>
<td>0.820</td>
</tr>
<tr>
<td>Bartlett’s Test of Sphericity</td>
<td>Chi-Square: 186.349 df: 15 Sig: &lt;0.001</td>
</tr>
</tbody>
</table>

Table 3: Internalized Homophobia Confirmatory Factor Analysis

<table>
<thead>
<tr>
<th>I have tried to stop being queer.</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.500</td>
</tr>
</tbody>
</table>
If someone offered me the chance to be completely heterosexual, I would accept the chance.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>I wish I weren’t queer.</td>
<td>0.849</td>
</tr>
<tr>
<td>I feel that being queer is a personal shortcoming for me.</td>
<td>0.856</td>
</tr>
<tr>
<td>I would like to get professional help in order to change my sexual orientation from queer to straight.</td>
<td>0.695</td>
</tr>
<tr>
<td>I feel alienated from myself because of being queer.</td>
<td>0.671</td>
</tr>
</tbody>
</table>

| EigenValue | 3.777 |
| % of Variance Explained | 62.951 |

| Cronbach’s Alpha | 0.808 |
| KMO             | 0.722 |
| Bartlett’s Test of Sphericity | Chi-Square: 379.037, df: 15, Sig: <0.001 |

The second I.V., which stems from Internalized Homophobia, is Internalized Mad-Phobia. I used the same six questions from the *Internalized Homophobia Scale*, but tailored the questions to ask about mental illness (see Table 4). For example, “I have tried to stop being mentally ill.” This is a scale of 6 questions, each ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), with a range of 9 to 30. The internalized mad-phobia scale is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater mad-phobia or a worse health outcome.

You can see in the Table 4 that the Cronbach’s Alpha is 0.718, indicating the scale is reliable. Next I ran confirmatory factor analysis and confirmed a single factor. The KMO had a value of 0.734 which is considered excellent and the test of sphericity is significant which tells us that factor analysis is appropriate. It has one eigenvector and explains 44.164% of the total variance.

**Table 4: Internalized Mad-Phobia Confirmatory Factor Analysis**

<table>
<thead>
<tr>
<th>Here are some statements about attitudes. Strongly agree or disagree to the following statements…</th>
<th>Factor Loadings</th>
</tr>
</thead>
</table>
(Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have tried to stop being mentally ill.</td>
<td>0.369</td>
</tr>
<tr>
<td>If someone offered me the chance to be completely mentally healthy, I would accept the chance.</td>
<td>0.611</td>
</tr>
<tr>
<td>I wish I weren’t mentally ill.</td>
<td>0.922</td>
</tr>
<tr>
<td>I feel that being mentally ill is a personal shortcoming for me.</td>
<td>0.589</td>
</tr>
<tr>
<td>I would like to get professional help in order to change my mental illness.</td>
<td>0.418</td>
</tr>
<tr>
<td>I feel alienated from myself because of being mentally ill.</td>
<td>0.495</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EigenValue</td>
<td>2.650</td>
</tr>
<tr>
<td>% of Variance Explained</td>
<td>44.164</td>
</tr>
<tr>
<td>Cronbach’s Alpha</td>
<td>0.718</td>
</tr>
<tr>
<td>KMO</td>
<td>0.734</td>
</tr>
<tr>
<td>Bartlett’s Test of Sphericity</td>
<td>Chi-Square: 132.512, df: 15, Sig: &lt;0.001</td>
</tr>
</tbody>
</table>

The third I.V. is Social Stress which I used questions from the *Questionnaire for the Physical Challenge & Health Study* (Life Course and Health Research Center 2006). Social Stress is a scale of three questions (1. You have to go to social events alone and you don’t want to; 2. You don’t have enough friends; 3. You don’t have time for your favorite leisure time activities) each ranging from 1 (Not True) to 3 (Very True) (see Table 5). The social stress scale is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater stress or a worse health outcome.

The Cronbach’s Alpha was 0.590. This is low, but I went ahead and ran a confirmatory factor analysis using all three items. You can see that one of the factor loadings is low, but I kept the scale together based on theory, not on statistics. The KMO had a value of 0.550 which is considered lower and the test of sphericity is significant which tells us that factor analysis is appropriate. It has one eignenvector that explains 56.096% of the total variance.
Table 5: Social Stress Confirmatory Factor Analysis

<table>
<thead>
<tr>
<th>Factor Loadings</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have to go to social events alone and you don’t want to.</td>
<td>0.753</td>
</tr>
<tr>
<td>You don’t have enough friends.</td>
<td>0.758</td>
</tr>
<tr>
<td>You don’t have time for your favorite leisure activities.</td>
<td>0.258</td>
</tr>
</tbody>
</table>

EigenValue | 1.683 |
% of Variance Explained | 56.096 |
Cronbach’s Alpha | 0.590 |
KMO | 0.550 |
Bartlett’s Test of Sphericity | Chi-Square: 43.320, df: 3, Sig: <0.001 |

The forth I.V. is discrimination for which I used questions from the Questionnaire for the Physical Challenge & Health Study (Life Course and Health Research Center 2006).

“Discrimination,” consists of nine questions, each ranging from Almost Always (5), Often (4), Sometimes (3), Rarely (2), Never (1) (see Table 6). The discrimination scale is standardized with a mean of zero, standard deviation of 1.0 and higher values indicate greater discrimination or a worse health outcome.

This particular scale has not been validated, however, Calabrese et al. (2015) validated a similar set of items and found a single factor using nine item. The nine items were reliable with a Cronbach’s Alpha of 0.837. Initially, I ran an exploratory factor analysis on all nine items and obtained three factors. Unsure what to do with this, I returned to the literature. Following Calabrese’s methods, I ran a confirmatory factor analysis for a single factor using all nine items. My, meaning reliability and my KMO was 0.772 meaning validity. The test of sphericity is significant which tells us that factor analysis is appropriate.
**Table 6: Discrimination Confirmatory Factor Analysis**

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are treated with less courtesy than other people.</td>
<td>0.615</td>
</tr>
<tr>
<td>You are treated with less respect than you deserve.</td>
<td>0.722</td>
</tr>
<tr>
<td>You receive worse service than other people at restaurants or stores.</td>
<td>0.669</td>
</tr>
<tr>
<td>People act as if they think you are not smart.</td>
<td>0.599</td>
</tr>
<tr>
<td>People act as if they are afraid of you.</td>
<td>0.594</td>
</tr>
<tr>
<td>People act as if they think you are dishonest.</td>
<td>0.515</td>
</tr>
<tr>
<td>People act as if they are better than you are.</td>
<td>0.729</td>
</tr>
<tr>
<td>You are called names or insulted.</td>
<td>0.581</td>
</tr>
<tr>
<td>You have threatened or harassed.</td>
<td>0.543</td>
</tr>
<tr>
<td><strong>EigenValue</strong></td>
<td>4.083</td>
</tr>
<tr>
<td><strong>% of Variance Explained</strong></td>
<td>45.365</td>
</tr>
<tr>
<td><strong>Cronbach’s Alpha</strong></td>
<td>0.837</td>
</tr>
<tr>
<td><strong>KMO</strong></td>
<td>0.772</td>
</tr>
<tr>
<td><strong>Bartlett’s Test of Sphericity</strong></td>
<td>Chi-Square:</td>
</tr>
<tr>
<td></td>
<td>316.599</td>
</tr>
<tr>
<td></td>
<td>df: 36</td>
</tr>
<tr>
<td></td>
<td>Sig: &lt;0.001</td>
</tr>
</tbody>
</table>

With the next two I.V.’s are coming out as queer and coming out as with a mental illness. “Coming Out Queer,” is a scale compromising items that ask about level of “outness” with family, friends, and workplace colleagues. It is a sum of three scales, the higher the number, the more out as queer the participant is. The range is 0 to 6, this means that 0 is not out as queer, and 6 is completely out as queer. “Coming Out with a Mental Illness,” is a scale compromising the sum of coming out with a mental illness to family, friends, and workplace. It is a sum of three scales, the higher the number, the more out as mad the participant is. The range is 0 to 6, meaning 0 is not out with a mental illness and 6 is completely out with a mental illness.

### 3.2.3 Controls

Initially I intended to control for age sexual orientation, race, gender, and student and/or employment status. Given the small sample size, I assessed each control and only race appeared
related to my dependent variables. Therefore, race, measured as nonwhite=1, versus white (0 reference category) was the only control variable in my analyses.

3.3 Analysis

I started with univariate statistics to understand who was in the sample and get baseline measures on all variables. Next I ran bivariate analyses to unpack what coming out as mental ill really means and how it operates with coming out as queer. Likewise, I closely examined internalized stigmas due to being queer and having a mental illness diagnosis. These preliminary findings are examined in chapter 3.

In chapter 4, I turn to multivariable regression to explore the modified minority stress model on quality of life and psychological distress. I used Ordinary Least Squares (OLS) regression to analyze my results as my dependent variables are continuous. The a’s and b’s in my regression equation are estimated by ordinary least squares meaning minimizing the sum of errors (Frost 2019). In order to have the best parameters, OLS has several assumptions. The first assumption is that the model is linear. The second assumption is that the error term has a population mean of zero. The error term explains the variation of the D.V. that the I.V. does not explain. If the error term is zero, that means the model is unbiased (Frost 2019). The third assumption for OLS regression is all I.V.’s are not correlated with the error term, meaning the error term only predicts random error. If the I.V. is correlated with the error term, this could be a confounding variable (Frost 2019).

The fourth assumption is that each participant’s residue or error term is not associated with another participant’s error term. This means that one error term does not predict another error term, which is autocorrelation. If the errors are correlated, this relationship needs to be captured in the OLS equation (Frost 2019). The fifth assumption is that the error term does not
have heteroscedasticity, which means the error term has constant variance (Frost 2019). The sixth assumption is that the I.V.’s do not have a perfect correlation with other variables. If the I.V.’s had a perfect correlation with another variable, they would move in unison, and OLS cannot distinguish between the two (Frost 2019). This means no multicollinearity. The last assumption is that the error term is normally distributed. I ran diagnostics on the error terms for the final models of both dependent variables and all assumptions were reasonably met.

I ran a series of bivariate regression models first to assess the bivariate associations between each dependent variable and each minority stress model predictor. Next, I tested the full minority stress theory model on my doubly minoritized and stigmatized sample to assess how well the model works with this population. The next model assesses if coming out as queer mediates the minority stress model indicators on my outcomes. Next, I add in similar minority stress variables for the second minoritized identity: mentally ill. Lastly, I ran a model including one control, race.

For the best fitting model, I will utilize $R^2$. “R-squared evaluates the scatter of the data points around the fitted regression line… higher R-squared values represent smaller differences between the observed data and the fitted values. R-squared is the percentage of the dependent variable variation that a linear model explains” (Frost 2019:127). $R^2 = \frac{\text{Variance explained}}{\text{Total Variance}}$. $R^2$ ranges from 0%, meaning no variance is explained, to 100%, meaning all the variance is explained. The higher the $R^2$, the more variance explained, meaning a better fitting model.

