

Does “It Get Better”?: Childhood Bullying and the Positive Mental Health of LGBT Canadians  
in Adulthood

by

Tamara Edkins

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Department of Sociology

University of Manitoba

Winnipeg

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## Abstract

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals belong to one of the most discriminated groups in Canada and abroad. Using minority stress theory, researchers have found that such a climate of homophobia and transphobia has been associated with negative mental health outcomes among LGBTQ individuals. However, despite the presence of campaigns such as the “It Gets Better Project”, few academics have explored whether it does “get better” for LGBTQ people who have experienced anti-LGBTQ prejudice in their youth; and further, few academics have explored whether such individuals who have experienced prejudice can flourish in terms of their positive mental health. Positive mental health explores how individuals can be resilient and thrive within society; it looks at positive feelings people have about themselves, others and society. However, it does not mean an absence of negative mental health outcomes, in that individuals with depression, for example, can also flourish in respect to their positive mental health. The purpose of the current thesis is to extend minority stress theory in order to consider the long-term relationship between childhood bullying and positive mental health among LGBTQ adults. Using a hierarchical ordinary least squares regression model and a sample of LGBTQ education professionals, the current study found that there was a negative long-term relationship between childhood bullying and positive mental health among LGBTQ individuals. Further, disclosing one’s LGBTQ identity, and measures of LGBTQ-inclusion and support were all associated with flourishing levels of positive mental health, although they did not fully mitigate the effects of childhood bullying. The implications of the results were discussed in relation to future practices to reduce homophobia and transphobia within society, and in turn, reduce minority stress and maintain a flourishing state of positive mental health among all LGBTQ members.

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## Chapter 1: Introduction

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals<sup>1</sup> continue to belong to one of the most discriminated and excluded groups in the world. All countries, including Canada, have been involved in historic and more recent pieces of legislation, actions and discourse directed at the exclusion or stigmatization of LGBTQ individuals (e.g. the various responses to the AIDS epidemic). However, despite the history of violence and discrimination against LGBTQ individuals, through social movements and the perseverance of the LGBTQ community and its allies, LGBTQ rights have been recognized through the implementation of policies and legislation in Canada, and in other countries worldwide.

After the Stonewall riots in New York City in 1968, gay and lesbian movements began in both the U.S. and Canada (McLeod, 1996). In Canada, the rise of the gay, lesbian, and eventually bisexual movement helped bring about important legal protections – such as court challenges to have sexual orientation recognized under Section 15 of the *Canadian Charter of Rights and Freedoms* in *Vriend v. Alberta* in 1988 and *Egan v. Canada* in 1995; the amendment of the *Canadian Human Rights Act* in 1996 to include sexual orientation as one of the prohibited grounds of discrimination; and the legalization of same-sex marriage in 2005 (Knecht, 2011). Moreover, while transgender legal protections have been slower to progress federally (Browne, 2015), differential treatment based on gender identity is currently recognized as a form of discrimination within the provincial legislation of Prince Edward Island, Nova Scotia, Newfoundland and Labrador, Northwest Territories, Ontario, Manitoba, and Saskatchewan (Ubelacker, 2015). Notably, on May 17, 2016, the International Day Against Homophobia, Transphobia and Biphobia, the federal government tabled Bill C-16, which would add gender

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<sup>1</sup>The current research recognizes the importance of other ‘queer’ identities such as asexual, genderless, genderqueer, intersex, polyamorous, and numerous other important self-identifiers; however for the purpose of this project, LGBTQ is being used as a way to encapsulate all gender and sexual minority identities.

expression and gender identity to both the Canadian Human Rights Act as means for discrimination, and to the Criminal Code as a means for a hate crime (Lambert, 2016). Such legal protections, and the increased visibility and support of the LGBTQ community has promoted social change, and caused a significant transformation in the Canadian-LGBTQ climate.

Despite the success of LGBTQ rights movements, homophobic and transphobic prejudice still exists within the larger Canadian and international society. The exclusionary, hostile, and discriminatory actions or language directed at LGBTQ individuals have been associated with increased rates of mental health disorders among LGBTQ individuals. However, little to no research has explored the adverse effects of these discriminatory or exclusionary experiences on positive mental health. Positive mental health (commonly referred to as “mental wellbeing”, “wellness” or “psychological wellbeing”) comes from the introduction of the salutogenesis model (or positive sociology) by Aaron Antonovsky, a medical sociologist (Antonovsky, 1996). Antonovsky’s research on positive sociology arose from a study that explored how stress inhibited healthy living and contributed to the growth of disease (as noted in Schueller, 2009, p. 6). Antonovsky developed the concept “sense of coherence”, which he refers to as an individual’s ability to cope with or adapt to everyday life stress (Antonovsky, 1996; Lindström, & Eriksson, 2005).

In response to the large proportion of research focusing on pathology, deviance, or disorders (as noted in Barry, 2001, 2009), using positive health concepts such as sense of coherence, the salutogenic movement began exploring questions such as what makes people want to live, what factors foster resilience or help cope with stress, and ultimately, what promotes productive, optimistic, as well as emotionally, psychologically, and socially thriving



individuals in society (Lindström, & Eriksson, 2005). In other words, the salutogenesis model looks to promote the growth of an area of positive sociology or health research, wherein the focus is on what promotes happiness, healthy living, and the ability to adapt to life challenges and stress. Notably, despite the overlap between the prevention of mental illness and the promotion of positive mental health, both avenues of research are grounded in different goals and values (Barry, 2001). Barry (2001) indicates that the promotion of positive mental health focuses on empowerment and fostering resilience and strength in communities and individuals, (i.e., the competence enhancement model); whereas the prevention of mental illness looks to inhibit the formation of mental health disorders and their risk factors (i.e., a risk reduction model). Using a metaphor employed by Antonovsky to explain the importance of salutogenesis or positive mental health, Langeland and Vinje (2013) write:

All human beings are in a river that is a stream of life, and nobody stays on the shore. It is not enough to promote health by avoiding stress or by building bridges to keep people from falling into the river. Instead, people have to learn to swim. There are forks in the river that can lead to gentle streams or to dangerous rapids and whirlpools. The crucial, salutogenic question is, 'Wherever one is in the stream, what shapes and promotes one's ability to swim well?' (p. 311)

Corey Keyes, through developing the concept of positive mental health, has contributed to the salutogenesis model of health. Positive mental health, drawing on work by Keyes (2007) and the earlier work of Marie Jahoda (1950, 1958), refers to a multidimensional concept comprised of eudaimonic and hedonic wellbeing. Eudaimonic wellbeing refers to emotional wellbeing such as optimism or happiness, whereas hedonic wellbeing refers to positive functioning in society in terms of psychological wellbeing and the ability to contribute or engage with other people in society (i.e., social wellbeing) (Keyes, 2007; Keyes, & Simoes, 2012). In brief, according to Keyes, a holistic conception of positive mental health includes measures of emotional, psychological, and social wellbeing (as discussed in Keyes, 2009).

Further, although the term ‘positive mental health’ suggests a concept of mental health that is always ‘good’ or ‘healthy’, Keyes (2002) conceptualized positive mental health into levels, wherein *languishing* refers to low or depleted levels of positive mental health, *flourishing* refers to high or exceptional levels of positive mental health, and *moderately mentally healthy* refers to a state of positive mental health in between flourishing and languishing. Therefore, Keyes conceptualized positive mental health as not just something beneficial for a person, but something that can be lacking or moderate. Although the definition of positive mental health has been contested and critiqued in the literature (e.g. de Chavez, Backett-Milburn, Parry, & Platt, 2005; Smith, 1959), it has been defined by the World Health Organization (2004) as, “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 10; as cited in Keyes, & Simoes, 2012, p. 2164). The operationalization of positive mental health will be further elaborated on in the theoretical framework section, as well as the methodology section of the current thesis.

Keyes, throughout his research, has asserted and validated the importance of exploring a salutogenic model of mental health. Keyes, going beyond the continuum of mental health suggested by Antonovsky, asserts that there is a dual-continuum of mental illness and mental wellbeing (or positive mental health), wherein an individual can still lead a happy productive life with a mental illness such as depression, and further, an individual without a mental health disorder can still suffer from stress and languishing levels of positive mental health (Keyes, 2002, 2005, 2007). For instance, Keyes (2005) found, among a national sample of American adults, that adults with languishing positive mental health were just as mentally unwell as an individual with a severe mental illness. Most mental health initiatives have focused on reducing

the number of mentally ill people; however, as Keyes (2007) argues, “Curing or eradicating mental illness will not guarantee a mentally healthy population” (p. 95); and further, Keyes (2007) asserts that, “the absence of mental illness is not the presence of mental health” (p. 95).

Therefore, while the majority of research focuses on how prejudice perpetuates mental health disorders among LGBTQ individuals, few researchers have explored such a relationship in regard to positive mental health, which, if at flourishing levels, has been shown to increase the ability to be resilient or to cope with physical and mental health disorders or stress (Dyrbye, et al., 2012; Gable, & Haidt, 2005; Henderson, 2012; Keyes, 2007; Keyes, Satvinder, Dhingra, & Simoes, 2010; Keyes, & Simoes, 2012). For instance, Keyes et al. (2010) explored the relationship between mental illness and positive mental health among a sample of American adults. Keyes et al. (2010) found that individuals reporting languishing levels of positive mental health were 6 times more likely to report a mental illness as their flourishing counterparts, and moderately mentally healthy individuals were 4 times more likely to report a mental illness in comparison. In sum, lower and moderate levels of positive mental health were associated with an increase in the odds of having a mental illness, while higher levels were associated with a decrease in such odds (Keyes, et al., 2010).

In essence, while researchers have focused on how prejudice contributes to the growth of mental illness among LGBTQ individuals, the literature has neglected to consider how such forms of prejudice can promote languishing levels of positive mental health, and inhibit the ability of LGBTQ individuals to be resilient in response to social inequalities and prejudice, as well as inhibit their ability to live a healthy, flourishing life of happiness and gratification. Further, using a similar rationalization as de Chavez, et al. (2005, p. 76), the majority of academics have focused on mental disorder issues among LGTBQ individuals. However,

research has demonstrated that LGBTQ individuals can be resilient and cope in the face of adversity (e.g. Adams, Cahill, & Ackerlind, 2005; DiFulvio, 2011; Kwon, 2013; Scourfield, Roen, & McDermott, 2008). To this end, researchers have neglected an avenue of research that explores how LGBTQ individuals cope with such prejudice in their everyday life. Put another way, what allows LGBTQ individuals who experience discrimination to be resilient or cope, and continue to lead happy and healthy lives?

Further, the majority of research has explored the short-term effects of discrimination on the mental health of LGBTQ individuals, in looking at the relationship between mental health and experiences of prejudice in the past year. However, few academics have examined how experiences of discrimination can affect LGBTQ individuals over the long term; or how early experiences of prejudice such as childhood bullying can negatively affect LGBTQ individuals in adulthood. Despite the breadth of research exploring the short-term effects of discrimination in contributing to mental health disparities among LGBTQ individuals, and a few studies focusing on measures of positive mental health, no research has explored the long-term effects of prejudice events on the positive mental health of LGBTQ adults using Keyes' holistic concept. A few years ago, the 'It Gets Better' campaign was launched as a way to encourage LGBTQ youth facing harassment, namely in-school bullying, that their lives will get better with time; yet few researchers have explored whether it really does 'get better' once they reach adulthood.

Keyes (2007) wrote, "...much more research is needed to understand how mental health unfolds developmentally and over the lifespan, acting as protective (i.e., flourishing) and risk (i.e. languishing and moderate mental health) factors within specific racial and ethnic subpopulations" (p. 105). The current study will extend such a demand for more research into the development of positive mental health to a minority or subpopulation, namely LGBTQ

individuals. Although, Keyes (2007) indicates that a complete state of mental health must include the acknowledgement of both a pathogenic model and a salutogenic model, there is a lack of literature exploring the effects of prejudice on positive mental health among LGBTQ adults specifically, and therefore the current project looks to fill such a gap in the literature. The main research question of the current thesis is: What are the effects of childhood bullying on the positive mental health of LGBTQ individuals in adulthood? Or more specifically: Does childhood bullying negatively affect or inhibit the formation of flourishing levels of positive mental health among LGBTQ individuals later in life?

In addition to this introductory chapter, the current thesis includes the following chapters: (2) the theoretical framework, (3) the literature review, (4) methodology, (5) results, and (6) discussion. First, the theoretical framework chapter includes a discussion of the theoretical approaches and insights that inform the current research. Second, the literature review focuses on a review of the relevant research on mental health, both in regard to mental illness and positive mental health, and other factors related to bullying and mental health among LGBTQ individuals. Third, the methodology chapter outlines the research questions and tentative hypotheses; the proposed sample and data; the variables, including the main dependent and independent measures. This section also outlines the four analytical procedures that are employed in the current research, as well as the methodological limitations of current data and statistics. Fourth, the results chapter reports the findings in regard to each research question, and finally, the discussion chapter focuses on relating the findings to the relevant literature and theoretical framework, the limitations of the current thesis, and lastly, suggestions or avenues for future research, as well as recommendations for policy and practice.

## **Chapter 2: Theoretical Framework**

The theoretical underpinnings of the current thesis rely upon and are grounded in Émile Durkheim's work on the social fact and deviance; Michel Foucault's work on discourse and the history of sexuality; Irving Goffman's work on stigma theory and health, with a focus on Ilan Meyer's more macro and contemporary minority stress theory; and finally, the academic work of Corey Keyes in regard to positive social science research on the topic of positive mental health. Each will be discussed in turn in the following sections.

### **Durkheim, Deviance, and "Homosexuality"**

Émile Durkheim (1938) introduces the idea of the "social fact", a social phenomenon that compels individuals in society to abide by the respective societal norms and values within social institutions. In other words, these social facts create a "collective conscience" or "collective sentiment", wherein individuals in a society are to abide by the views of the collective whole. Durkheim indicates that this collective conscience (or social fact) is enforced by either precise sanctions or by the opposition of people who infringe on these stated social facts. To this end, it is through this collective conscience that the idea of the "criminal" and "crime" was born. Durkheim (1938, p. 99) defines a crime as: "...an action which offends certain collective feelings which are especially strong and clear-cut". Durkheim (1938) states that the collective conscience of a society defines people that diverge from the stated social facts or social norms as "criminal" or "deviant". Although criminals do not abide by the social norms and values prescribed by society, Durkheim (1938) indicates that "criminality" is necessary for the proper functioning of society to continue. Durkheim (1938, p. 75) states:

It is no longer a matter of pursuing desperately an objective that retreats as one advances, but of working with steady perseverance to maintain the normal state, of re-establishing it if it is threatened, and of rediscovering its conditions if they have changed.

In this regard, Durkheim explains that the role of the “criminal” is to sustain social norms, to solidify what is “normal” or “right” by illustrating what is “criminal” or “wrong”, or to prepare society for change by questioning the current social facts.

Using a Durkheimian lens, one could argue that it is through this idea of the collective conscience that the LGBTQ community has been criminalized and denounced throughout Canadian history. The strictly heterosexual and religious climate of Canada in the past has criminalized homosexuality, and later classified homosexuality as a mental illness (Green, 1972; Kimmel, & Robinson, 2001). For example, beginning in 1841, by law, homosexuality was considered a capital crime in Canada, which was eventually changed to one punishable by a sentence of life imprisonment. Such a draconian law was ‘necessary’ and justified through canon law, which defined sodomy as an ‘abominable’ act contrary to God’s law (Strange & Loo, 1997).

It was only in 1969 that Prime Minister Pierre Elliott Trudeau amended Canadian legislation, and removed homosexuality as a criminal offence (or more specifically, the acts of “gross indecency” and “buggery” in private between two consenting adults) (McLeod, 1996). Even though homosexuality was decriminalized, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, a guideline of mental health disorders also used by Canadian doctors, considered homosexuality a mental disorder that could be ‘cured’. It was not until 1973 that the American Psychiatric Association removed homosexuality as a mental disorder; however, it was only in 1992 that the World Health Organization declassified homosexuality as a mental illness, and it took until 2010 for the Canadian province of

Alberta to remove homosexuality as a mental disorder (Bayer, 1987; CBC News, 2010; Pickett, 2009).

These examples help illustrate that members of the LGBTQ community have continuously been regarded as outsiders in the discourse of a heteronormative and cisgender Canadian and international culture. LGBTQ individuals have had to constantly fight to be accepted as 'normal' in society; they have had to fight to be considered equal to cisgender heterosexual Canadian citizens. Despite social movements in support of LGBTQ rights and changes in policy and legislation, there are climates of homophobia and transphobia that continue to extend into the Canadian landscape. LGBTQ adults and youth still experience discrimination, victimization, and harassment in Canada and around the world (Katz-Wise, & Hyde, 2012; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Taylor, & Peter, 2011; Van den Akker, Van der Ploeg, & Scheepers, 2013), especially transgender adults and youth (Bradford, Reisner, Honnold, & Xavier, 2013; Greytak, Kosciw, & Diaz, 2009a, 2009b; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2014; Taylor, & Peter, 2011). Although most people in Canada now accept different sexualities, the majority of people still regard gender as a binary, instead of a fluid spectrum; and therefore transgender people are still commonly seen as having a mental disorder, because they violate the feminine/masculine dichotomy largely upheld by today's social institutions (e.g., educational system, medical system).

Using a Durkheimian lens, LGBTQ individuals, whether non-heterosexual or transgender, still do not readily conform to the cisgender heterosexual normative or 'collective conscience' that largely influences and constrains Canadian society today. To Durkheim, the LGBTQ community is the 'outsider' or 'deviant' community that enforces the social norms,



morals, and values that ultimately uphold the heteronormative and gender binary that rejects them. In this regard, a Durkheimian lens is important as a beginning point, because it provides the social context within which homophobia and transphobia came about and were ultimately legitimized in society.

### **Foucault, the Power of Discourse, and “Homosexuality”**

Using a Durkheimian perspective invites critiques due to the ‘othering’ nature of ideas such as social facts, the collective conscience, norms, values, and normative social institutions.

‘Othering’ refers to a process that promotes an “us vs. them” mentality between the dominant and subordinate groups of society (Johnson, et al., 2004; Riggins, 1997). Essentially, this dichotomy presents itself between people who abide by the ‘appropriate’ social norms, morals and values (“us”), and people who reject or deviate from the accepted norms (“them”). Othering has been used to talk about the social exclusion or subordination of groups such as sexual minorities, racial minorities, and immigrants (Dhamoon, & Abu-Laban, 2009; DuCille, 1990; Johnson, et al., 2004). Theoretical frameworks that follow Durkheim’s terminology and ideas invite a dominant discourse that encourages an “us vs. them” dichotomy between groups. In other words, the idea that there is only one way to live and think or a collective conscience in society without disrupting normative social function is “othering” to individuals that do not conform to these stated social norms, such as LGBTQ individuals. For instance, through a Durkheimian lens, the LGBTQ community is deviant; they are ‘othered’ from the identified cisgender heterosexual society. However, it is not being ‘deviant’ or ‘different’ from the norm that ‘others’ them, it is the dominant heteronormative, cisgender discourse that promotes heterosexuality and a gender binary throughout society and creates the homosexual or

transgendered 'other'. In sum, according to post-structuralist theorists, it is through this Durkheimian-esque discourse that the LGBTQ community is marginalized and stigmatized in society.

Throughout his academic career, Michel Foucault (1978, 1980) has discussed the idea of discourse, and how discourse is constantly produced and reproduced throughout society. Foucault believed that individuals were consistently shaped and constrained by the language or discourse that surrounded and was produced in everyday interactions and institutions. According to Foucault, discourse has the power to promote certain truths over other truths in the world; discourse has the power to create discursive norms, similar to the idea of the social normative advanced by Durkheim. People in society are constantly compared to these discursive norms to evaluate their level of 'normality' (Drazenovich, 2012; Foucault, 1978, 1980).

For Foucault, the pathological and adverse discourse that encircles homosexuality began in the 18<sup>th</sup> and 19<sup>th</sup> centuries or the Victorian era (Drazenovich, 2012; Foucault, 1978). Despite the idea that in the Victorian era discourse about sex and sexuality was very restricted and censored, or as Foucault labels it the idea of the "repressive hypothesis" (Foucault, 1978, p.11), Foucault believed that sexuality was not repressed. To him, it had been thoroughly discussed and was a highly relevant topic in discourse throughout the 18<sup>th</sup> and 19<sup>th</sup> centuries (Drazenovich, 2012; Foucault, 1978). For Foucault, there was a very lively "incitement to discourse" surrounding sexuality as a means to control and exert power over it through religious, medical and psychological fields; and through this began the rise of the *scientia sexualis* discourse (Drazenovich, 2012; Foucault, 1978). Foucault explains the incitement to discourse of sex and sexuality; he indicates that, "...sex was taken charge of, tracked down as it were, by a discourse that aimed to allow it no obscurity, no respite" (Foucault, 1978, p. 20). This incitement to

discourse was a dynamic struggle to obtain full control and knowledge of sex and sexuality (Drazenovich, 2012; Foucault, 1978). One could argue that it was through this need to so thoroughly analyze sex that the “homosexual” became known and pathologized through discourse.

The *scientia sexualis* discourse began with the confessional in the church, where confessions were focused mainly on the topic of sex. The church made an extensive list of all sexual acts and organized them as either natural or sinful/unnatural; this list included homosexuality and sodomy as sins. This collected information on sexuality and sex represented the start of the *scientia sexualis* discourse (Drazenovich, 2012; Foucault, 1978). Discourse evolved and spread throughout the years; the confession about sex and sexuality had become ingrained into scientific fields such as medicine, psychology, and social justice (Foucault, 1978). Through this expansion of the *scientia sexualis* into the medical, legal, and psychological fields, negative discourse on homosexuality expanded; discussing non-heterosexual tendencies as abnormal, unnatural, or criminal. Foucault wrote (1978):

Through the various discourses, legal sanctions against minor perversions were multiplied; sexual irregularity was annexed to mental illness; from childhood to old age, a norm of sexual development was defined and all the possible deviations were carefully described; pedagogical controls and medical treatments were organized; around the least fantasies, moralists, but especially doctors, brandished the whole emphatic vocabulary of abomination. (p. 36)

The “homosexual” had become considered as ‘abnormal’ or ‘unnatural’; the heteronormative cisgender discourse prevailed. The “homosexual” was pressured to confess to the psychologist or medical doctor their ‘medical condition’ (i.e. the ‘homosexual disorder’) (Foucault, 1978). Further, through the expansion of discourse, the ideal of opposite-sex marriage came to the forefront. The idea of “heterosexual monogamy” became a foundation for promoting heterosexuality as the “internal standard” for society (Foucault, 1978, p. 38). Heterosexuality and

marriage became a normative discourse that constrained individuals and was ingrained in society. As Foucault (1978) noted, “It tended to function as a norm, one that was stricter, perhaps, but quieter” (p. 38).