To interpret my coefficients and know they are statistically significant, I will use raw regression coefficients and the t-statistic, which is calculated by the regression coefficient divided by the standard error. I will use a two-tailed test to understand the relationship between
my x’s and the quality of life/Kessler 6 outcomes. To know statistical significance, I will use $\alpha=0.025$ for each side, summing up to $\alpha=0.05$.

the equation for the full model is as follows:

1. $y = a + b_1(x_1) + b_2X_2 + b_3X_3 + b_4X_4 + b_5X_5 + b_6X_6 + \text{controls} + e$

$y =$ quality of life/Kessler 6

$a =$ intercept

$x_1 =$ discrimination

$x_2 =$ social stress

$x_3 =$ internalized homophobia

$x_4 =$ internalized mad-phobia

$x_5 =$ coming out as queer

$x_6 =$ coming out with a mental illness

controls = race

$e =$ error
4 FINDINGS: UNIVARIATE AND BIVARATE ANALYSES

4.1 Descriptive Statistics

First, we will take a look at who is in my sample and then later on, I will include my independent and dependent variables. Table 7 below presents descriptive statistics of the 98 participants in the sample. A majority of the participants are women (54.5%), then gender non-conforming (38.4%), and then men (7.1%). The participants are mainly white (75.8%), compared to non-white (24.2%). Many of the participants are working (51.5%), students (42.4%), or unemployed (6.1%). The mean age is 31.6 years, with a majority being on the younger side. When it comes to sexuality, bisexual women (N=25) are the majority, followed by queer women (N=16) and queer, gender non-conforming participants (N=16). When it comes to mental health diagnoses, a majority of participants have anxiety (N=88) and depression (N=88), followed by panic attacks (N=50) and PTSD (N=41).
### Table 7: Descriptive Statistics

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Gay/Lesbian</th>
<th>Bisexual</th>
<th>Queer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man/Male</td>
<td>7 (7.1%)</td>
<td>5 (16.7%)</td>
<td>0 (0.0%)</td>
<td>2 (5.9%)</td>
</tr>
<tr>
<td>Woman/Female</td>
<td>54 (54.5%)</td>
<td>13 (43.3%)</td>
<td>25 (71.4%)</td>
<td>16 (47.1%)</td>
</tr>
<tr>
<td>Gender Non-Conforming</td>
<td>38 (38.4%)</td>
<td>12 (40.0%)</td>
<td>10 (28.6%)</td>
<td>16 (47.1%)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>75 (75.8%)</td>
<td>24 (80.0%)</td>
<td>27 (77.1%)</td>
<td>24 (70.6%)</td>
</tr>
<tr>
<td>Non-White</td>
<td>24 (24.2%)</td>
<td>6 (20.0%)</td>
<td>8 (22.9%)</td>
<td>10 (29.4%)</td>
</tr>
<tr>
<td><strong>Work Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>51 (51.5%)</td>
<td>18 (60.0%)</td>
<td>19 (54.3%)</td>
<td>14 (41.2%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6 (6.1%)</td>
<td>4 (13.3%)</td>
<td>1 (2.9%)</td>
<td>1 (2.9%)</td>
</tr>
<tr>
<td>Student</td>
<td>42 (42.4%)</td>
<td>8 (26.7%)</td>
<td>15 (42.9%)</td>
<td>19 (55.9%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>54 (54.5%)</td>
<td>17 (56.7%)</td>
<td>17 (48.6%)</td>
<td>20 (58.8%)</td>
</tr>
<tr>
<td>31-40</td>
<td>31 (31.1%)</td>
<td>9 (30.0%)</td>
<td>14 (40.0%)</td>
<td>8 (23.5%)</td>
</tr>
<tr>
<td>41-50</td>
<td>10 (10.1%)</td>
<td>3 (10.0%)</td>
<td>3 (8.6%)</td>
<td>4 (11.8%)</td>
</tr>
<tr>
<td>51-58</td>
<td>4 (4.0%)</td>
<td>1 (3.3%)</td>
<td>1 (2.9%)</td>
<td>2 (5.9%)</td>
</tr>
<tr>
<td><strong>Mental Illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnoses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>88 (88.9%)</td>
<td>26 (86.7%)</td>
<td>32 (91.4%)</td>
<td>30 (88.2%)</td>
</tr>
<tr>
<td>Depression</td>
<td>88 (88.9%)</td>
<td>26 (86.7%)</td>
<td>33 (94.3%)</td>
<td>29 (85.3%)</td>
</tr>
<tr>
<td>Bipolar</td>
<td>20 (20.2%)</td>
<td>10 (33.3%)</td>
<td>7 (20.0%)</td>
<td>3 (8.8%)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>12 (12.1%)</td>
<td>5 (16.7%)</td>
<td>5 (14.3%)</td>
<td>2 (5.9%)</td>
</tr>
<tr>
<td>OCD</td>
<td>19 (19.2%)</td>
<td>9 (30.0%)</td>
<td>7 (20.0%)</td>
<td>3 (8.8%)</td>
</tr>
<tr>
<td>ADHD</td>
<td>26 (26.3%)</td>
<td>8 (26.7%)</td>
<td>8 (22.9%)</td>
<td>10 (29.4%)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1 (1.0%)</td>
<td>1 (3.3%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Autism</td>
<td>11 (11.1%)</td>
<td>4 (13.3%)</td>
<td>2 (5.7%)</td>
<td>5 (14.7%)</td>
</tr>
<tr>
<td>PTSD</td>
<td>41 (41.4%)</td>
<td>14 (46.7%)</td>
<td>17 (48.6%)</td>
<td>10 (29.4%)</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>28 (28.3%)</td>
<td>11 (36.7%)</td>
<td>9 (25.7%)</td>
<td>8 (23.5%)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>14 (14.1%)</td>
<td>3 (10.0%)</td>
<td>5 (14.3%)</td>
<td>6 (17.6%)</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>50 (50.5%)</td>
<td>17 (56.7%)</td>
<td>20 (57.1%)</td>
<td>13 (50.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (4.0%)</td>
<td>1 (3.3%)</td>
<td>3 (8.6%)</td>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>
As can be seen in Table 8, most participants had four mental health diagnoses (60.6%). Approximately 22% had six or more diagnoses, while only seven percent had a single diagnosis. According to NAMI, 1 out of 5 adults experience mental illness and 1 out of 20 experience severe mental illness each year (NAMI 2023). According to Mental Health America, 39% of Americans identify as LGBT+ and experience mental illness (Mental Health America n.d.-a). These statistics indicate high rates of mental illness. The way I collected my sample was that everyone experiences mental illness and identifies as LGBT+.

There are not any recent statistics about the comorbidity of mental illnesses in the United States. The most current statistics are from 2005, which state that prevalence of 2 disorders is 27.7% and the prevalence of 3 disorders is 17.3% (Kessler et al. 2005). My sample has a higher number of comorbid diagnoses compared to the general population. This suggests that either those who are queer have higher mental illness rates, or that when you seek a mental ill population, you find greater comorbidity.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent (%)</th>
<th>Cumulative Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>7.1%</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>20.2%</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>41.4%</td>
</tr>
<tr>
<td>4</td>
<td>19</td>
<td>60.6%</td>
</tr>
<tr>
<td>5</td>
<td>17</td>
<td>77.8%</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>90.9%</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>96.0%</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 8: Frequencies and Percentages of Diagnoses

Table 9 presents the main variables used in my analyses. I calculated means and standard deviations (SD) of both the raw scores and the standardized factor scores for all scales to provide context for the standardized scales (mean of 0, standard deviation of 1) used in the analyses.
For the dependent scale variable, Quality of Life (QoL) the raw mean was 21.230 and the SD was 6.350, with a range of 7 (low QoL) to 38 (high QoL). This means that QoL for most participants was in the middle of the range. For the Kessler 6 (K6) dependent scale variable, the raw mean was 11.484 with a SD of 4.338, and a range of 2 to 21 (high distress). Since we know the cutoff for the K6 is 13, the mean is below that, meaning most participants are below the threshold for psychological distress (Kessler et al. 1996).

For Social Stress, the raw mean was 5.408 with a SD of 1.604, and a range of 3 to 9 (high social stress). This means that average Social Stress was on the lower end of the range. For Everyday Discrimination, the raw mean was 21.506 with a SD of 5.477, and a range of 9 to 41 (high discrimination). This means that Everyday Discrimination was an average range for most participants. For Internalized Homophobia, the raw mean is 7.335 with a SD of 2.932 and a range of 6 to 21 (high internalized homophobia). This means that most participants did not have high levels of internalized homophobia. Lastly, for Internalized Mad-Phobia the raw mean was 21.524 with a SD of 4.558 and a range of 9 to 30 (high internalized mad-phobia). This means most participants had high amounts of internalized mad-phobia. The same 6 items were used for Internalized Homophobia as Internalized Mad-Phobia, yet there is much more internalized mad-phobia in my sample. Coming Out as Queer has a mean of 4.122 and a standard deviation of 1.777 and a range of 0 to 6. This means most participants are out as queer in some way. Coming Out with a Mental Illness has a mean of 3.632 and a standard deviation of 1.568 and a range of 0 to 6. This means my participants are out with a mental illness in an average way.
Table 9: Means of Dependent and Independent Variables. Mean (Standard Deviation)

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Raw Mean (SD)</th>
<th>Range (Min-Max)</th>
<th>Factor Mean (SD)</th>
<th>Range (Min-Max)</th>
<th>Items (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life</td>
<td>21.230(6.350)</td>
<td>7-38</td>
<td>0.00(1.00)</td>
<td>-2.369-2.430</td>
<td>7</td>
</tr>
<tr>
<td>Kessler 6</td>
<td>11.484(4.338)</td>
<td>2-21</td>
<td>0.00(1.00)</td>
<td>-2.210-2.265</td>
<td>6</td>
</tr>
<tr>
<td>Social Stress</td>
<td>5.408(1.604)</td>
<td>3-9</td>
<td>0.00(1.00)</td>
<td>-1.360-2.227</td>
<td>3</td>
</tr>
<tr>
<td>Everyday Discrimination</td>
<td>21.506(5.477)</td>
<td>9-41</td>
<td>0.00(1.00)</td>
<td>-2.163-3.192</td>
<td>9</td>
</tr>
<tr>
<td>Internalized Homophobia</td>
<td>8.511(3.590)</td>
<td>6-23</td>
<td>0.00(1.00)</td>
<td>-0.548-4.659</td>
<td>6</td>
</tr>
<tr>
<td>Internalized Mad-Phobia</td>
<td>21.514(4.558)</td>
<td>9-30</td>
<td>0.00(1.00)</td>
<td>-2.737-1.752</td>
<td>6</td>
</tr>
<tr>
<td>Coming Out Queer</td>
<td>4.122(1.777)</td>
<td>0-6</td>
<td>N/A</td>
<td>N/A</td>
<td>6</td>
</tr>
<tr>
<td>Coming Out with a Mental Illness</td>
<td>3.632(1.568)</td>
<td>0-6</td>
<td>N/A</td>
<td>N/A</td>
<td>6</td>
</tr>
</tbody>
</table>

### 4.2 Coming Out Variables

In this section I examine the coming out as queer and with a mental illness variables. I hypothesize these variables will mediate the minority stress model (social stress, discrimination, and internalized homophobia) on quality of life and psychological distress. I am examining coming out to family, friends, and work.

The concept of coming out as queer has been around for a long time. People who identify as queer have ‘coming out’ stories. There is even a national coming out day (Anon n.d.-b). People may be out as queer selectively to family, friends, and work colleagues. Time, location, and to whom are all considered when coming out as queer (Anon n.d.-c). Around 7% of
Americans identify as gay, lesbian, or bisexual, with the majority identifying as bisexual (Anon n.d.-a).

There is no national coming out day for mental health. Do people ‘come out’ as having a mental health illness in the same way? Table 10 addresses this by presenting a crosstab of the variable coming out to family as queer (on the rows) by the variable coming out to family with a mental illness along the columns. Few participants are not at all out as queer (n=13). In fact, the majority are out as queer to some family members (n=46). A large number are also out as queer to all family members (n=39). Being out with a mental illness to family members does not differ greatly from being out to family as queer on the margins. Few are out to none (n=7), the majority are out to some family (n=48), and a large number are out with a mental illness to all family members (n=43).

Thirteen are not at all out as queer to their family, but only six are not out as mentally ill to family. Does this suggest it is harder to hide a mental illness to family? Those who are not at all out as queer are all out to some extent with a mental illness. Those who are not at all out with a mental illness, are all out as queer to some extent, which is interesting, but what it means is not clear. The motivations and needs for being out may differ substantially for queerness and for mental health but is beyond the scope of this study. There is a need for more research understanding what this may mean.

While there are slight differences between the two variables, the pattern of outness is fairly consistent leading to the Chi-Square test (p=0.072) not being statistically significant. Therefore, I fail to reject the null hypothesis of no association. It is possible that with a larger sample size, we might see a stronger pattern.
Table 10: Coming Out to Family Crosstabs and Chi-Square

<table>
<thead>
<tr>
<th></th>
<th>Not Out to Family with Mental Illness</th>
<th>Out to Some Family with Mental Illness</th>
<th>Out to All Family with Mental Illness</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Out to Family as Queer</strong></td>
<td>0 (0.0%)</td>
<td>9 (69.2%)</td>
<td>4 (30.8%)</td>
<td>13 (100.0%)</td>
</tr>
<tr>
<td><strong>Out to Some Family as Queer</strong></td>
<td>6 (13.0%)</td>
<td>23 (50.0%)</td>
<td>17 (37.0%)</td>
<td>46 (100.0%)</td>
</tr>
<tr>
<td><strong>Out to All Family as Queer</strong></td>
<td>1 (2.6%)</td>
<td>16 (41.0%)</td>
<td>22 (56.4%)</td>
<td>39 (100.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>48</td>
<td>43</td>
<td>98</td>
</tr>
<tr>
<td><strong>Linear by Linear Chi-Square</strong></td>
<td>3.245</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td></td>
<td>0.072</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11 presents a crosstab of the variable coming out to friends as queer (on the rows) by the variable coming out to friends with a mental illness along the columns. We first note that few participants are not at all out as either queer or mentally ill. In the case of friends, fewer are not out in the case of being queer compared to being mentally ill which is the reverse of the pattern above regarding being out to family. A majority of participants are out to friends as queer. The majority, in the case of mental health, are out to some friends. In the first cell of the first row, we find that there is one participant (25.0%) not out as queer and not out with a mental illness to their friends. There are two participants (50.0%) not out to their family as queer but are out with a mental illness to some family members. Finally, one participant (25.0%) is not out as queer but is out to all family members with a mental illness. There are major differences between the two variables, the pattern of outness is different, leading to the Chi-Square test (p=<0.001) being statistically significant. Therefore, I reject to null hypothesis of no association. A majority of participants are completely out as queer and with a mental illness to all their friends. This means that there is a positive association between coming out as queer and with a mental illness to friends; meaning that participants willing to be out as queer to their friends are more likely to
also be out with a mental illness to their friends. According to this sample, coming out to friends, as queer and/or mentally ill, is safe.