The medical and psychological discourse considered sexual practices that were not heterosexual, such as homosexual behaviour, as unnatural or abnormal. In essence, homosexuality was medicalized and/or psychologized; homosexuality became something that needed to be treated or corrected through scientific means such as conversion therapy<sup>2</sup>, which in turn would further endorse this idea of the homosexual as wrong or unnatural (Drazenovich, 2012). Through these types of treatment and through discourse, heterosexuality became the goal or the normal, dominant sexuality. Once homosexuality as a behaviour became medicalized, and homosexual people became clustered as one ‘population’ or ‘species’, all people that were attracted to the same sex bore the same pathologized ‘identity’ (Drazenovich, 2012; Foucault, 1978). Foucault (1978, p.43) said:

Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphroditism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species.

Notably, the negative discourse surrounding homosexuality in the medical and psychological domains have become diminished in Canada as a result of the removal of homosexuality as a mental illness or disorder; however, the discursive practice of heteronormativity and cisgenderism still remains in many social arenas – one of which is the educational system (Taylor & Peter, 2011).

Focusing on the transgender community, for example, such a negative discourse is still very prominent in the medical, psychological, and educational communities. Transgender

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<sup>2</sup> Conversion therapy involves attempting to convert a homosexual individual into a heterosexual individual through therapeutic means. Conversion therapy was just recently banned in Ontario and Manitoba in 2015, but not yet federally in Canada.

individuals, youth especially, are examined and questioned to ensure that they fit into the gender dysphoria or gender identity disorder (GID) diagnosis by a physician or psychiatrist. Gender dysphoria or GID is a psychological or medical disorder included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The diagnosis is used to describe people who feel strongly that their physical body does not reflect their true gender identity or sex, and as such, identify as transgender (Newman, 2002). In the educational system, children are continuously influenced by the gender binary in schools; the idea that heterosexuality is the normal sexuality; the idea that people must fit into the category of femininity or masculinity that are transmitted through education. Research suggests that homophobic and transphobic discourse and speech are prominent in Canadian schools (Taylor, & Peter, 2011). For instance, Taylor and Peter (2011) found that 70.4 percent of students hear “that’s so gay” daily in their school, while three-quarters of LGBTQ students hear negative comments about gender expression.

Ultimately, the dominant pathological or unnatural discourse associated with “homosexuality”, and more recently “transsexuality” has been created and re-created through everyday social interactions, as well as social institutions in the past and present. This discourse that surrounds “homosexuality” and “transsexuality” has now been transformed into a more modern heteronormative cisgender discourse produced through psychological, medical, and educational institutions. In essence, the negative discourse that encircles the LGBTQ community still thrives in Canadian society, despite the rise of a positive counter-discourse (e.g., pride parades, the legalization of same-sex marriage) surrounding LGBTQ individuals.

### **Goffman, Stigma, and Minority Stress Theory**

From the condemned past associated with the LGBTQ community, despite the rise of rights and freedoms for this population, there is still a negative discourse associated with this community. Through his theoretical explorations, Erving Goffman began to conceptualize such shameful, dishonoring, or negative discourse or actions as a process of “stigma” or “stigmatization”. The idea of stigma, from the work of Goffman, is now a major focus of research in journals of social psychology, sociology and psychology. In his work, “Stigma: Notes on the Management of a Spoiled Identity”, Goffman (1963) introduces the idea of stigma, as well as the consequences of stigmatization. Stigma refers to a sign, identity or trait of physical, mental, or social pathologization or degeneration (e.g. AIDS, mental illness, homosexuality) that invites dishonor or shame upon the individual that bears such a stigmatized identity or trait. Goffman (1963) dates the idea of stigma back to ancient Greece, where stigma referred to placing marks on the body of an individual as to indicate a negative or wicked identity. Practices included burning or cutting individuals’ bodies to indicate that they are tainted or criminal (Goffman, 1963). Goffman recognized that stigmatized identities can also refer to characteristics that people are able to hide from the larger society, such as sexual orientation. Goffman divided stigmatized identities into two groups: (1) the discredited, and (2) the discreditable. For Goffman (1963), an individual with a visible stigma or “known” stigma such as a bodily deformity was the ‘discredited’, and an individual with a hidden stigma or “unknown” stigma such as homosexuality was the ‘discreditable’ (p. 4). Goffman further classified types of stigma into three categories: (1) abominations of the body (e.g. a lazy eye), (2) blemishes of individual character (e.g. homosexuality), (3) and tribal stigma (e.g. race) (Goffman, 1963, p. 4).

As noted by Goffman (1963) and other researchers (e.g. Chaudoir, Earnshaw, & Andel, 2013; Quinn, & Earnshaw, 2013), homosexuality has been considered a discreditable or concealable stigmatized identity. However, despite the ability to conceal homosexuality, the effects of stigmatization have been just as hard on LGBTQ individuals that conceal their stigma as visibly discredited individuals (Chaudoir, & Quinn, 2010; Pachankis, 2007). According to Goffman, stigmatized groups such as LGBTQ individuals experience three different types of stigma: (1) internalized stigma, (2) enacted stigma, and (3) anticipated stigma.

An internalized stigma refers to when an individual feels shame for an attribute or identity they possess, which is viewed negatively by the larger society. Although not described as such explicitly in the literature, internalized stigma in simple terms can refer to a form of self-loathing (Chaudoir, Earnshaw, & Andel, 2013). For example, non-heterosexual individuals that have been influenced by the dominant heteronormative standard in society, and now believe that they must either hide their sexual identity by following the heterosexual norm (remain the 'discreditable'), or reveal their status and become stigmatized (become the 'discredited') would be said to have internalized the stigma. Another example is a transgender individual who feels the pressure of conforming to one's birth sex, as well as the pressure of the stigma associated with sex changes and gender identities that do not perfectly conform to the prevailing cisgender standards. Internalized stigma ultimately can lead people such as gender- or sexual-minorities to stigmatize themselves for not meeting the cisgender heterosexual standards of society.

Enacted stigma refers to prejudice or discrimination that is directed at an individual by others in society (Chaudoir, Earnshaw, & Andel, 2013). The discrimination, harassment or victimization that LGBTQ individuals experience in their communities are examples of enacted stigma. For instance, the high murder rate of transgender individuals (Langenderfer-Magruder, et

al., 2014) or the high prevalence of bullying directed at LGBTQ students in schools (Taylor & Peter, 2011) are both examples of enacted stigma in Canadian and international communities. Enacted stigma does not represent how LGBTQ individuals stigmatize themselves; it represents how society perpetuates homophobic and transphobic prejudice onto LGBTQ individuals by mode of verbal and physical stigmatization.

Anticipated stigma refers to when individuals constantly expect to experience discrimination, victimization or harassment as a consequence of a stigmatized characteristic or identity they possess (Chaudoir, Earnshaw, & Andel, 2013). Essentially, the homophobic and transphobic instances that LGBTQ individuals have either seen or personally experienced have created a sense of fear or an expectation to encounter discrimination, harassment, or victimization in their communities and abroad.

All three types of stigma have been associated with increased mental and physical health deficiencies in stigmatized peoples, including gender or sexual minorities (e.g. Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Denton, 2012; Fingerhut, Riggle, & Rostosky, 2011; Hatzenbuehler, Phelan, & Link, 2013; Hatzenbuehler, et al., 2014; Igartua, Gill, & Montoro, 2009; Mereish, 2014). As noted by Goffman (1963), “Failure or success at maintaining such norms [e.g. cisgender heterosexual] has a very direct effect on the psychological integrity [also can include physical health] of the individual” (p. 128; emphasis added). In other words, the pressure of attempting to conform to the cisgender heterosexual normative, or experiencing and/or anticipating discrimination, ultimately affects the mental and physical wellbeing of individuals who are a part of the LGBTQ community. For example, Igartua, Gill, and Montoro (2009) found that internalized homophobia or self-loathing of one’s homosexual identity accounted for 13% of the variance in anxiety and



18% of the variance in depression among a population of LGB adults. Further, focusing on physical health, Denton (2012) found that anticipated stigma, internalized stigma, and enacted stigma were all associated with greater physical health problems among a sample of LGB adults.

Despite the importance of recognizing Goffman's work in formulating and talking about stigma and health, academics have criticized Goffman for relying on symbolic interactionist and individualistic terms in explaining health-related stigma (Scambler, 2006, 2009). Researchers such as Scambler (2006, 2009) assert that Goffman neglects to consider or acknowledge the larger social processes and structures of marginalization and exclusion, and assert a need for a more macro, less individualistic approach to discuss and theorize stigma and health. Symbolic interactionism, the theoretical framework Goffman's work is based upon, focuses on face-to-face interactions and micro social processes such as how LGBTQ individuals engage in stigma management or dramaturgical performances to conceal their stigmatized identity. However, Goffman, although somewhat implied when talking about stigma, never engages with the structural or macro social processes, e.g., homophobia and transphobia that have created such a stigmatized identity for, as an example, LGBTQ individuals. Goffman or a symbolic interactionist approach explores how the social environment creates meaning for individuals, and through such a process of meaning-making and through social interactions, LGBTQ individuals can experience negative social interactions, which can negatively affect one's self-perception, and in turn, one's state of mental health (Meyer, 2003b). However, as mentioned, symbolic interactionism does not concern itself with structural aspects of inequality or discrimination.

Addressing this critique, the idea of stigma, in terms of internalized, anticipated and enacted stigma, and health has become a part of a more macro or structural contemporary theory entitled, "minority stress theory", which was explored in the current thesis. Minority stress

theory (Meyer, 1995, 2003), similar to Goffman's stigma theory, focuses on how groups such as racial or sexual minorities are subject to unique forms of stigma or stressors that affect their health; mental and physical. Minority stress theory posits that minorities are subject to unique experiences that substantially increase stress levels, and from the effects of the increased stress levels on the body or mind, minority groups experience a higher risk for physical and mental disorders or illnesses (Meyer, 1995, 2003). The heightened or unique form of stress comes from the fact that minority groups such as the LGBTQ community are incompatible with, or experience relative disadvantages within, the dominant social structures and culture (Meyer, 1995). Therefore, while Goffman or symbolic interactionism focuses on how negative interactions (e.g., enacted stigma) can negatively affect one's mental health, minority stress theory directs its attention to how a minority individual's incompatibility or disadvantaged status within the dominant structure of society increases stress among these individuals, which in turn, affects their state of mental health (as discussed in Meyer, 2003b).