### Table 11: Coming Out to Friends Crosstabs and Chi-Square

<table>
<thead>
<tr>
<th></th>
<th>Not Out to Friends as Queer</th>
<th>Out to Some Friends as Queer</th>
<th>Out to All Friends as Queer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Out to Friends with a Mental Illness</td>
<td>1 (25.0%)</td>
<td>2 (50.0%)</td>
<td>1 (25.0%)</td>
<td>4 (100.0%)</td>
</tr>
<tr>
<td>Out to Some Friends as Queer</td>
<td>5 (20.0%)</td>
<td>10 (40.0%)</td>
<td>10 (40.0%)</td>
<td>25 (100.0%)</td>
</tr>
<tr>
<td>Out to All Friends as Queer</td>
<td>3 (4.3%)</td>
<td>14 (20.3%)</td>
<td>52 (75.4%)</td>
<td>69 (100.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>26</td>
<td>63</td>
<td>98</td>
</tr>
</tbody>
</table>

Linear by Linear Chi-Square: 13.353, P=<0.001

Table 12 presents a crosstab of the variable coming out as queer at work (on the rows) by the variable coming out at work with a mental illness along the columns. We first note that quite a few participants are not out at work as queer (26). Even more participants are not out with a mental illness at work (45). In the first cell of the first row, we find that 16 (61.5%) are not out as queer and not out with a mental illness at work. There are seven (26.9%) participants not as queer at work and out to some with a mental illness at work. The majority, however, are out to all as queer at work. We find that when it comes to mental illness, the majority are not at all out at work. This may seem surprising, but maybe participants are afraid of being fired. It is hard to understand the motivations, and this would be an area for future research.

There are major differences between the two variables, the pattern of outness is different, leading to the Chi-Square test (p=0.018) being statistically significant. Therefore, I reject to null hypothesis of no association. A majority of participants are not out as queer or with a mental illness at work. This means that there is an association between coming out as queer and coming
out with a mental illness at work. Participants are less willing to be out as mentally ill at work than they are to be out as queer at work.

**Table 12: Coming Out at Work Crosstabs and Chi-Square**

<table>
<thead>
<tr>
<th></th>
<th>Not Out at Work with a Mental Illness</th>
<th>Out to Some at Work with a Mental Illness</th>
<th>Out to All at Work with a Mental Illness</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Out at Work as Queer</td>
<td>16 (61.5%)</td>
<td>7 (26.9%)</td>
<td>3 (11.5%)</td>
<td>26 (100.0%)</td>
</tr>
<tr>
<td>Out to Some at Work as Queer</td>
<td>15 (55.6%)</td>
<td>8 (29.6%)</td>
<td>4 (14.8%)</td>
<td>27 (100.0%)</td>
</tr>
<tr>
<td>Out to All at Work as Queer</td>
<td>14 (31.1%)</td>
<td>21 (46.7%)</td>
<td>10 (22.2%)</td>
<td>45 (100.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>36</td>
<td>17</td>
<td>98 (100%)</td>
</tr>
<tr>
<td>Linear by Linear Chi-Square</td>
<td>5.555</td>
<td></td>
<td></td>
<td>P=0.018</td>
</tr>
<tr>
<td>N</td>
<td>98</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall, based on the crosstabs and chi-squares of the coming out variables, most participants felt the safest to come out to friends, then to family, and lastly at work. This makes sense, as friends are usually a place of acceptance, while family can be, and work can be a place of discrimination.

### 4.3 Coming Out and Phobia Variables

Next, I am going to look at the coming out variables in conjunction with the internalized stigma variables. I used ANOVA’s (Analysis of Variance) to test these variables. An ANOVA tests the means between the independent variable and the dependent variable. The purpose of an ANOVA test is to see if there are differences in means, or the variance, between groups. In this case, I wanted to see if coming out in different levels impacts the overall internalized stigma experienced by my sample. Let us take a look below.

Table 13 presents results from three separate ANOVAs of internalized homophobia by categories of coming out as queer to family, friends, and at work. In the first column, we see
among those not out to family as queer report an average of 0.871 internalized homophobia, which is much higher than the mean of 0.00 for this standardized variable. Next, we see that internalized homophobia by out to some family as queer has a mean of 0.019 (0.955), which is slightly above average. Lastly, we see that internalized homophobia by out to all family as queer has a mean of -0.314 (0.563). This means that those who are out to all family as queer have a lower internalized homophobia compared to the average.

In the next column, we see internalized homophobia by not out to friends as queer has a mean of 0.137 (0.678). This means that those who are not out to friends as queer have a higher internalized homophobia compared to the average. Next, we see that internalized homophobia by out to some friends as queer has a mean of 0.810 (1.504). This means that those who are out to some friends as queer have an even higher internalized homophobia compared to the average. Maybe being out to only some friends, and not to others, causes anxiety because participants can be themselves to some, but not others. This would be an area for future research. Lastly, we see that internalized homophobia by out to all friends as queer has a mean of -0.301 (0.522). This means that those who are out to all friends as queer have a lower internalized homophobia compared to the average.

In the final column, we see internalized homophobia by not out at work as queer has a mean of 0.224 (1.216). This means that those who are not out at work as queer have a higher internalized homophobia compared to the average. Next, we see that internalized homophobia by out to some at work as queer has a mean of 0.266 (1.257). This means that those who are out to some at work as queer have a higher internalized homophobia compared to the average. Lastly, we see that internalized homophobia by out to all at work as queer has a mean of -0.289 (0.520).
This means that those who are out to all at work as queer have a lower internalized homophobia compared to the average.

Table 13: ANOVA: Standardized Internalized Homophobia and Coming Out as Queer

<table>
<thead>
<tr>
<th></th>
<th>Mean (Std Dev.)</th>
<th></th>
<th>Mean (Std Dev.)</th>
<th></th>
<th>Mean (Std Dev.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Out to Family as Queer</td>
<td>0.874 (1.580)</td>
<td>Not Out to Friends as Queer</td>
<td>0.137 (0.678)</td>
<td>Not Out at Work as Queer</td>
<td>0.224 (1.216)</td>
</tr>
<tr>
<td>Out to Some Family as Queer</td>
<td>0.019 (0.955)</td>
<td>Out to Some Friends as Queer</td>
<td>0.810 (1.504)</td>
<td>Out to Some at Work as Queer</td>
<td>0.266 (1.257)</td>
</tr>
<tr>
<td>Out to All Family as Queer</td>
<td>-0.314(0.563)</td>
<td>Out to All Friends as Queer</td>
<td>-0.301 (0.522)</td>
<td>Out to All at Work as Queer</td>
<td>-0.289 (0.520)</td>
</tr>
<tr>
<td>F Statistic</td>
<td>7.904, &lt;0.001</td>
<td></td>
<td>14.559, &lt;0.001</td>
<td></td>
<td>3.684, 0.029</td>
</tr>
<tr>
<td>N=98</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 14 presents results from three ANOVAs examining internalized mad-phobia by categories of coming out with a mental illness to family, friends, and at work. First, unlike the findings for homophobia, none of the findings in Table 14 are statistically significant which tells us that respondent’s level of internalized mad-phobia is not associated with how out they may be. The first column presents findings for being out to family. The mean internalized had-phobia for those not at all out to family is 0.659 (0.890), which demonstrates higher internalized mad-phobia compared to the average (0.0). Next, we see that internalized mad-phobia by out to some family with a mental illness has a mean of -0.011 (0.940). This means that those who are out to some family with a mental illness have a mostly average internalized mad-phobia. Lastly, we see that internalized mad-phobia by out to all family with a mental illness has a mean of -0.094 (1.060). It is likely the lack of statistical significance is due to the small sample size given the difference of those not out at all to family compared to the other two categories.
In the next column, we see results from an ANOVA examining internalized mad-phobia by level of outness with a mental illness to friends which has a mean of 0.710 (1.018). This means that those who are not out to friends with a mental illness have a higher internalized mad-phobia compared to the average. Next, we see that internalized mad-phobia by out to some friends with a mental illness has a mean of -0.058 (0.834). This means that those who are out to some friends with a mental illness have an average internalized mad-phobia. Lastly, we see that internalized mad-phobia by out to all friends with a mental illness has a mean of -0.077 (1.033). This means that those who are out to all friends with a mental illness have an average internalized mad-phobia.

In the last column, we see internalized mad-phobia by not out at work with a mental illness, which has a mean of 0.150 (0.873). This means that those who are not out at work with a mental illness have a higher internalized mad-phobia compared to the average. Next, we see that internalized mad-phobia by out to some at work with a mental illness has a mean of -0.237 (1.068). This means that those who are out to some at work with a mental illness have a lower internalized mad-phobia compared to the average. Lastly, we see that internalized mad-phobia by out to all at work with a mental illness has a mean of 0.103 (1.123). This means that those who are out to all at work with a mental illness have a higher internalized mad-phobia compared to the average. This column is not statistically significant (0.201, which means it does not differ from the average.

Overall, for coming out to family as queer, it is statistically significant and has a linear pattern. We see that those who are not out to family as queer have the highest internalized homophobia, while those who are out to all family as queer have the lowest internalized homophobia. For friends, it is also statistically significant, but the pattern is not linear, like for
family. For friends, being out to some friends has the highest internalized homophobia, compared to being out to all friends as queer has the lowest internalized homophobia. This makes sense, because if the sample is only partially out to friends, they might have to hide their identity in some circumstances, which is the definition of internalized homophobia. Those out to all at work have significantly lower than average internalized stigma while there is little difference between those out to some and those not at all out at work.

Overall, for coming out to family with a mental illness, it is not statistically significant, but does have a linear pattern. We see that those who are not out to family with a mental illness have the highest internalized mad-phobia, while those who are out to all family with a mental illness have the lowest internalized mad-phobia. For friends, it is statistically significant at the 0.1 level and has a linear pattern. We see that those who are not out to friends with a mental illness have the highest internalized mad-phobia, while those who are out to all friends with a mental illness have the lowest internalized mad-phobia. Those out to all at work have significantly higher than average internalized stigma, similar to those who are not out at work, but those out to some at work have the lowest internalized mad-phobia.

These ANOVA’s address hypotheses 11 and 12, which state (11) as a person comes out in terms of their sexuality and mental illness, their internalized homophobia will decrease and (12) as a person comes out in terms of their sexuality and mental illness, their internalized mad-phobia will decrease. Both hypotheses are supported, as coming out as queer and with a mental illness elevates the internalized stigmas.

Table 14: ANOVA: Standardized Internalized Mad-Phobia and Coming Out with a Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>Mean (Std Dev.)</th>
<th>Mean (Std Dev.)</th>
<th>Mean (Std Dev.)</th>
</tr>
</thead>
</table>

Table 14: ANOVA: Standardized Internalized Mad-Phobia and Coming Out with a Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>Mean (Std Dev.)</th>
<th>Mean (Std Dev.)</th>
<th>Mean (Std Dev.)</th>
</tr>
</thead>
</table>
Coming Out Bivariate Regressions

Next, I run bivariate regressions of quality of life and psychological distress on the coming out variables to understand how the various coming out scenarios play out in terms of these health outcomes. Table 15 presents three bivariate regressions of QoL on coming out as queer. Model 1 shows that coming out queer to family is not significantly associated with QoL. Since the family variables are not statistically significant, I fail to reject the null hypothesis, meaning the level of outness in terms of family has no impact on my sample’s quality of life.

Model 2 regresses QoL on coming out as queer to friends. Those who are out to some friends are associated with a 0.703 lower QoL compared to those out to all friends and it is statistically significant. Those out as queer to no friends are not statistically different in terms of QoL compared to those out to all friends. Thus, there is a curvilinear association, meaning coming out to all friends and no friends is associated with greater quality of life, than coming out to some friends. Model 3 regresses QoL on coming out as queer at work. The association appears to be linear, meaning as coming out increases, QoL increases, but again only the association with
not at all out at work is statistically significant. Apparently, coming out at work as queer appears to be a protective measure for my sample or potentially could be if the sample size were larger.