Meyer (2003a) outlines three main assumptions of minority stress theory: (1) minority groups experience both unique stressors, as well as general stressors experienced by all individuals, (2) minority stress is persistent and strongly based on the stability of the dominant social structures; and finally, (3) minority stress is perpetuated not from the individual, but from larger "social processes, institutions and structures (e.g., homophobia and transphobia) beyond the individual" (p. 4; emphasis added). Hence, unlike symbolic interactionism, which focuses on how stigma is transmitted by social interaction, minority stress theory focuses on how stigma is transmitted through more systemic, or structural avenues of transmission. In other words, minority stress theory re-conceptualizes stress as not simply personal or individualistic, but based on interactions with larger social processes and institutions (Meyer, 2003a). Further,

minority stress theory is focused on how minority groups conflict with the social environment, and again, although minority group members may experience interactions like enacted stigma, minority stress theory is not a symbolic interactionist theory focused on how people interact or manage stigma, it is a theory that focuses on how LGBTQ individuals or other minority groups are incompatible with the dominant structure of society, and it is from such a disconnect that induces increased rates of enacted stigma or other minority stressors for minority group members. Therefore, experiences of enacted stigma or prejudice among LGBTQ individuals, according to minority stress theory, should not be characterized as a personal tragedy or stigma, but should be regarded as an outcome or symptom of the larger social structure of heteronormativity and cisgenderism (Meyer, 2003b). Notably, as argued by Meyer (2003a), larger statistical analysis is beneficial in exploring structural forms of discrimination such as minority stress rather than single or personal accounts of discrimination (p. 23); which justifies, to some degree, the use of statistics within the current research project. Ultimately, as argued by Meyers (2010), “Minority stress rests on sociological theory that links social structure with health outcomes (through the impact of stress)” (p. 2).

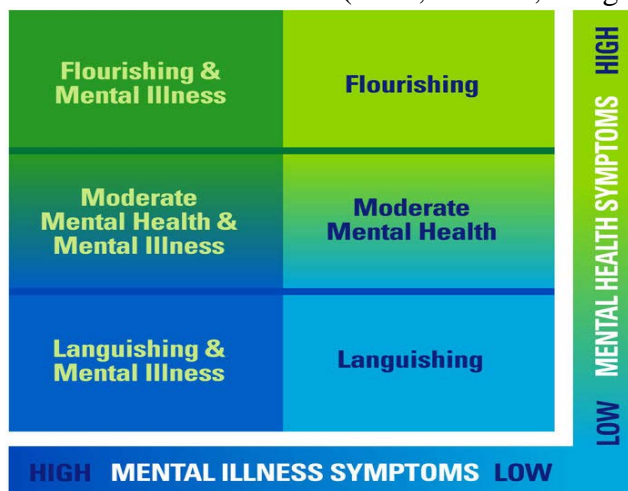
In summary, despite the continued struggle for LGBTQ rights and de-stigmatization, there still remains a stigma associated with the LGBTQ community in Canada and internationally. Unfortunately, as research consistently demonstrates, through the theoretical lens of Goffman and now minority stress theory, the effects of homo/transphobic stigma create mental and physical health disparities between the LGBTQ community and their cisgender heterosexual counterparts. Notably, the majority of research relates stigma to mental health disorders or illness among the LGBTQ community. However, as argued by Corey Keyes, mental health is not only concerned with mental illness and disorders, but should also be concerned with

positive mental health (Keyes, 2002). As argued by Keyes (2002), mental health is a multi-dimensional concept, and, therefore, mental health should be explored using a dual-continuum model that addresses both mental illness and mental wellbeing (commonly referred to as positive mental health).

### **Corey Keyes, Positive Mental Health, and the Mental Health Continuum Short-Form**

Research consistently shows that LGBTQ individuals experience higher levels of mental health disorders and illnesses, compared to their cisgender heterosexual counterparts (e.g. Meyer, 2003a; Woodford, Han, Craig, Lim, & Matney, 2014); and in turn, research relates these negative mental health disparities to a homophobic and transphobic social environment (Bockting, et al., 2013; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Most research on LGBTQ individuals and mental health typically focuses on mental health disorders. However, again, as noted by Corey Keyes, mental health is not only measured by the presence or absence of mental illness; mental health can also be measured on a positive mental health spectrum (Keyes, 2005; Provencher, & Keyes, 2011). As a result, the presence of both mental wellbeing and mental illness, as suggested by Keyes, can be plotted on separate, but related axes of a “Complete State of Mental Health” model (Keyes, 2005; Keyes, 2010; Provencher, & Keyes, 2011; See Figure 1).

Figure 1: Dual-Continuum Model (Peter, Roberts, Dengate, 2011)



Studying the positive spectrum of mental health is important because it allows researchers to explore what encourages positive or good feelings among individuals, and in turn, it helps understand how to better promote positive mental health in society (Keyes, 2002, 2006). Research demonstrates that individuals with flourishing levels of positive mental health are less likely to report mental health disorders; and, therefore, positive mental health has been conceptualized as a form of resilience to mental, as well as physical health disorders (Keyes, 2002, 2006; Keyes, Satvinder, Dhingra, & Simoes, 2010; Keyes, & Lopez, 2009; Keyes, & Simoes, 2012). In theorizing about minority status and positive mental health, one study by Ryff, Keyes, and Hughes (2003) explored this relationship in terms of racial minority status and eudaimonic wellbeing. More specifically, Ryff, Keyes, and Hughes (2003) examined whether experiencing adversity and challenges due to one's racial minority status would "contribute to a deepened sense of purpose and meaning in life" (p. 276); or if such experiences were detrimental to the growth and flourishing of an individual's positive mental health. Ryff, Keyes, and Hughes (2003) found that racial minority individuals reported higher levels of psychological wellbeing than white participants, however, experiences of everyday discrimination were associated with

lower levels of psychological wellbeing. Ryff, Keyes, and Hughes (2003) posit that social inequality and mental health is a complex relationship; and that at times, social inequality can help one to grow as a person, but it can also be detrimental to one's positive mental health. Therefore, in studying this topic using a sample of LGBTQ individuals, researchers can further understand (or explore other interpretations of) how LGBTQ individuals flourish or report higher levels of positive mental health, despite being part of a community that experiences prejudice and discrimination in numerous social environments (Keyes, 2002). For the purpose of the current study, due to the breadth of research on the mental illness aspect of mental health, the focus is the positive mental health aspect of the dual-continuum model.

Through the introduction of the dual-continuum model of mental illness and positive mental health by Keyes, positive mental health has become a viable research area among the social sciences, albeit a new and developing area (Keyes, 2002; Keyes, & Lopez, 2009; Provencher, & Keyes, 2011). To Keyes, positive mental health refers to a holistic measure of emotional, psychological and social wellbeing. In other words, positive mental health is defined as the good feelings people have about themselves, others, and society (Keyes, 2002). Keyes includes measures of emotional, psychological, and social wellbeing in his conception of positive mental health in order to address the multi-dimensional nature of mental health (Keyes, 2002). Emotional wellbeing refers to one's overall positive affect, as well as lifetime happiness or satisfaction (Deiner, Suh, Lucas, & Smith, 1999; Joshanloo, Wissing, Khumalo, & Lamers, 2013; Keyes, 2002). Psychological wellbeing addresses psychological functioning in terms of how individuals think about themselves in terms of, for example, personal growth or autonomy (Keyes, 2002; Ryff, 1989; Ryff, & Keyes, 1995). Finally, social wellbeing refers to how well an

individual interacts or feels connected with people and the overall society (Keyes, 1998; Keyes, 2002; Keyes, & Shapiro, 2004).

Through the introduction of a comprehensive model of mental health, and in response to the numerous indices created to measure mental health disorders or illnesses such as depression or anxiety, Keyes created the Mental Health Continuum. The first index, referred to as the Mental Health Continuum-Long Form (MHC-LF), comprises 40-items (Keyes, 2002). However, to create a more robust self-report measure of positive mental health, Keyes introduced the Mental Health Continuum-Short Form (MHC-SF), a 14-item index with 3 items of emotional wellbeing, 5 items of social wellbeing, and 6 items for psychological wellbeing (Keyes, 2002). The psychometric properties and internal consistency of the three-dimensional MHC-SF of positive mental health has been supported or validated cross-culturally in countries such as Netherlands, Iran, South Africa, Poland, Italy, Egypt, Canada, and the United States (Gallagher, Lopez, & Preacher, 2009; Joshanloo, Wissing, Khumalo, & Lamers, 2013; Karaś, Ciecuch, & Keyes, 2014; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011; Peter, Roberts, & Dengate, 2011; Petrillo, Capone, Caso, & Keyes, 2015; Salama-Younes, 2011).

There has been a relatively clear consensus in regard to the psychometric properties of the MHC-SF, but some academics have challenged the integrity of this multi-dimensional measure of positive mental health. For instance, Jovanović (2015) found, in testing the MHC-SF using confirmatory factor analysis, that there was one overall wellbeing factor that accounted for the majority of the variance in measuring positive mental health. Although Jovanović (2015) indicated that positive mental health, consistent with Keyes (2002), should not be separated into three separate scales, Jovanović (2015) also questioned the structural integrity of the MHC-SF, and questioned whether it was worthwhile to add multiple dimensions, e.g., social, emotional,

and psychological measures of positive mental health together, when one general factor accounted for a majority of the variance. However, despite such critiques directed at Keyes' positive mental health model, for purposes of practicality, the current project only uses Keyes' uni-dimensional conception of positive mental health, which has been empirically verified, even by Jovanović (2015).

### **Chapter 3: Literature Review**

The following review of the literature will focus on the prevalence of mental health disparities, experiences of enacted stigma, and the short-term and long-term relationship of enacted stigma on the mental health (including both mental illness and positive mental health), of LGBTQ individuals. The review is predominantly focused on studies that include LGBTQ adults. However, numerous studies exploring mental health and/or enacted stigma among LGBTQ individuals have used samples of LGBTQ youth, and therefore, literature on youth specifically may provide some important insights in thinking about LGBTQ adults.

#### **Mental Health Disparities: LGBTQ vs. Heterosexual Individuals**

Mental health disparities between the LGBTQ and heterosexual communities are consistently noted in the literature. In conducting an extensive review of the literature, numerous studies have focused on mental health disparities between LGBTQ and cisgender heterosexual youth, commonly focusing on middle to high school or university/college students (for example, Abele, 2014; Bostwick, et al., 2014; Cohen, Blasey, Taylor, Weiss, & Newman, 2016; Silva, Chu, Monahan, & Joiner, 2015; Tsypes, Lane, Paul, & Whitlock, 2016; Woodford, Han, Craig, Lim,



& Matney, 2014). A smaller collection of literature has found mental health disparities between LGBTQ adults and cisgender heterosexual adults in terms of depression (e.g. Frost, & LeBlanc, 2014; Rosario, et al., 2014), anxiety (e.g. Bostwick, Boyd, Hughes, & McCabe, 2010; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006), mood or affect disorders (e.g. Gilman, et al., 2001; Pakula, Shoveller, Ratner, & Carpiano, 2016; Sandfort, de Graaf, Bijl, & Schnabel, 2001), suicidality (e.g. Balsam, Beauchaine, Mickey, & Rothblum, 2005; Bolton, & Sareen, 2011; Conron, Mimiaga, & Landers, 2010), post-traumatic stress disorder (e.g. Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010), as well as general psychological distress or poor mental health (e.g. Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Fredriksen-Goldsen, et al., 2013a; Kim, & Fredriksen-Goldsen, 2012; Ward, Dahlhamer, Galinsky, & Joestl, 2014).