Table 15: Regressing Quality of Life on Coming Out as Queer. Standard Errors in Parentheses.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>0.146</td>
<td>0.171</td>
<td>0.294</td>
</tr>
<tr>
<td></td>
<td>(0.161)</td>
<td>(0.115)</td>
<td>(0.140)</td>
</tr>
<tr>
<td>Coming Out as Queer to Some Family</td>
<td>-0.233</td>
<td>-0.278</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.218)</td>
<td>(0.321)</td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to No Family</td>
<td>-0.703*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.224)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to Some Friends</td>
<td>0.208</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.493)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to No Friends</td>
<td>0.274</td>
<td>-0.274</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.229)</td>
<td>(0.229)</td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to Some Work</td>
<td>-0.857*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.235)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to No Work</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>N</td>
<td>0.014</td>
<td>0.100</td>
<td>0.123</td>
</tr>
<tr>
<td>R²</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References:
Coming Out as Queer to All Family
Coming Out as Queer to All Friends
Coming Out as Queer to All Work
*p<0.05
+p<0.1

Table 16 regresses quality of life on coming out with a mental illness. First, note that coming out with a mental illness to family (Model 1) is curvilinearly associated with quality of life. Since the family variables are not statistically significant, I fail to reject the null hypothesis, meaning the level of outness in terms of family has no impact on my sample’s quality of life. Model 2 regresses quality of life on coming out with a mental illness to friends. Here we find statistically significant differences in quality of life by level of coming out. In this case, we see a linear model, meaning coming out with a mental illness to all friends increases quality of life (b=0.222), coming out to some decreases quality of life (b= -0.505), and coming out to none
further decreases quality of life (b= -1.085). Model 3 regresses quality of life on coming out with a mental illness at work levels. Since the work variables are not statistically significant, I fail to reject the null hypothesis, meaning the level of outness in terms of work has no impact on my sample’s quality of life.

**Table 16: Regressing Quality of Life on Coming Out with a Mental Illness. Standard Errors in Parentheses.**

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>0.160 (0.152)</td>
<td>0.222+ (0.119)</td>
<td>0.200 (0.242)</td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to Some Family</td>
<td>-0.320 (0.209)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to No Family</td>
<td>-0.039 (0.407)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to Some Friends</td>
<td></td>
<td>-0.505* (0.221)</td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to No Friends</td>
<td></td>
<td></td>
<td>-1.085* (0.356)</td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to Some Work</td>
<td></td>
<td></td>
<td>-0.100 (0.294)</td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to No Work</td>
<td></td>
<td></td>
<td>-0.356 (0.284)</td>
</tr>
<tr>
<td>N</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>R²</td>
<td>0.025</td>
<td>0.115</td>
<td>0.022</td>
</tr>
</tbody>
</table>

References:
Coming Out with a Mental Illness to All Family
Coming Out with a Mental Illness to All Friends
Coming Out with a Mental Illness to All Work
*p<0.05
+p<0.1

Next, I regress psychological distress on the two coming out variables. Table 17 breaks out the three coming out as queer variables and Table 18 regresses psychological distress on the three coming out with a mental illness variables. Table 17 shows that coming out as queer is not statistically associated with psychological distress. Likewise, Table 18 finds that coming out with a mental illness is not associated with psychological distress. This could be due to a lack of
variation, or the small N. Quality of life and psychological distress are different from one another. Quality of life is looking at general capabilities of my participants, while psychological distress is looking out how overwhelmed my participants are. The difference in the two could be problematic for coming out variables, as coming out may impact one and not the other.

Table 17: Regressing Kessler 6 on Coming Out as Queer. Standard Errors in Parentheses.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-0.092</td>
<td>-0.059</td>
<td>-0.130</td>
</tr>
<tr>
<td></td>
<td>(0.161)</td>
<td>(0.121)</td>
<td>(0.147)</td>
</tr>
<tr>
<td>Coming Out as Queer to Some Family</td>
<td>0.218</td>
<td>0.186</td>
<td>0.108</td>
</tr>
<tr>
<td></td>
<td>(0.218)</td>
<td>(0.235)</td>
<td>(0.242)</td>
</tr>
<tr>
<td>Coming Out as Queer to No Family</td>
<td>-0.074</td>
<td>0.273</td>
<td>0.391</td>
</tr>
<tr>
<td></td>
<td>(0.321)</td>
<td>(0.517)</td>
<td>(0.248)</td>
</tr>
<tr>
<td>Coming Out as Queer to Some Friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to No Friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to Some Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out as Queer to No Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>R^2</td>
<td>0.015</td>
<td>0.009</td>
<td>0.026</td>
</tr>
</tbody>
</table>

References:
Coming Out Queer to All Family
Coming Out Queer to All Friends
Coming Out Queer to All Work
*p<0.05
+p<0.1

Table 18: Regressing Kessler 6 on Coming Out with a Mental Illness. Standard Errors in Parentheses.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>0.066</td>
<td>0.048</td>
<td>0.299</td>
</tr>
<tr>
<td></td>
<td>(0.154)</td>
<td>(0.126)</td>
<td>(0.242)</td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to Some Family</td>
<td>-0.133</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.212)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to No Family</td>
<td>-0.011</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.411)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness to Some Friends</td>
<td></td>
<td></td>
<td>-0.166</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.234)</td>
</tr>
</tbody>
</table>
Coming Out with a Mental Illness to No Friends
-0.051 (0.378)

Coming Out with a Mental Illness to Some Work
-0.263 (0.294)

Coming Out with a Mental Illness to No Work
-0.440 (0.284)

N 98 98 98
R² 0.004 0.005 0.025

References:
Coming Out with a Mental Illness to All Family
Coming Out with a Mental Illness to All Friends
Coming Out with a Mental Illness to All Work
*p<0.05
+p<0.1

The sample size is very small, and the associations of each grouping of coming out mainly show linear trends, the next set of regressions treat each coming out variable as continuous (0-2) with higher values indicating out to more people among family, friends, or work. I took each coming out category (family, friends, and work) and summed them together (none, some, all) to create a coming out variable that might be more useful in the final regression model. Let’s take a look at the regressions with these summed coming out variables with the dependent variables, quality of life and Kessler 6.

Table 19 regresses QoL on coming out bivariately in Models 1-6 and includes all the coming out variables in model 7. Few of the coming out variables are significantly associated with quality of life. Model 2, coming out queer to friends is significant at the 0.1 level, meaning that a one unit increase in coming out to friends as queer is associated with a 0.344 standard deviation increase in quality of life. Model 3, coming out as queer at work is statistically significant at the 0.05 level, meaning that a one unit increase in coming out as queer at work is associated with a 0.382 standard deviation increase in quality of life. Model 5, coming out with a mental Illness to friends is statistically significant at the 0.05 level, meaning that a one unit
increase in coming out with a mental illness to friends is associated with a 0.587 standard deviation increase in quality of life. These variables show that coming out under some conditions positively impacts quality of life. In the multivariable regression shown in Model 7, only coming out as mentally ill to friends has a significant association with quality of life.

Table 19: Regressing Quality of Life on Coming Out Factors. Standard Errors in Parentheses.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-0.208</td>
<td>-0.572*</td>
<td>-0.456*</td>
<td>-0.224</td>
<td>-0.910*</td>
<td>-0.138</td>
<td>-0.800*</td>
</tr>
<tr>
<td></td>
<td>(0.214)</td>
<td>(0.316)</td>
<td>(0.169)</td>
<td>(0.247)</td>
<td>(0.240)</td>
<td>(0.139)</td>
<td>(0.364)</td>
</tr>
<tr>
<td>Coming Out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queer Family</td>
<td>0.164</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.008</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.149)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(0.200)</td>
<td></td>
</tr>
<tr>
<td>Queer Friends</td>
<td></td>
<td>0.344</td>
<td></td>
<td></td>
<td></td>
<td>-0.144</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0.180)</td>
<td></td>
<td></td>
<td></td>
<td>(0.246)</td>
<td></td>
</tr>
<tr>
<td>Queer Work</td>
<td></td>
<td></td>
<td>0.382*</td>
<td></td>
<td></td>
<td>0.276</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.116)</td>
<td></td>
<td></td>
<td>(0.171)</td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td>0.164</td>
<td></td>
<td>-0.072</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td>(0.165)</td>
<td></td>
<td>(0.181)</td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.587*</td>
<td>0.544*</td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(0.143)</td>
<td>(0.196)</td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>R²</td>
<td>0.013</td>
<td>0.036</td>
<td>0.101</td>
<td>0.010</td>
<td>0.150</td>
<td>0.021</td>
<td>0.186</td>
</tr>
</tbody>
</table>

*p<0.05
+p<0.1

Table 20 presents seven models regressing psychological distress on the continuous versions of the coming out variables. For the most part, none of the coming out variables are statistically associated with psychological distress, until Model 7. In Model 7, coming out at work as mentally ill is statistically significant at the 0.1 level, however, when ran alone, it was not significant. This suggests that one of the other coming out variables suppresses this
association when it is not included. Basically, coming out in different capacities does not really affect psychological distress (Kessler 6).

**Table 20: Regressing Kessler 6 on Coming Out Factors. Standard Errors in Parentheses.**

<table>
<thead>
<tr>
<th>Model</th>
<th>Constant</th>
<th>Coming Out Queer Family</th>
<th>Coming Out Queer Friends</th>
<th>Coming Out Queer Work</th>
<th>Coming Out Mentally Ill Family</th>
<th>Coming Out Mentally Ill Friends</th>
<th>Coming Out Mentally Ill Work</th>
<th>N</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.040</td>
<td>-0.032</td>
<td>-0.164</td>
<td>-0.142</td>
<td>0.067</td>
<td>0.009</td>
<td>0.212</td>
<td>98</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>(0.215)</td>
<td>(0.150)</td>
<td>(0.183)</td>
<td>(0.122)</td>
<td>(0.166)</td>
<td>(0.155)</td>
<td>(0.135)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.273</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>(0.321)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0.170</td>
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<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.014</td>
</tr>
<tr>
<td></td>
<td>(0.177)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-0.091</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>(0.248)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-0.014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>(0.260)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>-0.151</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.025</td>
</tr>
<tr>
<td></td>
<td>(0.139)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>0.063</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td>0.061</td>
</tr>
<tr>
<td></td>
<td>(0.391)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<0.05
+p<0.1

In this chapter, we learned that coming out to friends, both as queer and with a mental illness, is the safest place for my sample. We also learned that those who are out as queer have less internalized homophobia, while those who are out with a mental illness is more nuanced when it comes to internalized mad-phobia. Perhaps, coming out is less about whom you come out to, and more about some underlying desire or need to come out. Given the small sample size, in the next set of analyses, I sum each of the three coming out categories together for coming out as queer into a single continuous variable where higher numbers reflect being out to the large circle of family, friends and work colleagues. I do the same for the coming out as mentally ill variables. This addresses both the overall desire to come out and the small sample size issue.
You can see the “coming out queer” and “coming out as mentally ill” variables in my next chapter.
5 FINDINGS: MULTIVARIABLE REGRESSIONS PREDICTING QUALITY OF LIFE AND PSYCHOLOGICAL DISTRESS

5.1 Final Regressions

In this section, I present multivariable regressions predicting first quality of life and then psychological distress. Table 21 presents models run on quality of life and Table 22 presents models run on psychological distress. Models 1-4 examine the minority stress model variables of social stress, discrimination, and internalized homophobia bivariately first and then all together in the final model. Models 5-7 modify the minority stress model by adding my theorized additions of coming out as queer, internalized mad-phobia, and coming out with a mental illness. Finally, in Model 7, I add a control variable, race, as that was the only control variable that was close to being statistically significant. Given the small sample size and lack of statistically significant, I left out gender, sexual orientation, age, and employment status.

In Table 21, Model 1 shows that the association between social stress and poor quality of life is statistically significant. A one standard deviation increase in social stress (worsening) is associated with a 0.460 standard deviation decrease (worsening) in quality of life. The intercept is essential zero, which is the mean of the standardized quality of life scale and will be essentially zero for Models 1-4 as all three minority stress model variables are standardized scales as well with a mean of zero and standard deviation of 1. Model 2 examines the association between discrimination and quality of life. We find that as discrimination increases (worsens) by one standard deviation, then quality of life becomes 0.088 standard deviations lower (worse), but it is not statistically significant. Model 3 regresses quality of life on internalized homophobia and it is not statistically significant. Model 4 regresses quality of life on all three of the minority stress model variables. Social stress remains statistically significant at the 0.05 level net of
discrimination and internalized homophobia. As social stress increases (worsens) by one standard deviation, then quality of life decreases (worsens) by 0.438 standard deviations.

Model 5 adds coming out as queer to the minority stress model to determine if it attenuates the associations between quality of life and the minority stress model variables. Coming out as queer is not statistically associated with quality of life. Social stress remains statistically significant, and the magnitude of the effect is only marginally reduced which suggests that coming out as queer is not a confounder for the minority stress model. The intercept has changed here as the new reference group consists of those not at all out as queer with average levels of stress, discrimination, and internalized homophobia. While not statistically significant, this reference group has an average quality of life that is .218 standard units lower than average.

Model 6 adds internalized mad-phobia and coming out with a mental illness to the variables in Model 5. As coming out with a mental illness increases by one unit, then quality of life increases (improves) by 0.095 standard deviations. Social stress remains statistically significant, but the magnitude has dropped. As social stress increases (worsens) by one standard deviation, quality of life decreases (worsens) by 0.377 standard deviations. I ran Model 6 with just coming out with a mental illness and just with internalized mad-phobia, and neither were significant, meaning neither mediate the association between social stress and quality of life.

Model 7 adds the control variable race to Model 6. The intercept in this model, again not statistically significant, tells us that, net of all other variables, whites who are not out as queer or mentally ill, score .344 standard units lower than average on the quality of life scale.

Nonwhites with average values on all the other variables, report a lower quality of life compared to Whites (0.352 standard deviations below the mean), but it is not statistically
significant. Social stress is the only variable that remains statistically significant, but race was verging on significance at the 0.1 level. Controlling for race does not, however, change the associations between social stress or coming out with a mental illness and quality of life in any substantive way. This model has the highest $R^2$ at 0.272, meaning that 27.2% of the variance in quality of life is explained by this model. Since this is the model with the highest $R^2$, this is the model which I will use to compare my hypotheses against.

*Table 21: Regressing Quality of Life on Minority Stress Model Factors. Standard Errors in Parentheses.*

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-7.137E-17 (0.090)</td>
<td>-8.463E-17 (0.101)</td>
<td>-1.183E-16 (0.100)</td>
<td>-8.329E-17 (0.090)</td>
<td>-0.218 (0.253)</td>
<td>-0.488 (0.312)</td>
</tr>
<tr>
<td>Social Stress</td>
<td>-0.460* (0.091)</td>
<td>-0.438* (0.093)</td>
<td>-0.414* (0.097)</td>
<td>-0.377* (0.102)</td>
<td>-0.393* (0.101)</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>-0.088 (0.110)</td>
<td>-0.004 (0.100)</td>
<td>-0.013 (0.101)</td>
<td>-0.034 (0.102)</td>
<td>0.009 (0.104)</td>
<td></td>
</tr>
<tr>
<td>Internalized Homophobia</td>
<td>-0.196+ (0.100)</td>
<td>-0.106 (0.094)</td>
<td>-0.075 (0.100)</td>
<td>-0.055 (0.100)</td>
<td>-0.065 (0.100)</td>
<td></td>
</tr>
<tr>
<td>Coming Out Queer</td>
<td></td>
<td>0.053 (0.057)</td>
<td>0.035 (0.058)</td>
<td>0.030 (0.058)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalized Mad Phobia</td>
<td></td>
<td></td>
<td>-0.039 (0.097)</td>
<td>-0.032 (0.096)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming Out with a Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td>0.095 (0.062)</td>
<td>0.084 (0.062)</td>
<td></td>
</tr>
<tr>
<td>Nonwhite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.352 (0.216)</td>
</tr>
</tbody>
</table>

| | Model 1 | Model 2 | Model 3 | Model 4 | Model 5 | Model 6 | Model 7 |
| | | | | | | | |
| N | 98 | 98 | 98 | 98 | 98 | 98 | 98 |
| $R^2$ | 0.212 | 0.007 | 0.039 | 0.222 | 0.229 | 0.251 | 0.272 |

Reference: White
*p<0.05
+p<0.1

As you can see in Table 22, I have included the final regression model for regressing Kessler 6 on the minority stress model factors. This table is the same as the one we discussed above, but instead of quality of life, the dependent variable is Kessler 6 (psychological distress).

Models 1-4 include the minority stress model variables of social stress, discrimination, and
internalized homophobia. Models 5-7 modify the minority stress model by adding my theorized additions of coming out as queer, internalized mad-phobia, and coming out with a mental illness. Finally, in Model 7, I add a control variable, race, as that was the only control variable that was close to being statistically significant. Given the small sample size and lack of statistically significant, I left out gender, sexual orientation, age, and employment status.

Based on results from Models 1 and 7, hypothesis 1, that as social stress increases, quality of life decreases, is supported. Hypothesis 3 which examines the association between discrimination and quality of life is not supported in the bivariate model (2) or in the multivariate model (7). Hypothesis 5, which examines the association between internalized homophobia and quality of life is partially supported in the bivariate model (2) at the p<.10 level but not in the multivariate model (7). Hypothesis 7, which examines the association between internalized mad-phobia and psychological distress is not supported in models 6 and 7. Hypothesis 9, As a person comes out in terms of their sexuality and mental illness, their quality of life will improve, is not supported. It is likely that in a larger sample, I would find it statistically significant at the .05 level.

In Table 22, Model 1 shows that the association between social stress and psychological distress is statistically significant. A one standard deviation increase in social stress (worsening) is associated with a 0.419 standard deviation increase (worsening) in psychological distress. Model 2 examines the association between discrimination and psychological distress. We find that as discrimination increases (worsens) by one standard deviation, then psychological becomes 0.288 standard deviations higher (worse) and is statistically significant. Model 3 regresses psychological distress on internalized homophobia and it is not statistically significant. Model 4 regresses quality of life on all three of the minority stress model variables. Social stress
and discrimination remain statistically significant at the 0.05 level net of internalized homophobia. As social stress increases (worsens) by one standard deviation, then psychological distress increases (worsens) by 0.397 standard deviations. As discrimination increases (worsens) by one standard deviation, then psychological distress increases (worsens) by 0.235 standard deviations.

Model 5 adds coming out as queer to the minority stress model to determine if it attenuates the associations between psychological and the minority stress model variables. Coming out as queer is not statistically associated with psychological distress. Social stress and discrimination remain statistically significant, and the magnitude of the effect is only marginally reduced which suggests that coming out as queer is not a confounder for the minority stress model.

Model 6 adds internalized mad-phobia and coming out with a mental illness to the variables in Model 5. As internalized mad-phobia increases by one unit, then psychological distress also increases (declines) by 0.288 standard deviations. As coming out with a mental illness increases by one unit, then psychological distress increases (declines) by 0.128 standard deviations. Social stress and discrimination remain statistically significant. As social stress increases (worsens) by one standard deviation, psychological distress increases (worsens) by 0.359 standard deviations. As discrimination increases (worsens) by one-unit, psychological distress increases (worsens) by 0.240 standard deviations. We can see that internalized mad-phobia and coming out with a mental illness mediates the association between social stress and discrimination and psychological distress.

Model 7 adds the control variable race to Model 6. The intercept of -0.404 tells us that whites with average values on all the other variables, have a low psychological distress (0.214
standard deviations below the mean). It is not statistically significant. Social stress, discrimination, internalized mad-phobia, and coming out with a mental illness remain statistically significant. Controlling for race does not, however, change the associations between these variables and psychological distress in any substantive way. This model has the highest $R^2$ at 0.286, meaning that 28.6% of the variance is explained by this model. Since this is the model with the highest $R^2$, this is the model which I will use to compare my hypotheses against.

Model 7 is all the variables previously discussed, as well as race. The intercept is -0.543 and statistically significant at the 0.1 level, meaning that when all the variables in the model equal zero, psychological distress is 0.543 standard deviations below the mean. There are three statistically significant variables in this model: social stress, internalized mad-phobia, and coming out with a mental illness. As social stress increases, psychological distress increases. As internalized homophobia increases, psychological distress increases. As coming out with a mental illness increases, psychological distress increases. This model has the highest $R^2$ at 0.332, meaning that 33.2% of the variances is explained by the model. Since this model has the highest $R^2$, this is the model which I will use to compare my hypotheses against.

Based on results from Models 1 and 7, hypothesis 2, that as social stress increases, psychological distress increases, is supported. Hypothesis 4 which examines the association between discrimination and psychological distress is supported in the bivariate model (2) and in the multivariate model (7). Hypothesis 6, which examines the association between internalized homophobia and psychological distress is not supported in the bivariate model (2) or the multivariate model (7). Hypothesis 8, which examines the association between internalized mad-phobia and psychological distress is supported in models 6 and 7. Hypothesis 10, As a person
comes out in terms of their sexuality and mental illness, their psychological distress will
decrease, is not supported.

*Table 22: Regressing Kessler 6 on Minority Stress Model Factors. Standard Errors in Parentheses.*

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constant</strong></td>
<td>-4.012E-17 (0.092)</td>
<td>-1.131E-16 (0.101)</td>
<td>-1.711E-17 (0.101)</td>
<td>-1.321E-16 (0.091)</td>
<td>-0.057 (0.254)</td>
<td>-0.492 (0.297)</td>
<td>-0.404 (0.308)</td>
</tr>
<tr>
<td><strong>Social Stress</strong></td>
<td>0.419* (0.093)</td>
<td>0.397* (0.094)</td>
<td>0.404* (0.098)</td>
<td>0.359* (0.097)</td>
<td>0.349* (0.097)</td>
<td>0.349* (0.097)</td>
<td>0.349* (0.097)</td>
</tr>
<tr>
<td><strong>Discrimination</strong></td>
<td>0.288* (0.106)</td>
<td>0.235* (0.100)</td>
<td>0.233* (0.101)</td>
<td>0.240* (0.097)</td>
<td>0.267* (0.100)</td>
<td>0.267* (0.100)</td>
<td>0.267* (0.100)</td>
</tr>
<tr>
<td><strong>Internalized Homophobia</strong></td>
<td>0.078 (0.102)</td>
<td>-0.039 (0.094)</td>
<td>-0.031 (0.100)</td>
<td>-0.039 (0.095)</td>
<td>-0.045 (0.096)</td>
<td>0.003 (0.055)</td>
<td>0.003 (0.055)</td>
</tr>
<tr>
<td><strong>Coming Out Queer</strong></td>
<td></td>
<td>0.014 (0.058)</td>
<td>0.006 (0.055)</td>
<td>0.006 (0.055)</td>
<td>0.003 (0.055)</td>
<td>0.003 (0.055)</td>
<td>0.003 (0.055)</td>
</tr>
<tr>
<td><strong>Internalized Mad Phobia</strong></td>
<td></td>
<td></td>
<td>0.288* (0.092)</td>
<td>0.292* (0.092)</td>
<td>0.292* (0.092)</td>
<td>0.292* (0.092)</td>
<td>0.292* (0.092)</td>
</tr>
<tr>
<td><strong>Coming Out with a Mental Illness</strong></td>
<td></td>
<td></td>
<td>0.128* (0.059)</td>
<td>0.122* (0.059)</td>
<td>0.122* (0.059)</td>
<td>0.122* (0.059)</td>
<td>0.122* (0.059)</td>
</tr>
<tr>
<td><strong>Nonwhite</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>R²</td>
<td>0.176</td>
<td>0.071</td>
<td>0.006</td>
<td>0.221</td>
<td>0.222</td>
<td>0.324</td>
<td>0.332</td>
</tr>
</tbody>
</table>

Reference: White
*+p<0.05
+p<0.1

Overall, the minority stress model did not really work on my sample, as social stress was
the only of the three variables that was significant across my two outcomes. Discrimination was
significant for psychological distress, but not for quality of life. The variables I added to the
minority stress model, coming out and internalized mad-phobia did not seem to make much of a
difference to the model, but I suspect that is because my sample was so small. Future research
should look at people who are queer and experience mental illness to see how the minority stress
model operates, particularly with coming out and internalized mad-phobia.
6 DISCUSSION

This dissertation aimed to answer two major research questions. First, following the minority stress model, how does internalized stigma, stressors, and discrimination affect quality of life and psychological distress among those who are queer and diagnosed with a mental illness? Secondly, I ask does the coming-out process, both in terms of queerness and mental health, mediate the process between the minority stress model (internalized homophobia, stressors, and discrimination) and quality of life/psychological distress outcomes? To answer these two questions, I developed a broad-topic survey to collect the data on my two health outcomes, quality of life and psychological distress. I used Meyer’s (1995) minority stress model to better understand these health outcomes. I extended the minority stress model by adding coming out, as queer and with a mental illness, along with stigma, internalized mad-phobia.