For example, Conron, Mimiaga, and Landers (2010), using a sample of 67,359 adults aged 18-64 from Massachusetts, explored health differences by sexual orientation and gender. Data were collected using a self-reported population-based survey from the Behavioral Risk Factor Surveillance System. Three percent of the sample identified as lesbian, gay, or bisexual. Using age, gender, and education-adjusted odds ratios, Conron, Mimiaga, and Landers (2010) found mental health disparities between LGB and heterosexual adults, in terms of frequent tension or worry, suicidal ideation, and feelings of sadness. For instance, bisexual adults were 11.3 times more likely than heterosexual adults to report suicidal ideation in the past year.

Using data from the Dutch National Survey of General Practice, Sandfort, Bakker, Schellevis, and Vanwesenbeeck (2006) also found mental health disparities between gay/lesbian and heterosexual respondents in terms of nervousness and anxiety, as well as both general and acute mental health scales. Finally, using a population-based sample of older LGB adults (i.e. 50-94 years, n=96,992) from the Washington State Behavioral Risk Factor Surveillance System,

Fredriksen-Goldsen and colleagues (2013a) explored mental health disparities between LGB and heterosexual older adults. Using a similar model to Conron, Mimiaga, and Landers (2010), Fredriksen-Goldsen and colleagues (2013a) found that lesbian/bisexual women were at a higher risk for poor mental health<sup>3</sup> compared to their heterosexual counterparts; the same relationship was found among gay/bisexual men in comparison to heterosexual men. Although the literature on mental health among transgender adults remains relatively limited, research demonstrates that transgender adults report increased mental health disparities compared to both cisgender heterosexual and LGB individuals (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Dargie, Blair, Pukall, & Coyle, 2014; Mathy, 2003; Mustanski, & Liu, 2013; Su, et al., 2016)<sup>4</sup>. In essence, from such an extensive review of the literature, academics have consistently noted mental health disparities between LGBTQ and cisgender heterosexual adults as well as youth.

### **Enacted Stigma: LGBTQ vs. Heterosexual Individuals**

Research also demonstrates that LGBTQ individuals experience a greater number of hostile and prejudiced events compared to their cisgender heterosexual peers. Enacted stigma can come in many forms, from anti-LGBTQ hate crimes, to anti-LGBTQ bullying or in-school/workplace victimization, or more subtle forms of discrimination such as the use of homophobic or transphobic language (Burn, Kadlec, & Rexer, 2005; Christman, 2012; Herek, 2009; Kosciw, et al., 2012; Taylor & Peter, 2011). A large body of Canadian and international literature has illustrated how LGBTQ youth are significantly more likely to experience in-school and out-school discrimination, harassment or victimization compared to cisgender heterosexual youth

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<sup>3</sup> Poor mental health was defined as “14 or more days of poor mental health during the previous 30 days” (p. 1803).

<sup>4</sup> Due to the small number of transgender participants, the current thesis could not make a comparison between transgender and non-transgender participants. Also, it could not explore gender non-conforming vs. gender conforming respondents.

(e.g. António, & Moleiro, 2015; Fedewa, & Ahn, 2011; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Kosciw, Greytak, Palmer, & Boesen, 2014; Olsen, Kann, Vivolo-Kantor, Kinchen, & McManus, 2014; Taylor, & Peter, 2011; for review, see Toomey, & Russell, 2013). For instance, in a Canada-wide study, Taylor and Peter (2011) found that LGBTQ students are more subject to verbal (43.5% versus 12.65%) and physical abuse (20.8% versus 7.9%) than heterosexual students.

The same prevalence of enacted stigma such as verbal, sexual or physical harassment, discrimination or victimization has also been found among LGBTQ adults both within the educational system, and in other social spaces such as the health-care system, including mental health services (Eliason, Dibble, & Robertson, 2011; Grant, et al., 2011; Simeonov, Steele, Anderson, & Ross, 2015), the workforce (Drydakis, 2009; Einarsdóttir, Hoel, & Lewis, 2015; Eliason, Dibble, & Robertson, 2011; Gates, & Mitchell, 2013; Grant, et al., 2011; Jones, Robinson, Fevre, & Lewis, 2010; Pizer, Sears, Mallory, & Hunter, 2011; Sears, Hasenbush, & Mallory, 2013; Tilcsik, 2011; Weichselbaumer, 2003), within familial and interpersonal relationships (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Corliss, Cochran, & Mays, 2002; Langenderfer-Magruder, et al., 2014; Roberts et al., 2010), and in the form of hate crimes or other violent or prejudice encounters that happen within a hostile or exclusionary public climate of heteronormativity and cisgenderism (Alessi, Martin, Gyamerah, & Meyer, 2013; Grant, et al., 2011; Gruenewald, 2012; Katz-Wise, & Hyde, 2012; Lombardi, Wilchins, Priesing, & Malouf, 2002; Mathy, & Cochran, 2001; McGarrity, Huebner, & McKinnon, 2013; Meyer, 2012; Rothman, Exner, & Baughman, 2011; Stotzer, 2009; Wagner, et al., 2013).

For example, among a representative sample of American adults, Mathy and Cochran (2001) found that LGB adults<sup>5</sup>, compared to heterosexual adults, were more likely to have encountered day-to-day<sup>6</sup> and/or lifetime<sup>7</sup> experiences of discrimination, which is attributed to their experiences of discrimination due to their sexual orientation. For instance, LGB adults were 4.3 times more likely to have been fired from a job compared to heterosexual adults. In another American study, Roberts et al. (2010) found that both female and male LGB adults were more likely to have experienced interpersonal violence such as stalking, domestic violence, or physical violence, as well as childhood abuse, compared to heterosexual respondents. Finally, in a British study exploring assault or harassment in the workplace, Jones, Robinson, Fevre, and Lewis (2010) found that gay or bisexual adults were more likely to experience workplace violence or assault compared to their heterosexual counterparts. Again, among youth and adults, transgender individuals are more likely to encounter discrimination, harassment, and victimization, compared to both cisgender heterosexual and LGB individuals (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Greytak, Kosciw, & Diaz, 2009b; Kattari, Whitfield, Walls, Langenderfer-Magruder, & Ramos, 2016; Langenderfer-Magruder, et al., 2014; Mustanski, & Liu, 2013; Su, et al., 2016). All in all, previous research demonstrates that LGBTQ adults experience a disproportionate amount of discrimination, harassment, and victimization, compared to their cisgender heterosexual counterparts in numerous social spaces.

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<sup>5</sup> The authors named LGB participants “homosexual” and “bisexual”.

<sup>6</sup> Day-to-day discrimination included, but was not limited to, “You are called names or insulted”, “You are threatened or harassed”, and/or “People act as if they are afraid of you”.

<sup>7</sup> Lifetime discrimination included, but was not limited to, “Not hired for a job”, “Hassled by the police”, and/or “Denied or given inferior medical care”.

### **Minority Stress: The Relationship Between Enacted Stigma and Mental Health**

Following minority stress theory, research has also found a significant relationship between enacted stigma and increased mental health disparities among LGBTQ individuals. Again, numerous studies have focused on the relationship between enacted stigma and increased mental health disparities among LGBTQ youth (e.g. António, & Moleiro, 2015; Baams, Grossman, & Russell, 2015; Goldblum, et al., 2012; Patrick, Bell, Huang, Lazarakis, & Edwards, 2013; Poteat, Mereish, DiGiovanni, & Koenig, 2011; Russell, et al., 2011; van Beusekom, Baams, Bos, Overbeek, & Sandfort, 2016; Woodford, et al., 2014)<sup>8</sup>. For instance, Russell and colleagues (2011) found that LGBTQ youth who report higher frequencies of in-school victimization were 2.6 times more likely to be depressed, and 5.6 times more likely to attempt suicide at least once.

However, among the scholarly literature, there were an estimated 40 peer-reviewed articles (see, for example Bockting et al., 2013; for review, see Collier, van Beusekom, Bos, & Sandfort, 2013; Dunn, Gonzalez, Costa, Nardi, & Iantaffi, 2014; Fingerhut, Peplau, & Gable, 2010; Morrison, 2012; Kuyper, & Fokkema, 2011; Parra, Benibgui, Helm, & Hastings, 2016; Wight, LeBlanc, de Vries, & Detels, 2012) that supported the minority stress model, or more explicitly the relationship between enacted stigma and mental health disparities among LGBTQ adults. For instance, Bockting and colleagues (2013), using a sample of 1093 transgender individuals aged 18 or older, found that psychological distress<sup>9</sup> is positively correlated with increased stigmatization due to gender identity or expression, while controlling for age and sex. Similarly, among a sample of 449 lesbian (n=188) and gay male (n=261) adults, Fingerhut and

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<sup>8</sup> This relationship has also been found among heterosexual students that have been bullied (Bogart, et al., 2014), as well as heterosexual students that have experienced anti-LGBTQ bullying (Patrick, et al., 2013; Poteat, Scheer, DiGiovanni, & Mereish, 2014).

<sup>9</sup> Measured by the Brief Symptom Inventory (BSI)-18, including a Global Severity Index, and three sub-scales for depression, somatization, and anxiety (Bockting et al., 2013).

colleagues (2010) found that respondents who had reported higher levels of discrimination<sup>10</sup> reported higher levels of depression<sup>11</sup>. Finally, among a Canadian sample of 348 gay and lesbian adults, experiences of discrimination in the previous 12 months (e.g., verbal threats, physical or sexual assault, and property damage) were associated with higher levels of depression<sup>12</sup> (Morrison, 2012).

Even fewer studies focus on the relationship between positive mental health and enacted stigma among LGBTQ individuals. The majority of research on positive mental health among the LGBTQ community focuses on single measures such as self-esteem, quality of life, or life satisfaction (D'Augelli, & Grossman, 2001; Frable, Wortman, & Joseph, 1997; Huebner, Rebchook, & Kegeles, 2004; Kosciw, Palmer, Kull, & Greytak, 2013; Logie, & Earnshaw, 2015; Morrison, 2012; Patrick, et al., 2013; Russell, et al., 2011; Swim, Johnston, & Pearson, 2009). For instance, Morrison (2012) found that, among gay and lesbian adults, experiencing discrimination was associated with lower levels of self-esteem and optimism (e.g. “I always look on the bright side of things”) (pp. 83-84). Further, Patrick et al. (2013) found youth who experienced bullying because of their perceived sexual orientation were more likely to report lower levels of quality of life compared to youth who had no such experiences<sup>13</sup>. Finally, Frable, Wortman, and Joseph (1997) found, among a sample of gay men, that experiencing gay stigmatization such as unfair treatment or discrimination were associated with lower levels of positive self-perceptions or self-esteem.

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<sup>10</sup> Measured by “Schedule of Homophobic Events” adapted from the “Schedule of Racist Events” scale (found in Landrine, & Klonoff, 1999, as cited by Fingerhut et al., 2010). Included, for example, “being treated unfairly by strangers because of your sexual orientation” (Fingerhut et al., 2010, p. 106).

<sup>11</sup> Measured using the CES-Depression Scale (introduced by Radloff, 1977, as cited in Fingerhut et al., 2010).

<sup>12</sup> Using the same CES-Depression Scale as Fingerhut et al, 2010.

<sup>13</sup> Quality of life was measured by using six-item scale including, “I feel I am getting along with my parents or guardian”, “I look forward to the future”, “I feel good about myself”, “I am satisfied with the way my life is now”, “I feel alone in my life”, and “Compared with others my age, my life is much worse or much better” (p. e2).