There were several limitations to my dissertation. The first being the use of the word “mad.” I decided to use the word “mad” as a reclamation of the slur, for this dissertation to be an activist project, however, many gatekeepers, and potential participants, were offended by this word, which harmed data collection efforts. In the final write up of my dissertation, I decided to use the word mad only when referring to internalized mad-phobia. I decided to use this term because I am struggling to find a better term and so I am using it now for brevity, but hopefully by the time I publish I can think of a better term. Another limitation of my dissertation was the length of the survey; the survey took around 30 minutes to complete, and I lost many participants because they did not complete the entire survey. In the future, it would better to reduce the length of the survey to 10-15 minutes.

A third limitation was that my population was hard to reach. They are a hidden population because queerness and mental illness are not necessarily visible characteristics. Also,
having both of these identities is a limited percentage of the general population, thus making them even harder to reach. I did a majority of my recruiting online, and some in-person, but maybe I should have reconsidered my recruiting tactics. And lastly, given that my population was hard to reach, my sample size ended up being smaller than desired. I ended up with a usable sample size of 98. Given the smallness and the homogenous nature of the sample (lack of variability), a lack of significance of the minority stress theory variables is likely due to methodological reasons. Again, I think my recruiting tactics should be reevaluated in the future.

Next, I want to discuss my findings in comparison to previous literature. Yazmin Meza Lazaro and Guadalupe A. Bacio (2021) used the minority stress model to understand the mental health of a doubled stigmatized population: transgendered and Latinas. They conducted a secondary analysis of Latina participants with a sample size of 1,363. They collected data from the 2015 U.S. Transgender Survey. My dissertation is similar because I also have two minority statuses. They used coming out to family as a resilience factor, similar to me, but I also included coming out to friends and work. They looked at mental health outcomes, such as distress, substance abuse, and suicidality. They found that being out to family (.38 times, SE = .14, p = .008, 95% CI [.19, .77]) and having supportive families (.39 times, SE = .12, p = .002, 95% CI [.21, .71]) mitigated psychological distress (2021, p. 5). My dissertation found, for my sample, that coming out in terms of sexuality and mental illness led to experiencing more psychological distress. I am not sure why our studies had different findings, and this would be a good area for future research.

Shepler et al. (Shepler et al. 2021) recruited 93 gay and bisexual men to better understand their relationship satisfaction using the minority stress theory. Using factor analysis, they found four variables (identity concealment, uncertainty, centrality, and affirmation) \( F(6, 86) = 9.42, p \)
≤ .001, R² = .40) that explained 40% of the variance of relationship satisfaction (2021, p. 296, 302). “Concealment motivation (β = −.20, p = .029), identity uncertainty (β = −.44, p = .003, and identity centrality (β = −.33, p = .003) were inversely and significantly predictive of relationship satisfaction, whereas identity affirmation (β = .47, p ≤ .001) was positively and significantly predictive of relationship satisfaction” (2021, p. 302). My dissertation did not look at relationship satisfaction, but instead quality of life and psychological distress. Some could argue that relationship satisfaction is related to quality of life and psychological distress. While this study had a different outcome than mine, it is important to see that the minority stress theory can work for multiple outcomes.

My dissertation had similarities and differences to the current literature using the minority stress model. Like Yazmin Meza Lazaro and Guadalupe A. Bacio (2021), I had a double-stigmatized sample. Shepler et. al (2021) did not have a double-stigmatized sample. I wonder if the minority stress model works only on one stigmatized identity or if it can handle multiple stigmatized identities? More research on this is needed. Meza Lazaro and Bacio (2021) used psychological distress as an outcome, similar to me; we both used the Kessler 6 to address psychological distress. Shepler et. al (2021) looked at relationship satisfaction as an outcome, which I did not. They used the Lesbian, Gay, Bisexual Identity Scale (LGBIS) and the Relationship Assessment Scale (RAS). Both scales are valid and reliable, looking at different aspects of relationship satisfaction. My other outcome was quality of life, which I used the Quality of Life Scale (Burckhardt et al. 2003; Flanagan 1978). This scale was way more complicated than the scales Shepler used and in the future another quality of life scale should be used. Meza Lazaro found that coming out to families mitigated psychological distress, while I found, with my sample, coming out led to more psychological distress. More research should be
done on psychological distress and the minority stress model to figure out which direction the association is.

Even with my limitations, I was able to contribute to the minority stress model. First, I created a new scale, Internalized Mad-Phobia, that replicates items from the Internalized Homophobia Scale, focusing the questions on mental health. Since my participants all had a mental illness, it made sense to add this extension onto the minority stress model. The minority stress model includes internalized homophobia, so it made logical sense to look for internalized stigma around mental illness as well. Second, I looked at the coming out process, which is discussed in relation to the minority stress model but is not included as a part of it. I created a composite scale asking participants about coming out to family, friends, and work, for both queerness and mental illness. Both of these, internalized mad-phobia and coming out, somewhat improved the minority stress model.

My dissertation had three main takeaways. The first is that my sample suffered more from internalized mad-phobia than internalized homophobia. The queer community has done a lot to mitigate the effects of internalized homophobia, such as having a coming out day, using coming out narratives, and having pride month and events (Anon 2024; Human Rights Campaign n.d.; Library of Congress n.d.). By having more visibility, this creates more acceptance, thus limiting the negative messages about being queer thus improving internalized homophobia. On the other hand, internalized mad-phobia was more present in my sample. We do know somethings about internalized stigma around mental illness, particularly the “Internalized Stigma of Mental Health Inventory” (ISMI) (Boyd et al. 2014). The ISMI is reliable and valid across nations and higher scores indicate higher depression, lower self-esteem, and more severe mental
health symptoms. In the future this scale could be used to better understand internalized stigma around mental illness.

Erving Goffman (1963) wrote about three types of stigmas, (1) “physical deformities” (2) “blemishes of individual character” and (3) “tribal” (p. 4). “Blemishes of individual character” include homosexuality and mental illness. Goffman described stigma as the shame one feels for not meeting other’s standards and discussed how many individuals try to conceal their blemishes from others. This is interesting, but Goffman does not discuss how this stigma is internalized.

Meyer’s (1995) minority stress theory has internalized homophobia as a component of the model. “Internalized homophobia refers to the direction of societal negative attitudes toward the self” (1995, p. 40). Meyer described internalized homophobia as a process of learning about one’s homosexuality and questioning one’s heterosexuality, thus placing a label on themselves. This label is usually negative, as it stems from society’s understanding of homosexuality, a deviant identity. Meyer assumed that all gay people apply negative attitudes towards themselves and thus this impacts their overall mental health and well-being. However, in my dissertation, not many participants experienced internalized homophobia, but experienced more internalized mad-phobia. Based on my findings, internalized mad-phobia was not associated with quality of life or psychological distress. At least for my sample, it seems as if internalized stigma is not really associated these health outcomes or contributes to the minority stress model. It may well be that internalized stigma is no longer a relevant issue or it may be that those willing to take a survey are more confident in their identities.

Secondly, fewer participants came out or disclosed their mental illness compared to coming out as queer. Like I mentioned above, the queer community has done a lot to make queerness visible and accepted, making it easier for individuals to come out as queer. While the
mental health community has not done as much to combat stigma around coming out with a mental illness (NAMI n.d.). There is not a disclosure day or month for mental illness, which might actually be helpful. There is also not a pride day or month for mental health, which could also be helpful. Creating more visibility around mental illness could reduce stigma and thus make disclosure easier and less risky.

Diana Fuss (1991) and Judith Butler (1991) are both critical of the notion of coming out as queer. Fuss discussed the inside/outside which creates a binary between heterosexuality and homosexuality. Butler discussed the performance of gender and sexuality, where the closet and coming out is laden with value. While coming out can be criticized, it can still be an important aspect of queerness to individuals. Capturing coming out in survey can be a difficult feat, and I tried to make my coming out variable not a yes/no dichotomy. My coming out variable is a level of outness, accounting for two levels of family outness, two levels of friendship outness, and two levels of work outness; outness is on a scale of 0 to 6, with 0 being not out in any capacity, and 6 being out in all capacities. While this may not be a perfect solution to capturing coming out in a survey, at least it does not assume a yes/no binary. Ultimately, my sample was small and there was no association between coming out and quality of life. Maybe the reason is that coming out is not an important aspect of quality of life, like the critics are suggesting. The only way to get at the why is to do more qualitative work around this issue.

Lastly, of the minority stress theory constructs, only social stress significantly impacts both quality of life and psychological distress. This would suggest that social stress, compared to discrimination and internalized stigma, is more overwhelming for doubly stigmatized participants or perhaps, for participants with diagnosed mental illness. Remember that social stress includes the following items: (1) You have to go to social events alone and you don’t want
to, (2) You don’t have enough friends, and (3) You don’t have time for your favorite leisure time activities. So doing things alone, not having friends, or time for fun, leads to greater stress, which in turn, is associated with worse quality of life and more psychological distress.

My outcomes, quality of life and psychological distress, are health related. I could not do an outcome on mental health, since my sample already has a mental illness diagnosis and that would be tautological. Quality of life is measuring life satisfaction and well-being, while psychological distress is measuring suffering. Stress is associated with quality of life and psychological distress in a negative way, meaning worse quality of life and more psychological distress. Discrimination is not associated with quality of life, but is with psychological distress, meaning more psychological distress. Internalized homophobia is associated with quality of life, but not with psychological distress. Internalized mad-phobia is not associated with either quality of life or psychological distress. Coming out as queer and mentally ill are not associated with quality of life or psychological distress. It is interesting that some of my variables were associated with one outcome and not the other. I previously thought that quality of life and psychological distress were in opposition to one another, but I have reconsidered that stance.

How are quality of life and psychological distress related?

My dissertation had important findings, as the minority stress model did not work well with my sample. Previous literature has shown that the minority stress model can work with one stigmatized identity, and possibly two, but even though I had two stigmatized identities (queer and mental illness), only one component, social stress, was significant across the outcomes. Why was discrimination only significant for psychological distress and not quality of life? Why was internalized homophobia significant for quality of life but not psychological distress? Then, what I added to the model was theoretically sound, but did not result in much. Internalized mad-
phobia and coming out were not associated with either outcome. Why? Maybe my sample was too small or the outcomes were not sound or maybe what I added did not actually pertain to my sample. All of these questions could be answered in future research.

For this study, I focused on social aspects of quality of life as well as social aspects of coming out. It is possible that limiting the study to social engagement negatively impacted my study’s ability to test the minority stress theory. Future research may want to explore these issues in-depth to better understand these processes of what the survey questions were asking. For example, when it comes to coming out, what factors play a role in deciding to come out to family, friends, and work? Are these even the most appropriate arenas? My survey could not capture this data, but an interview could. Second, it would be helpful to rephrase the word “mad” into something that is less offensive. This would have helped me get access to more gatekeepers and participants. Third, when it comes to coming out, more questions could have been asked about disclosure. Fourth, when it comes to internalized homophobia and mad-phobia, it would be useful to better understand how they interact. For example, is one more dominant than the other, are they equal and additive or multiplicative, or does one influence the other? Black women scholars (Collins 2000; Crenshaw 1988, 1991) have discussed double consciousness, intersectionality and critical race theory, which may help inform this conversation of internalized stigma.

In my introduction, I stated that I identify as a bisexual woman who has also been diagnosed with bipolar disorder. To me, the process of accepting these identities were similar, but that does not seem to be the case for my sample. I was comparing queerness and mental illness as apples to apples, while in reality, they may operate more like a comparison of apples to oranges. Both are still fruits, but different fruits, with different processes. For queerness, this is
an identity that one places on themselves, by saying they are queer. However, mental illness is a label placed on the individual by a doctor (Scheff 1974, 2017). Queerness is a process that one most likely will come to terms with and accept, while a mental illness diagnosis is not necessarily ever accepted or welcomed (Kravetz, Faust, and David 2000; Soroka et al. 2022). For me, being diagnosed explained a lot of what was going on in my life, but for others, they may have gone through years of misdiagnosis or no diagnosis (not being validated) and this experience can be overwhelming and traumatic (Estroff and Gold 1984; McKenzie 1999). Overall, my dissertation sets up the identities of queerness and mental illness as parallel, but they seem to be more layered.

Saying these experiences are layered means that they do not happen at the same time or in the same way. It is likely that an individual will come to learn about their queerness before their mental health. What I mean by this is queer people in the U.S. grow up in a heteronormative world, feeling like they are outsiders (Rich 1980; Warner 1991). This experience can start at a very young age. Also, in addition to queerness and mental health being layered, they may be coupled as well. Because queer people live in a heteronormative world, they do struggle with accepting themselves, which can lead to adverse mental health outcomes, such as anxiety, depression, and panic attacks (Borgogna et al. 2019). This is consistent with my findings, as these three mental illnesses were the most experienced in my sample. So in one way, coming out as queer and with a mental illness is layered, but also coupled.