Some researchers have examined this relationship using more complete measures of positive mental health (Frost, & LeBlanc, 2014; Lyons, Pitts, & Grierson, 2013). One study in particular examined positive mental health among older gay men using the Short Warwick-Edinburgh Mental Well-being Scale<sup>14</sup> (Lyons, Pitts, & Grierson, 2013). Lyons, Pitts and Grierson (2013) found that participants scored higher on the positive mental health index if they had not experienced discrimination in the past year. Further, exploring mental health disparities between heterosexual and LGB adults, Frost and LeBlanc (2014) found that life barriers in terms of work and relationships mediated the relationship between LGB/heterosexual status and positive mental health (measured by an 18-item Psychological Well-Being Measure created by Ryff, & Keyes, 1995; see also Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015). In other words, lower levels of positive mental health among LGB adults were partly explained by stressful life experiences (Frost, & LeBlanc, 2014).

Studies have also explored whether or not LGBTQ individuals who have had minimal to no experience of enacted stigma report similar levels of mental health as their cisgender heterosexual counterparts (Bontempo, & D'Augelli, 2002; Birkett, Espelage, & Koenig, 2009). For instance, among a sample of American youth, Bontempo and D'Augelli's (2002) found that LGB youth who have experienced lower levels of in-school victimization (e.g., property damage or physical violence) have similar mental health outcomes (e.g., feelings of suicidality) as their heterosexual counterparts. Birkett, Espelage, and Koenig (2009), among an American sample of 7,736 middle-school students, also found that LGB students who reported no experiences of homophobic bullying resembled heterosexual youth on mental health outcomes (e.g., suicidality

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<sup>14</sup> The Short Form Warwick-Edinburgh Mental Well-Being is a 7-item positive mental health index including, "I've been feeling optimistic about the future", "I've been feeling useful", "I've been feeling relaxed", "I've been dealing with problems well", "I've been thinking clearly", "I've been feeling close to other people", and "I've been able to make up my own mind about things" (Lyons, Pitts, & Grierson, 2013, p. 1163).

and depression). In another study, D'Augelli and Grossman (2001) found that older LGB adults, who had experienced some form of verbal or physical victimization, reported lower levels of self-esteem and higher levels of suicidal ideation, compared to their non-victimized peers. In summary, enacted stigma is depicted as an important mediator of mental health disparities, and ultimately, the tenets of minority stress theory have been consistently verified within the academic literature.

### **Minority Stress and Control Factors: “Outness”, Support, and Intersectionality**

Minority stress theory is not attempting to portray LGBTQ individuals as helpless victims or powerless individuals. Minority stress is a factor in many marginalized individual's lives; however coping strategies, and other factors such as social support or resilience can also mitigate the effects of minority stress on mental health (Meyer, 2003a). Consistent with minority stress theory, academics report other factors that moderate the relationship between enacted stigma and mental health among LGBTQ individuals, such as degree of outness, social support, and intersectional experiences (double minority status, e.g. LGBTQ racial minority women) (Meyer, 1995, 2003).

**Outness.** Some studies have shown mixed results with respect to how or if ‘coming out’ about one’s LGBTQ identity moderates the relationship between enacted stigma and mental health (e.g. Christman, 2012; D'Augelli, Hershberger, & Pilkington, 1998; D'Augelli, Pilkington, & Hershberger, 2002; Dunn, et al., 2014; Lewis, Derlega, Griffin, & Krowinski, 2003). However, consistent with minority stress theory, research demonstrates that the degree or process of LGBTQ individuals ‘coming out’ about their LGBTQ identity is a moderating factor of



mental health (e.g. (Jordan, & Deluty, 1998; Kosciw, Palmer, & Kull, 2015; Legate, 2014; Legate, Ryan, & Weinstein, 2012; Morris, Waldo, & Rothblum, 2001; Russell, Toomey, Ryan, & Diaz, 2014; Schrimshaw, Siegel, Downing Jr, & Parsons, 2013; Strain, & Shuff, 2010).

Although researchers have reported that being ‘out’ about one’s LGBTQ status can increase the prevalence of victimization experienced or increase negative mental health outcomes (D’Augelli, Hershberger, & Pilkington, 1998; D’Augelli, 2003; D’Augelli, & Grossman, 2001; D’Augelli, Pilkington, & Hershberger, 2002; Frable, Wortman, & Joseph, 1997; Lewis, Derlega, Griffin, & Krowinski, 2003), research also illustrates that disclosing one’s sexual or gender minority status can encourage positive mental health, and in turn, lower levels of mental health disorders among LGBTQ individuals. For instance, using a population of lesbian participants, Morris, Waldo, and Rothblum (2001) found that as respondents became more ‘out’ about their sexual orientation, they experienced less psychological distress. In a more recent study, Kosciw, Palmer, and Kull (2015) found, among a sample of LGBT students, that being out about one’s LGBT identity increased levels of in-school victimization, but was also associated with higher levels of self-esteem and lower levels of depression among these youth. Finally, Strain, & Shuff (2010) found that among male-to-female transgender adults, disclosing one’s gender identity was associated with higher levels of self-esteem, and lower levels of depression and anxiety (for similar results, see Feldman, 2012; Jordan, & Deluty, 1998; Lewis, Derlega, Griffin, & Krowinski, 2003).

However, literature also indicates that how ‘coming out’ influences an individual’s mental health can be contingent on the social climate that one ‘comes out’ to, or the positive development of an LGBTQ-identity (Feldman, 2012; Feldman, & Wright, 2013; Legate, Ryan, & Weinstein, 2012; Luhtanen, 2002; Nuttbrock, et al., 2012). For example, Legate, Ryan, and

Weinstein (2012) reported that being more ‘out’ about one’s LGBTQ identity was associated with lower levels of depression and higher levels of self-esteem; however, this relationship was contingent on ‘coming out’ in a more open and supportive environment, rather than a controlling or oppressive environment. Further, Feldman and Wright (2013) found that disclosing one’s LGB identity was associated with higher levels of positive mental health<sup>15</sup>, but this relationship was contingent on a strong, well-developed LGB identity among the participants. Finally, Nuttbrock et al. (2012), among a sample of self-identified transgender women, found that disclosing one’s gender identity was a protective factor against major depression when it was met with affirmative or supportive responses from family or friends, compared to negative or conflict-based responses (e.g. “did or said things to make me feel bad about [the respondent’s] gender”) (p. 95). Therefore, the literature suggests that disclosing one’s LGBTQ identity fosters positive mental health among LGBTQ individuals despite increased rates of enacted stigma; but research also demonstrates how this relationship is moderated by the strength or confidence in one’s LGBTQ-identity, as well as the reception one receives upon disclosure.

**Social Support.** There has also been mixed results in regard to whether or not social support moderates the relationship between enacted stigma and mental health among LGBTQ people (e.g. Fredriksen-Goldsen et al., 2013b; Szymanski, 2009). Some studies, consistent with minority stress theory, demonstrate how social support from friends and family, or LGBTQ-supportive climates in terms of policy, programs or institutional support can significantly reduce the adverse effects of enacted stigma or promote positive mental health among the LGBTQ

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<sup>15</sup> The mental health measure was comprised of three items: self-esteem, life satisfaction, and the Brief Symptom Global Severity Index (BSI/GSI). Higher levels of mental health refer to higher levels of life satisfaction and self-esteem, and lower scores on the BSI/GSI.

community<sup>16</sup> (e.g. António, & Moleiro, 2015; Birkett, Espelage, & Koenig, 2009; Bockting et al., 2013; Dargie, Blair, Pukall, & Coyle, 2014; Doty, Willoughby, Lindahl, & Malik, 2010; Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, & Keyes, 2013; Kosciw, Palmer, Kull, & Greytak, 2013; Lyons, Pitts, & Grierson, 2013; Saewyc, Konishi, Rose, & Homma, 2014; Toomey, Ryan, Diaz, & Russell, 2011).

For instance, consistent with minority stress theory (Meyer, 2003a), Lyons, Pitts, and Grierson (2013) report that the level of overall social support was significantly associated with increased levels of psychological wellbeing among a sample of older gay men. Further, Saewyc, Konishi, Rose, and Homma (2014) found that LGB students in schools with a Gay-Straight Alliance and/or anti-homophobic policies reported lower levels of discrimination, suicidal behaviour, and depression (see also Birkett, Espelage, & Koenig, 2009; Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, & Keyes, 2013; Kosciw, Palmer, Kull, & Greytak, 2013). Finally, Bockting et al. (2013) found that for transgender adults with lower or moderate levels of social support, namely peer support, the relationship between enacted stigma and psychological distress was significant; however, for respondents with high levels of peer support this relationship was no longer statistically significant (see also António, & Moleiro, 2015). In essence, social support can be an important factor in fostering resilience and strength among LGBTQ adults and youth in combatting the negative effect of prejudiced events on their mental health, both in terms of mental health disorders and positive mental health.

**Intersectionality.** Following the arguments made by Bowleg (2012) in regard to an intersectional approach to health-based research, minority stress theory also suggests that

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<sup>16</sup> The current thesis will focus on the school climate (positive vs. negative) as an indicator of LGBTQ-specific support (e.g. support for LGBTQ-inclusive education, anti-homophobic or -transphobic policies).

intersectional experiences are important to consider in discussing the relationship between enacted stigma and mental health among LGBTQ individuals (Meyer, 2003a). As research demonstrates, intersectional experiences can mediate or alter the dynamics of the minority stress model. Notably, discussing intersectional experiences can become complicated and very precise as one person can identify with numerous minority statuses (e.g. elderly Hispanic Catholic lesbian living in a small rural town). However for the purpose of simplicity, intersectional experiences refers to an individual's LGBTQ identity in relation to other demographics such as race/ethnicity, religion, age, sex or gender, and urban/rural location. Other intersectional factors include socioeconomic status, having a disability, immigrant status, and/or within-LGBTQ comparisons such as bisexual versus gay individuals; although they are beyond the scope of the current thesis.

First, research suggests that race/ethnicity can moderate the minority stress that an LGBTQ individual will experience throughout the life course (Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015; Choi, Paul, Ayala, Boylan, & Gregorich, 2013; Kim, & Fredriksen-Goldsen, 2012; Liu, & Choi, 2006; Logie, & Earnshaw, 2015; Szymanski, & Gupta, 2009; Whitfield, Walls, Langenderfer-Magruder, & Clark, 2014). For instance, racialized LGBTQ people may experience a heightened level of discrimination due to their additive racial minority status within both heterosexual and LGBTQ communities. For example, Calabrese, Meyer, Overstreet, Haile, and Hansen (2015) found that Black sexual minority women were more likely to report discrimination and mental health issues such as depression and lower levels of psychological and social wellbeing, compared to their white female sexual minority counterparts (see also Kim, & Fredriksen-Goldsen, 2012, who found a similar pattern among Hispanic sexual minority women). Whitfield, Walls, Langenderfer-Magruder, and Clark (2014) also found that

the junction between a racialized and LGBTQ identity can promote higher levels of discrimination. Further, as demonstrated by Choi, Paul, Ayala, Boylan, and Gregorich (2013), racism, similar to the larger society, is also entrenched within the LGBTQ community. Choi et al. (2013) found that racialized men who have sex with men, notably Asian and Pacific Islander participants, were most likely to experience racial discrimination in the gay community, which thereby was correlated with higher levels of mental health disorders. Further, some cultures or ethnicities are, at times, more prejudiced towards “homosexuality”, and, therefore, LGBTQ individuals who are a part of such cultures or ethnicities may encounter increased minority stressors (e.g. Liu, & Choi, 2006; Nyanzi, 2013)<sup>17</sup>.

Second, and in part related to one’s culture or ethnicity, whether an LGBTQ individual identifies as religious can add to the complexity of the minority stress model in both positive and negative respects (Crowell, 2014; Dunbar, 2014; Gattis, Woodford, & Han, 2014; Hickey, 2014; Levy, & Lo, 2013; Meanley, Pingel, & Bauermeister, 2016; Smith, Poon, Stewart, Hoogveen, & Saewyc, 2011; Sherry, Adelman, Whilde, & Quick, 2010; Tozer, & Hayes, 2004; Yakushko, 2005; Yarhouse, & Carrs, 2012). For instance, Dunbar (2014) found that being invested in one’s religious community by living by the rules of one’s religion can negatively affect an individual’s LGBTQ identity, and was associated with deciding to not disclose one’s minority identity. In contrast, Gattis, Woodford, and Han (2014) found that compared to LGB respondents that were affiliated with a religious group supportive of same-sex marriage, non-religious LGB respondents or respondents affiliated with a religious group opposed to same-sex marriage reported a strong relationship between discrimination and depression. In other words, being affiliated with a religious community that accepted same-sex marriage helped diminish the

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<sup>17</sup> The two examples in the literature focus on Chinese and African cultures; however this is not to indicate that these cultures are ‘bad’ or ‘wrong’ – it is just an indication that some cultures/ethnicities (and religions), including Western cultures, are heavily invested in heterosexuality and/or cisgenderism.

relationship between discrimination and mental health issues such as depression. Ultimately, religion can be a supportive or negative network for LGBTQ peoples in regard to their mental health.

Third, one's gender identity or gender expression can influence the dynamics of the minority stress model (D'Augelli, Grossman, & Starks, 2006; DeBlaere, & Bertsch, 2013; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Fredriksen-Goldsen, et al., 2013a; Roberts, Rosario, Slopen, Calzo, & Austin, 2013; Saewyc, Bearinger, Heinz, Blum, & Resnick, 1998; Su, et al., 2016; Szymanski, 2005; Szymanski, Dunn, & Ikizler, 2014; Szymanski, & Owens, 2009). As noted throughout the review of the literature, transgender people experience increased levels of mental health issues and minority stressors compared to cisgender heterosexual and LGB individuals (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Mathy, 2003; Mustanski, & Liu, 2013; Su, et al., 2016). Therefore, identifying as transgender within the LGBTQ community can increase minority stressors, and in turn, mental health issues. Gender nonconformity has also been associated with mental health issues and increased levels of enacted stigma among both transgender and other lesbian, gay, or bisexual individuals (e.g. D'Augelli, Grossman, & Starks, 2006; Rieger, & Savin-Williams, 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013). Finally, in exploring the female/male gender binary, lesbian women have been found to experience sexism, as well as heterosexism, which can, at times, increase the general and minority stress of their everyday lives (Szymanski, 2005; Szymanski, Dunn, & Ikizler, 2014; Szymanski, & Owens, 2009). In essence, all of these factors, including gender identity, sex, or gender expression, can moderate or add to the minority stress model.

Fourth, urban/rural location also provides different contexts that can affect LGBTQ individuals in terms of discrimination and mental health (Lyons, Hosking, & Rozbroj, 2015;

Poon, & Saewyc, 2009; Rickard, 2014; Swank, Frost, & Fahs, 2012; Swank, Fahs, & Frost, 2013). As demonstrated by Lyons, Hosking, and Rozbroj (2015) gay men living in rural areas were more likely to report higher levels of psychological distress and discrimination or rejection based on their sexual orientation compared to gay men living in urban areas (see also Rickard, 2014). Further, Swank, Frost, and Fahs (2012) found that LGB respondents living in urban areas reported lower levels of felt stigma (e.g. “I fear that most of my neighbors object to my homosexuality” (p. 232)) and enacted stigma (e.g. physical violence or discrimination), compared to LGB respondents living in rural areas or small towns. Thus, the literature suggests that within rural areas or smaller towns, LGBTQ individuals have access to fewer resources and supports, compared to LGBTQ individuals in urban or metropolis regions (Lyons, Hosking, & Rozbroj, 2015), which can in turn increase minority stressors and negatively affect their mental health.

Finally, age (or year of birth) can also be a source of mediation or alteration in the minority stress model (Bybee, Sullivan, Zielonka, & Moes, 2009; Kertzner, Meyer, Frost, & Stirratt, 2009; Lelutiu-Weinberger, et al., 2013; Wight, LeBlanc, de Vries, & Detels, 2012). The literature demonstrates that age can moderate the minority stress model in various ways. For instance, Wight, LeBlanc, de Vries, and Detels (2012) argue that age-related and sexual orientation-related stress both affect mental health among middle-aged and older gay men. Further, Kertzner, Meyer, Frost, & Stirratt (2009) found that younger LGB respondents ages 18-29 reported lower levels of social wellbeing, compared to older LGB adults. Kertzner et al. (2009) indicated that perhaps older LGB adults have more resources or agency to find supportive networks, whereas younger LGB participants may not have these resources or avenues of support. Therefore, age, among LGBTQ individuals, seems to have varied effects on different

parts of the minority stress model. In the end, despite the established relationship between enacted stigma and mental health disparities among LGBTQ individuals in the literature, there are other moderating factors such social support, ‘outness’, and intersectionality that can increase or decrease the magnitude or significance of the relationship between enacted stigma and mental health.

### **Minority Stress: Childhood Bullying, Mental Health, and Long-Term Effects**

The negative short-term effects of enacted stigma on LGBTQ adolescents and adults have been noted in the literature. A smaller body of research focuses on the relationship between childhood experiences of enacted stigma (such as bullying) and mental health disparities in adulthood such as depression, anxiety, suicidal behaviour, lower self-esteem, or psychological distress (Allison, Roeger, & Reinfeld-Kirkman, 2009; Bouffard, & Koepfel, 2014; Carlisle, & Rofes, 2007; Due, et al., 2011; Friedman, Marshal, Stall, Cheong, & Wright, 2008; Lund, et al., 2009; Rivers, 2001, 2004; Roeger, Allison, Korossy–Horwood, Eckert, & Goldney, 2010; Rosen, Underwood, Gentsch, Rahdar, & Wharton, 2012; Schäfer, et al., 2004; Sigurdson, Undheim, Wallander, Lydersen, & Sund, 2015; Sourander, et al., 2007; Takizawa, Maughan, & Arseneault, 2014; Wolke, Copeland, Angold, & Costello, 2013). For instance, among a sample of 884 adults from Spain, United Kingdom, and Germany, Schäfer et al. (2004) found that individuals who had experienced bullying in primary or secondary school were more likely to report lower levels of self-esteem (“e.g. Nothing I do is really important” (p. 383)), and lower levels of emotional wellbeing (“e.g. There are people who really understand me” (p. 383)), compared to their non-bullied counterparts.



However, only a few studies focus on childhood experiences of bullying and mental health among LGBTQ adults specifically (Friedman, et al., 2008; Josephson, & Whiffen, 2007; Rivers, 2001, 2004). For instance, Friedman and colleagues (2008) report that gay or bisexual men who experienced homophobic harassment in their youth were more likely to have health problems such as depression. Further, Rivers (2004) reports, among a sample of LGB adults, that 26% of respondents indicated feelings of psychological distress in recollecting past experiences of in-school bullying (see Josephson, & Whiffen, 2007 for similar results). To this end, the majority of research on childhood bullying and the mental health of LGBTQ adults has focused on their propensity for mental illness or disorder; however, little of the previous literature has focused on the effect of childhood bullying on positive mental health among LGBTQ adults.

## **Chapter 4: Methods**

### **Hypotheses**

Although researchers have explored the short-term relationship between enacted stigma and mental health among LGBTQ individuals, upon reviewing the literature, there are relatively few researchers who have explored the minority stress model looking at the relationship between positive mental health and past experiences of prejudice such as childhood bullying among LGBTQ adults. The purpose of the current study is to address such a gap in the literature, and extend minority stress theory to consider the relationship between childhood bullying and positive mental health in adulthood using a sample of Canadian adults.

Specifically, the current thesis will explore positive mental health among LGBTQ adults in comparison to their cisgender heterosexual counterparts, as well as explore within-group comparisons, by answering the following research questions: (1) Is there a significant difference

between LGBTQ and cisgender heterosexual adults in terms of positive mental health?, (2) are LGBTQ adults more likely to have experienced childhood bullying compared to cisgender heterosexual adults?, (3) do LGBTQ adults who have not experienced childhood bullying exhibit similar levels of positive mental health compared to their cisgender heterosexual counterparts?; and finally, (4a) is there a relationship between childhood bullying and positive mental health among LGBTQ adults?; and, if yes, (4b) what significant factors influence this relationship? Based on the literature, minority stress theory, and the research questions, the current study will thus test the four following hypotheses:

*Hypothesis 1:* LGBTQ adults will have significantly lower levels of positive mental health compared to their cisgender heterosexual counterparts.

*Hypothesis 2:* A higher percentage of LGBTQ adults will have experienced childhood bullying than cisgender heterosexual adults.

*Hypothesis 3:* LGBTQ adults that have not experienced childhood bullying will exhibit similar levels of positive mental health to non-bullied cisgender heterosexual adults.

*Hypothesis 4:* Consistent with minority stress theory, childhood bullying will be negatively associated with positive mental health among LGBTQ adults.

## **Sample Description**

The current study uses data from the Every Teacher project for analysis. The Every Teacher project is a national Canadian study focusing on the presence and quality of LGBTQ-inclusive policies and practices in Canadian schools. The survey's target population included educators across all Canadian provinces and territories. The method used to obtain the sample involved contacting teacher organizations across Canada, and asking them to recruit potential participants from their current members (Taylor, et al., 2015). The teacher organizations contacted potential survey participants by e-mail, website promotion (<https://egale.ca/every-teacher-project/>),

newsletters, and in person. Willing participants were given a link to access the survey online (Taylor, et al., 2015). The final report for the Every Teacher project has more information on the survey development and data collection involved in this Canada-wide project (see Taylor, et al., 2015).

There were two surveys in which respondents could participate: a short-form questionnaire and a long-form questionnaire (i.e. supplemental questionnaire). The majority of respondents completed the short-form questionnaire (n=3319); however, fewer respondents (n=1974) agreed to continue and answer the long-form questionnaire. Questions addressing the main dependent measure (positive mental health) were asked in the supplemental questionnaire, and therefore the sample is substantially reduced, but nevertheless sufficiently large (n=1974). The sample is considered sufficiently large because the statistical difference between 1000 and 3000 respondents becomes minor as the sample size exceeds 1000 respondents. Of those respondents who listed their sexual orientation, the majority identified as cisgender, heterosexual (80.4%, n=1529), while one-fifth (19.6%, n=372) identified as LGBTQ<sup>18</sup>.