My dissertation does not account for the layered experience of coming out, as my dissertation assumes parallel processes. I set up coming out as queer and with a mental illness as the same 0-6 outness scale with friends, family, and work, but in reality, coming out is not this tidy and neat. We have to consider the picture that is painted by society about queerness and
mental illness. On the one hand, queerness, over the past decade, has been more accepted and even celebrated in the public eye, with coming out days and pride events (Human Rights Campaign n.d.; Library of Congress n.d.). On the other hand, mental illness in the public eye is not seen as a good thing, but rather a stigmatized thing. For example, we see school shooters in court rooms pleading insanity. These public images are completely different and should be accounted for.

This leads into more of a discussion about internalized stigma. Goffman (1963) sets the stage when discussing stigma, but Link and Phelan (2001) extend that conceptualization to argue that stigma is: “the co-occurrence of its components–labeling, stereotyping, separation, status loss, and discrimination–and further indicate that for stigmatization to occur, power must be exercised” (p. 363). This labeling occurs for those diagnosed with a mental illness, and thus many of these people experience internalized stigma about their diagnosis. This process is what I am talking about when I refer to internalized mad-phobia, the only difference is that I am using the word “mad” which seems to trigger an emotional response. I think more qualitative work needs to be done around internalized mad-phobia to truly understand where it stems from.

Overall, my dissertation adds an interesting conversation about the minority stress model and how coming out and internalized stigma play a role. However, my dissertation does not flesh out these processes in an in-depth way. More qualitative research should be done, even a mixed-methods study, to better flesh out these concepts. Since this dissertation was purely quantitative, it makes these concepts appear static and rigid, rather than dynamic and layered. In the future, I recommend interviews to ask this population more about timing of coming out, how queerness and mental illness are apples and oranges, how they experience internalized stigma, and how these processes are layered.
Overall, rephrasing the word “mad” and changing my recruitment tactics could have made my sample size bigger. There are several suggestions for future research, like interviews, that could fill in the gaps of my research. My three takeaways were somewhat surprising, but overall helpful in better understanding that mental illness stigma and internalized stigma need to be addressed. Maybe a mental illness coming out day or policies around better access to mental health services are needed.
7 CONCLUSION

In conclusion, I looked at quality of life and psychological distress of my sample of 98 participants who are queer and experience mental illness. I used the minority stress model to understand how stress, discrimination, and internalized homophobia play a role in quality of life and psychological distress. I added new variables to the minority stress model, including coming out (as queer and with a mental illness), as well as internalized mad-phobia. I argue that (1) my sample suffers more from internalized mad-phobia than internalized homophobia (2) fewer came out or disclosed their mental illness compared to coming out as queer and (3) stress has the most significant impact on quality of life and psychological distress. Overall, more research needs to be done to better understand how coming out and internalized stigmas influence the minority stress model, as well as how two stigmatized identities operate under the minority stress model.
REFERENCES


Thank you for your interest in my survey! I am a graduate student at Georgia State University, and I appreciate your time to click on my link! In this survey, I will be asking some confidential questions about coming out, relationships, sex, and your health status. Please know your answers will be anonymous and you can skip any question. Thank you for your time!
Purpose: You are invited to participate in a research survey. The purpose of this study is to understand how people who identify as queer and experience mental illness navigate life. We randomly selected individuals who are likely to be queer and mentally ill to take the survey. As a community member you can provide information that can help improve the lives of others in the community. A total of 300 participants will be recruited for this survey. Participation will take around 30 minutes of your time.

Procedures: If you decide to participate you will fill out the online survey about various aspects of your life of being queer and experiencing mental illness. After you fill out the survey, you will be asked to share the survey with someone you know. You can share the URL link or the QR code.

Risks: In this study, you will not have any more risks than you would in a normal day of life. You may skip any question you don’t wish to answer, and you can stop taking the survey at any time.

Benefits: Being in this study may or may not benefit you. Overall, we hope to gain knowledge about the quality of life of queer and mentally ill individuals. In the long run this will help others in the community understand life stressors.

Voluntary Participation and Withdrawal: Participation is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right skip questions you don’t want to answer or you can drop out at any time. Feel free to send us a partially completed survey; it’s entirely up to you.

Confidentiality: We will keep your records private to the extent allowed by law. Only Jennie Lambert and Erin Ruel will have access to the information you provide.
Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP)). We are not collecting names or other identifying information, therefore you will be anonymous.

Contact Persons: Contact Jennie Lambert or Erin Ruel at 770-282-4572 if you have questions, concerns, or complaints about this study.

If you are willing to volunteer for this research, please continue to the survey.

Yes, I volunteer to participate

No thank you

Prescreening Questions:

1. Have you ever been diagnosed with a mental illness by a medical professional? Y/N (MUST ANSWER YES TO MOVE FORWARD)

2. Do you identify as exclusively heterosexual? Y/N (MUST ANSWER NO TO MOVE FORWARD)

3. What is your age? (ENTER NUMBER) (MUST BE OVER 18 TO CONTINUE) (Make sure in Qualtrics, they can only enter numbers, not text)

Coming Out as Queer Relationships

First, I want to ask you a couple of questions about being out as queer in your relationships.

1. Are you out as queer to anyone in your family (i.e. told them, show them, on social media, etc.)? Answer YES to move forward. NO stops here.
   a. Yes
   b. No

2. Are you out as queer to everyone in your family? Answer NO to move forward. YES stops here.
   a. Yes
b. No

3. Are you out as queer to your parents?
   a. Out to Both
   b. Out to One
   c. Not Out
   d. N/A

4. Are you out as queer to your siblings?
   a. Out to All
   b. Out to a Few
   c. Out to One
   d. Not Out
   e. N/A

5. Are you out as queer to your extended family?
   a. Out to All
   b. Out to a Few
   c. Out to One
   d. Not Out
   e. N/A

6. Are you out as queer to any of your friends? YES moves forward. NO stops here.
   a. Yes
   b. No
   c. N/A

7. Are you out as queer to all of your friends? NO moves forward. YES stops here.
   a. Yes
   b. No

---

**Relationships (Life Course and Health Research Center 2006) p. 51-55**

Now I would like to know something about your present relationship with your family (other than your partner/boyfriend/girlfriend). For each of the statements, please use the scale shown to tell me the number of the category that best describes how true it is for you. In answering these questions think of those family members that you see or talk to most often.

(Not At All True, Somewhat True, Moderately True, Very True)

8. You feel close to your family.
9. You have family who would always take the time to talk over your problems, should you want.
10. Your family often lets you know that they think you are a worthwhile person.
11. You often feel that your family makes too many demands on you.
12. Your family is always pointing out mistakes you have made.
13. Your family is always telling you what to do and how to act.
14. When you are with your family, you feel completely able to relax and be yourself.
15. No matter what happens you know that your family will always be there for you should you need them.
16. You know that your family has confidence in you.
17. Your family is often critical of you.
18. You feel that your family really cares about you.
19. Sometimes you are not sure if you can completely rely on your family.
20. You often feel really appreciated by your family.
21. You sometimes feel that your family expects more from you than they are willing to give.
22. Your family often treats you like a child.
23. Your family often underestimates your abilities.

Break here

24. You feel very close to your friends.
25. You have friends who would always take the time to talk over your problems, should you want.
26. Your friends often lets you know that they think you are a worthwhile person.
27. When you are with your friends, you feel completely able to relax and be yourself.
28. No matter what happens you know that your friends will always be there for you should you need them.
29. You know your friends have confidence in you.
30. You feel that your friends really care about you.
31. You often feel really appreciated by your friends.

**Coming Out as Queer Work**

Next, I would like to ask you about being out as queer in your work/student life.

32. What is your current employment status?
   a. Working Full Time
   b. Working Part Time
   c. Unemployed and Looking for Work
   d. Unemployed and Not Looking for Work
   e. Retired
   f. Homemaker
   g. Student
   h. Other, please specify

33. Are you self-employed?
   a. Yes
   b. No

34. Do you work alone?
35. Are you out as queer to anyone at your current job? Answer YES to move forward. NO stops here.
   a. Yes
   b. No

36. Are you out as queer to everyone at your current job? Answer NO to move forward. YES stops here.
   a. Yes
   b. No

37. Are you out as queer to your boss?
   a. All
   b. Few
   c. One
   d. Not Out
   e. N/A

38. Are you out as queer to your coworkers?
   a. Out to All
   b. Out to a Few
   a. Out to One
   b. Not Out
   c. N/A

39. Are you out as queer to people who you don’t directly work with at your current job?
   a. Out to All
   b. Out to a Few
   c. Out to One
   d. Not Out
   e. N/A

40. You make decisions on your own.
41. You control the speed at which you work.
42. Your supervisor decides what you do and how you do it.
43. You have a lot of freedom to decide how to do your work.
44. You have more work than you can handle.
45. You have a lot of noise or a lot of dirt on the job.
46. You are in danger of injury or illness because of the job.
47. You do the same thing over and over again.
48. Do you work alone? YES stops here. NO moves forward.
   a. Yes
   b. No
   Now I would like to know something about your relationship with the people you work with. For each of the statements I read to you please use the scale shown tell me the number of the category that best describes your experience.

   (Not At All True, Somewhat True, Moderately True, Very True)

49. I feel close to the people at work.
50. I have people at work who would always take the time to talk over my problems should I want to.
51. I often feel really appreciated by the people I work with.

**Coming Out as Queer Healthcare**

Now I would like to ask you about coming out as queer in the healthcare setting.

52. Do you have a healthcare provider? YES moves forward. NO stops here.
   a. Yes
   b. No

53. Are you out as queer to any healthcare provider? YES moves forward. NO stops here.
   a. Yes
   b. No

54. Are you out as queer to all your healthcare providers? NO moves forward. YES stops here.
   a. Yes
   b. No

55. Which healthcare providers are you out to as queer?
   a. Primary Care Doctor
   b. Nurse
   c. Specialist
   d. Psychologist
   e. Psychiatrist
   f. Therapist
   g. Other, Please specify

**Healthcare Providers** (Life Course and Health Research Center 2006) p. 45
Now I would like to ask you how you feel about the people who provide treatment and about treatment itself. For each statement use the scale to describe how strongly you agree or disagree with each statement.

56. Most of the people who treat me take a personal interest in how I’m doing.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

57. The doctors who treat me don’t understand how I really feel.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

58. Most people who provide treatment would prefer to spend their time with other kinds of patients.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

59. I worry that my doctor is being prevented from telling me the full range of options for my treatment.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

60. I worry that I will be denied the treatment or services I need.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

61. I worry that my doctor will put cost considerations above the care I need.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
62. Doctors and other professionals don’t teach me the things I really need to know to deal with my condition.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

63. Treatment available for my condition is often more trouble than it is worth.
   a. Strongly Agree
   b. Mildly Agree
   c. Neither Agree or Disagree
   d. Mildly Disagree
   e. Strongly Disagree

**Health**

*Now, I am going to ask you a series of questions about your health.*

64. In the past thirty days, compared to someone your age, would you say that in general your health is…
   a. Poor
   b. Fair
   c. Good
   d. Very Good
   e. Excellent

65. Do you currently have health insurance?
   a. Yes
   b. No

66. In the last year, have you had health insurance?
   a. Yes
   b. No

67. In the last year, have you been covered by Medicare or Medicaid?
   a. Yes
   b. No

68. Have you ever been covered by Medicare or Medicaid?
   a. Yes
   b. No

69. Have you ever been tested for HIV?
   a. Yes
   b. No

70. What is your HIV status?
   a. HIV positive
   b. HIV negative
   c. I don’t know
71. In the last year, have you had an STD or STI?
   a. Yes
   b. No
   c. I don’t know

*Mental Health* (Safren, Berg, and Mimiaga 2000; Wright et al. 2019)

*Next, I am going to ask you a series of questions about your mental health.*

72. Compared to someone your age, would you say, in the last thirty days, in general your mental health is…
   a. Poor
   b. Fair
   c. Good
   d. Very Good
   e. Excellent

73. Please select all that you have been diagnosed with by a medical professional:
   a. Depression
   b. Anxiety
   c. Bipolar Disorder
   d. Personality Disorder
   e. Obsessive Compulsive Disorder
   f. Attention Deficit Hyperactivity Disorder
   g. Schizophrenia
   h. Autism
   i. Post Traumatic Stress Disorder
   j. Eating Disorder
   k. Substance Abuse
   l. Panic Attacks
   m. Something Else (Please Specify):_________

74. When were you first diagnosed? Please Enter date, MM/DD/YYYY:__________

75. Are you stable with your mental illness?
   a. Yes
   b. No

76. In the past thirty days, about how often did you feel nervous?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
   e. All of the time

77. In the past thirty days, about how often did you feel hopeless?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
e. All of the time

78. In the past thirty days, about how often did you feel restless or fidgety?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
   e. All of the time

79. In the past thirty days, about how often did you feel so depressed that nothing could cheer you up?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
   e. All of the time

80. In the past thirty days, about how often did you feel that everything was an effort?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
   e. All of the time

81. In the past thirty days, about how often did you feel worthless?
   a. None of the time
   b. A little of the time
   c. Some of the time
   d. Most of the time
   e. All of the time

82. Altogether, how much did these feelings interfere with your life or activities?
   a. A lot
   b. Some
   c. A little
   d. Not at all

83. In the past year, have you felt suicidal?
   a. Yes
   b. No

84. Have you ever attempted suicide?
   a. Yes, Once
   b. Yes, Multiple Times
   c. No

85. Who do you go to for your mental illness healthcare? Select all that apply.
   a. Psychiatrist
   b. Therapist/Counselor
   c. Group Therapy
   d. Outpatient Care
   e. Inpatient Care
   f. N/A
86. In the last year, have you seen any of the following healthcare providers? Select all that apply.
   a. Psychiatrist
   b. Therapist/Counselor
   c. Group Therapy
   d. Outpatient Care
   e. Inpatient Care
   f. N/A

87. Which of the following medications are you currently taking for your mental health? Select all that apply.
   a. None
   b. Anti-depressant
   c. Anti-anxiety
   d. Mood stabilizer
   e. Anti-psychotic
   f. Other, Please specify

88. How has your mood been lately?
   a. Poor
   b. Fair
   c. Good
   d. Excellent

89. Please answer the following statement, “I am fine managing my dual identities of being queer/questioning and mentally ill.”
   a. Strongly Agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly Disagree

90. How do you manage the dual identities of being mentally ill and queer? _____________

**Coming Out as Mad Healthcare**

Now, I am going to ask you a series of questions about coming out as mentally ill in different contexts.

91. Are you out as mentally ill to any healthcare provider? YES moves forward. NO stops here.
   c. Yes
   d. No

92. Are you out as mentally ill to all your healthcare providers? NO moves forward. YES stops here.
   c. Yes
93. Which healthcare providers are you out to as mentally ill?
   a. All
   b. Most
   c. Half
   d. Some
   e. None

**Coming Out as Mad Relationships**

94. Are you out as mentally ill to anyone in your family? Answer YES to move forward. NO stops here.
   a. Yes
   b. No

95. Are you out as mentally ill to everyone in your family? Answer NO to move forward. YES stops here.
   a. Yes
   b. No

96. Are you out as mentally ill to your parents?
   a. Out to Both
   b. Out to One
   c. Not Out
   d. N/A

97. Are you out as mentally ill to your siblings?
   a. Out to All
   b. Out to a Few
   c. Out to One
   d. Not Out
   e. N/A

98. Are you out as mentally ill to your extended family?
   a. Out to All
   b. Out to a Few
   c. Out to One
   d. Not Out
   e. N/A

99. Is there a family member with whom you can really share your very private feelings and concerns about your mental health?
   a. Yes
   b. No
   c. N/A

100. Are you out as mentally ill to any of your friends? YES moves forward. NO stops here.
    a. Yes
    b. No
101. Are you out as mentally ill to all of your friends? NO moves forward. YES stops here.
   a. Yes
   b. No

**Coming Out as Mad Work**

102. Are you out as mentally ill to anyone at your current job? Answer YES to move forward. NO stops here.
   c. Yes
   d. No
103. Are you out as mentally ill to everyone at your current job? Answer NO to move forward. YES stops here.
   c. Yes
   d. No
104. Are you out as mentally ill to your boss?
   f. All
   g. Few
   h. Some
   i. None
   j. N/A
105. Are you out as mentally ill to your coworkers?
   c. Out to All
   d. Out to a Few
   d. Out to One
   e. Not Out
   f. N/A
106. Are you out as mentally ill to people who you do not directly work with at your current job?
   f. Out to All
   g. Out to a Few
   h. Out to One
   i. Not Out
   j. N/A

**Internalized Mad-phobia** I created this scale as an adaption from the Internalized Homophobia Scale.

*Here are some statements about attitudes. Strongly agree or disagree to the following statements.*

107. I have tried to stop being mentally ill.
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

108. If someone offered me the chance to be completely mentally healthy, I would accept the chance.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

109. I wish I weren't mentally ill.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

110. I feel that being mentally ill is a personal shortcoming for me.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

111. I would like to get professional help in order to change my mental illness.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

112. I often feel it best to avoid personal or social involvement with other mentally ill people.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

113. I feel alienated from myself because of being mentally ill.  
a. Strongly Disagree  
b. Disagree  
c. Neutral  
d. Agree  
e. Strongly Agree  

Demographics
Now I am going to ask you some demographic questions about yourself.

114. In the last year, what were your earnings?
   a. $0-$20,000
   b. $20,001-$40,000
   c. $40,001-$60,000
   d. $60,001-$80,000
   e. $80,001-100,000
   f. $100,000+

115. How many years of education have you had thus far?
   a. Some High School
   b. High School
   c. Some College
   d. Associate’s Degree
   e. Bachelor’s Degree
   f. Some Graduate School
   g. Master’s Degree
   h. Doctorate

116. What race do you consider yourself to be? Select One.
   a. White
   b. Black/African American
   c. Asian
   d. Native American/Alaskan Native
   e. Pacific Islander
   f. Hispanic
   g. Latino
   h. Multiracial
   i. Something Else (Please Specify) _______

117. What sex were you assigned at birth?
   a. Male
   b. Female
   c. Intersex
   d. Something Else (Please Specify) _______

118. Select one. I consider myself to be…
   a. Man/Male
   b. Woman/Female
   c. Part-time in Both
   d. Gender Queer
   e. Transgender Man
   f. Transgender Woman
   g. Transgender
   h. Intersex
   i. Gender Non-conforming
   j. Non-Binary
   k. Something Else (Please Specify) _______

119. Check one that you identify with:
a. Straight
b. Lesbian
c. Gay
d. Bisexual
e. Pansexual
f. Something Else (Please Specify): _________

120. People are different in their sexual attraction to other people. In general, which of the following best describes your feelings?
a. Only attracted to females
b. Mostly attracted to females
c. Equally attracted to females and males
d. Mostly attracted to males
e. Only attracted to males
f. Gender does not matter
g. Not sure
h. Something Else (Please Specify): _________

Internalized Homophobia (Martin and Dean 1992) I have adapted this survey to use a scale of Strongly Disagree to Strongly Agree instead of Yes/No to get at more variation. Changing the range of responses will also be more consistent with how I ask other survey questions.

Here are some statements about attitudes. Strongly agree or disagree to the following statements.

121. I have tried to stop being attracted to the same sex in general.
   f. Strongly Disagree
g. Disagree
h. Neutral
i. Agree
j. Strongly Agree

122. If someone offered me the chance to be completely heterosexual, I would accept the chance.
   f. Strongly Disagree
g. Disagree
h. Neutral
i. Agree
j. Strongly Agree

123. I wish I weren't queer.
f. Strongly Disagree

124. I feel that being queer is a personal shortcoming for me.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

125. I would like to get professional help in order to change my sexual orientation from queer to straight.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

126. I have tried to become more sexually attracted to the opposite sex.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

127. I often feel it best to avoid personal or social involvement with other queer people.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

128. I feel alienated from myself because of being queer.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

129. I wish that I could develop more erotic feelings about the opposite sex.
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
Stressors (Life Course and Health Research Center 2006)

The following section describes some stressors that sometimes come up in people’s lives.

Please select whether these things are not true, somewhat true, or very true for you at this time.

General p. 143

130. You’re trying to take on too many things at once.
131. There is too much pressure put on you to be like other people.
132. Too much is expected of you by others.
133. People expect you to do things faster than you are able.
134. There is seldom enough time to complete the things you need to do.

Employed p. 144

135. Your supervisor is always watching what you do at work.
136. You want to change jobs but don’t feel you can.
137. Your job often leaves you feeling both mentally and physically tired.
138. You don’t get paid enough for the job you have.
139. Your work is boring and repetitive.
140. You are looking for a job and can’t find the one you want.

141. Are you in a relationship or dating anyone right now? YES move forward. NO stops here.
    a. Yes
    b. No

If partnered... p. 145

142. You have a lot of conflict with your partner.
143. Your partner doesn’t understand you.
144. Your relationship restricts your freedom.
145. Your partner expects too much of you.
146. You don’t get what you deserve out of your relationship.
147. Your partner doesn’t show enough affection.
148. Your partner is not committed enough to your relationship.
149. Your sexual needs are not fulfilled by this relationship.

**Never married/single only p. 146**

150. You wonder whether you will ever get married.
151. You find it is too difficult to find someone compatible with you.

**Ever divorced or separated p. 146**

152. You have a lot of conflict with your ex-spouse.
153. You don’t see your children from a former marriage as much as you would like.

**Social Life and Recreation p. 148**

154. You have to go to social events alone and you don’t want to.
155. You don’t have enough friends.
156. You don’t have time for your favorite leisure time activities.

**Discrimination (Life Course and Health Research Center 2006) p. 109**

*In this next section, we are interested in the treatment you have experienced from other people. Please answer yes or no to the following statements.*

157. For unfair reasons, do you think you have ever not been hired for a job?
158. Have you ever been unfairly treated by the police (e.g. stopped, searcher, questions, physically threatened or abused)?
159. Have you ever been unfairly discouraged by a teacher or advisor from continuing your education?
160. Have you ever been unfairly discouraged by a teacher or advisor from pursuing the job/career you want?
161. For unfair reasons, has a landlord or a realtor ever refused to sell or rent you or your family a house or apartment?
162. For unfair reasons, have neighbors ever made life difficult for you and your family?

*In your day-to-day life, how often have any of the following things happened to you?*

*Answer Almost Always, Often, Sometimes, Rarely, Never.*
163. You are treated with less courtesy than other people.
164. You are treated with less respect than you deserve.
165. You receive worse service than other people at restaurants or stores.
166. People act as if they think you are not smart.
167. People act as if they are afraid of you.
168. People act as if they think you are dishonest.
169. People act as if they are better than you are.
170. You are called names or insulted.
171. You have threatened or harassed.
172. What do you think was the main reason(s) for your experiences? Please tell me all
the reasons you think apply to you.
   a. Your Ethnicity
   b. Your Gender
   c. Your Race
   d. Your Age
   e. Your Religion
   f. Your Personal Appearance
   g. Your Sexual Orientation/Preference
   h. Your Income Level/Social Class
   i. The darkness or lightness of your skin
   j. Your education level
   k. Your Hair Style
   l. Your Accent
   m. Your Disability
   n. Your Mental illness
   o. Other, specify____________

Quality of Life Scale (QOLS) (Flanagan 1982)

Please answer the following with Delighted (0), Pleased (1), Mostly Satisfied (2), Mixed
(3), Mostly Dissatisfied (4), Unhappy (5), Terrible (6)

173. Material comforts home, food, conveniences, financial security
174. Health-being physically fit and vigorous
175. Relationships with parents, siblings and other relatives- communicating, visiting,
   helping
176. Having and rearing children
177. Close relationships with spouse or significant other
178. Close friends
179. Helping and encouraging others, volunteering, giving advice
180. Participating in organizations and public affairs
181. Learning- attending school, improving understanding, getting additional
   knowledge
182. Understanding yourself-knowing your assets and limitations- knowing what life is about
183. Work- job or in home
184. Expressing yourself creatively
185. Socializing- meeting other people, doing things, parties, etc.
186. Reading, listening to music, or observing entertainment
187. Participating in active recreation
188. Independent, doing for yourself

**Having Sex** (Wright et al. 2019)

Please answer the following section about sexual interactions.

189. Have you ever had vaginal, anal, or oral sex?
   a. Yes
   b. No

190. Thinking back over your entire life, with how many people, including men and women, have you had vaginal or anal sex, even if only one time? ___________

191. Have you had sex with anyone in the past year?
   a. Yes
   b. No

192. If yes, please select the gender(s) of sexual partners you have had in the past year:
   a. Men
   b. Women
   c. Trans Men
   d. Trans Women
   e. Non-binary
   f. Something Else (Please Specify):_______

193. Are you legally married?
   a. Yes
   b. No

**Concluding Questions**

194. What is the biggest issue you have faced in terms of your mental health and/or being queer?
Thank you for taking my survey! I appreciate your time! This is really going to help me and others who are queer and mentally ill. Please share the link with a friend if you think they would be interested!