Further comparing LGBTQ and cisgender heterosexual respondents, the large majority of LGBTQ respondents were classroom teachers (90.3%), followed by non-teachers such as administrators or librarians (6.2%), and counselors (i.e. guidance counselors, social workers, school psychologists) (3.5%). Similarly, the majority of cisgender heterosexual respondents were classroom teachers (87.8%), followed by counselors (6.9%), and other non-teachers (5.4%). The majority of both LGBTQ and cisgender heterosexual participants identified as female (53.2%, 75.9%, respectively). Both LGBTQ and cisgender heterosexual respondents had a mean age of 41 years. The largest proportion of LGBTQ respondents were employed in Ontario (42.5%),

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<sup>18</sup> 3.7% or 73 respondents chose “Don’t Know” or did not answer the question and were set to missing.

followed by Manitoba (27.2%), British Columbia (7.3%), and Alberta (6.2%). The remaining LGBTQ participants (16.8%) were located across the Atlantic provinces, the Territories, Saskatchewan, and Québec. In comparison, the largest proportion of cisgender heterosexual respondents were employed in Manitoba (42.9%), followed by Ontario (16.2%), British Columbia (8.8%), and Alberta (5.6%); and again the remaining cisgender heterosexual respondents (26.5%) were located across Saskatchewan, the Atlantic provinces, the Territories, and Québec. Manitoba-based participants were overrepresented in the sample due to the close affiliation between the Every Teacher Project and the Manitoba Teacher's Association. To account for this overrepresentation, the current project used a weighting algorithm so that the data conformed to the overall number of teachers in each province/territory (see Taylor, et al., 2015).

In terms of race/ethnicity, the majority of both LGBTQ and cisgender heterosexual participants identified as white (87.3% and 90.4%, respectively), followed by Aboriginal (First Nations, Métis, and Inuit) (6.2% and 6.3%, respectively), and other racialized groups (i.e. Black African/Caribbean/Canadian, Asian, South or Southeast Asian, Arab, Latin American, and French Canadian/Acadian) (6.5% and 3.3%, respectively). The majority of LGBTQ participants were employed on permanent contracts rather than term, occasional, casual or substitute contracts (87.1% vs. 12.9%, respectively). Cisgender heterosexual respondents had a similar distribution in terms of employment contract (88.1% vs. 11.9%, respectively). Focusing on school demographics, LGBTQ respondents reported that there were on average 705 students enrolled in their schools ( $s=602.32$ ), compared to an average of 558 students reported by cisgender heterosexual respondents ( $s=432.55$ ). The majority of schools, for both LGBTQ and cisgender heterosexual respondents, were located in urban (93.5% and 87.2%, respectively)

rather than rural areas (6.5% and 12.8%, respectively), and were non-religious (90.8% and 92.4%, respectively) rather than Catholic (9.2% and 7.6%, respectively). For sample descriptions of LGBTQ and cisgender heterosexual respondents see Table 1.

Table 1

*Sample Description: LGBTQ vs. Cisgender Heterosexual (CH) respondents  
(Unweighted)*

	<u>LGBTQ</u>	<u>CH</u>
Current Position		
Teachers	90.3%	87.8%
Non-Teachers	6.2%	6.9%
Counselors	3.5%	5.4%
Gender		
Male	46.8%	24.1%
Female	53.2%	75.9%
Age (mean)	41.13	40.94
Province		
Alberta	6.2%	5.6%
Atlantic Provinces**	9.4%	14.9%
British Columbia	7.3%	8.8%
Manitoba	27.2%	42.9%
Ontario	42.5%	16.2%
Quebec	1.9%	1.2%
Saskatchewan	2.2%	6.1%
Territories***	3.5%	4.0%
Race/Ethnicity		
White	87.3%	90.4%
Aboriginal	6.2%	6.3%
Other Racialized	6.5%	3.3%
Employment Contract		
Permanent	87.1%	88.1%
Term, casual, substitute	12.9%	11.9%
School Size (mean number of students)	705 (602.32)	558 (432.55)
School location		
Urban	93.5%	87.2%
Rural	6.5%	12.8%
School Religious Affiliation		
Non-religious	90.8%	92.4%
Catholic school	9.2%	7.6%

\*\*Atlantic provinces Prince Edward Island, Nova Scotia, New Brunswick, and Newfoundland and Labrador.

\*\*\*Territories include the Yukon, Nunavut, and the Northwest Territories.

## Measures

### **Dependent measures.**

*Positive mental health (flourishing vs. languishing).* The dependent variable for the first part of the analysis was a categorical positive mental health variable. Using criteria from the Mental Health Continuum-Short Form (MHC-SF) created by Keyes (2002, 2009b), respondents were coded into flourishing, moderate, or languishing levels of positive mental health. To be considered “flourishing”, a participant has to have a response of “every day” or “almost every day” on at least one of the emotional well-being measures, and at least six of the social and psychological wellbeing measures. In contrast, to be categorized as “languishing”, a participant has to have a response of “never” or “once or twice” on at least one of the emotional wellbeing measures, and at least six of the social and psychological wellbeing measures (Keyes, 2002, 2007; Gilmour, 2014; Howell, Keyes, & Passmore, 2013). Respondents that did not fit the criteria for languishing or flourishing levels of mental health were inserted into a third, middle-category of “moderately mentally healthy”. However, for the purpose of the current project, due to the low number of respondents in the languishing category, respondents that fell into the moderately mentally healthy category were combined with the languishing respondents; because according to Keyes (2002, 2006, 2007, p.103), whether moderate or languishing, if one is not flourishing in terms of positive mental health, then they have a less than healthy or optimal state of mental health.

*Positive mental health index.* The dependent variable for the second and third parts of the analysis was a continuous positive mental health index (Keyes, 2002). The positive mental

health index was computed using 14 items on a 5-point Likert scale (see Table 2), that asked respondents how frequently in the past month they had experienced feelings of emotional, psychological and social wellbeing. The 14 items form the Mental Health Continuum Short-Form Index introduced by Corey Keyes. Before computation, the 14 items were reversed-coded so that the highest value reflects the lower frequency of feeling emotional, psychological and social wellbeing. A principal component factor analysis was then used to explore underlying themes of the 14 positive mental health items. Preliminary analyses indicate that the 14 items loaded onto two factors with eigenvalues greater than one (see Table 1). However, the scree plot (Cattell, 1988), suggested a single factor solution because of the 5.8-point difference between the eigenvalues scores on the first and second factor. The 14 items were thus computed into a uni-dimensional index ( $\alpha=.91$ ), which is consistent with Keyes' argument that emotional, psychological and social wellbeing compose one robust measure of positive mental health (Keyes, 2002). The positive mental health index was then mean-centered, and finally, standardized into z-scores. Mean centering and standardizing measures are useful for interpretation, because it allows researchers to compare different variables on a common measurement using standard deviations from the mean (or average scores).

Table 2

*Dependent Measure: Mean, Standard Deviation, and Factor Loadings*

	<u>Mean</u>	<u>SD</u>	<u>Factor Loadings</u>	<u>% Of Variation</u>	<u>Eigenvalue</u>
<u>Factor 1 – Positive Mental Health</u>					
“Happy”	4.06	.983	.802	50.004	7.001
“Interested in life”	4.37	.975	.811		
“Satisfied with life”	3.92	1.13	.828		
“Contribution to society”	3.99	1.22	.733		
“Belonging to a community”	3.63	1.45	.694		
“Like most parts of your personality”	4.05	1.07	.784		
“Managing responsibilities of daily life”	3.89	1.09	.681		
“Warm and trusting relationships”	4.29	1.04	.758		
“Confident to think or express opinions/ideas”	4.19	1.02	.675		
“Sense of direction or meaning”	4.05	1.21	.797		
“Society is becoming a better place for people”	2.42	1.53	.545		
“People are basically good”	3.89	1.18	.650		
“The way society works makes sense to you”	2.47	1.53	.532		
“Experiences challenged you and made you a better person”	3.74	1.30	.499		
Total Variance (n=1330)				50.004	
KMO=.952					
Bartlett’s p<.001					
Cronbach’s alpha=.912					



### **Independent measures.**

*Experiences of childhood bullying (or enacted stigma).* The main independent variable was past experiences of bullying in childhood. Two measures of childhood bullying were employed. The first measure computed childhood bullying into a dummy variable with two possible values: “yes” (a respondent reported any childhood bullying), or “no” (a respondent had never experienced childhood bullying). “Yes” was coded as 1 (64%). Past experiences of bullying was also re-computed into a discrete dummy variable with the following five categories: not bullied (36%), bullied with minimal impact (15%), bullied with moderate impact (24%), bullied with a severe impact at the time, but is now over it (18%), and bullied with a severe impact that is still distressing for the respondent (6%). The ‘not bullied’ dummy category was excluded from the regression analysis, and used as the reference category. Both measures were used in separate parts of the analysis.

*Supportive measures.* Five variables were included in the regression to measure supportive LGBTQ environments (following measures suggested by Oswald, Cuthbertson, Lazarevic, & Goldberg, 2010): (1) the presence of policies that address homophobic harassment, (2) the presence of policies that address transphobic harassment, (3) whether or not the respondent was ‘out’ about their LGBTQ identity, (4) support in dealing with LGBTQ-related issues at school, and (5) feelings of school safety for LGBTQ students. The presence of policies that address homophobic and/or transphobic harassment, and whether a respondent is ‘out’ about their LGBTQ identity were coded into dummy variables.

The ‘perceived support of LGBTQ issues’ index was computed from 4 items that asked respondents whether they felt they would receive support in addressing LGBTQ issues at school

( $\alpha=.82$ ). The LGBTQ school safety index was computed from 6 items that asked respondents how safe they felt the school environment was for LGBTQ students ( $\alpha=.94$ ). Both indices were then mean-centered, and finally, standardized into z-scores.

**Demographics.** Two demographic items were controlled for in the analysis: age and employment status. Employment status was coded into a dummy variable, with ‘permanent contract’ coded as 1 (87%), and the current age of respondents was coded as the stated age of a respondent. Age ranged from 23 to 66 years of age ( $\bar{x}=41.35$ ,  $s=9.53$ ). Descriptive statistics for all continuous and dummy variables can be found in Table 3.

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Table 3

*Descriptive Statistics: Independent Measures*

<u>Continuous measures</u>	<u>Mean</u>	<u>Standard Deviation</u>
Age	41.06	9.90
School Safety	0	1
LGBTQ Support	0	1
<u>Dummy measures</u>	<u>% Yes</u>	
LGBTQ/CH	19.6% (LGBTQ)	
Childhood Bullying	64.0%	
Past Experiences of Bullying		
Not bullied (reference)	36.0%	
Minimal Impact	15.4%	
Moderate Impact	23.9%	
Severe Bullying, But Over it	18.3%	
Severe Impact, But Distressing	6.4%	
Employment Status	88.1% (Permanent)	
Homophobic Harassment Policies	66.4%	
Transphobic Harassment Policies	50.3%	
Out to anyone at school*	78.2%	

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\*LGBTQ-identified respondents only.

## **Analytical Procedures**

Four separate analyses were conducted throughout the course of the study using the Statistical Package for the Social Sciences (SPSS). First, the current study compared positive mental health between LGBTQ and cisgender heterosexual respondents. Chi-square analysis was then used to compare differences between these groups in terms of the percentage of LGBTQ and cisgender heterosexual respondents that are flourishing, and the percentage of LGBTQ and cisgender heterosexual respondents that are languishing (or “moderately mentally healthy”) in positive mental health. Cramer’s V was used to measure the effect size<sup>19</sup> of the relationship between LGBTQ/cisgender heterosexual status and positive mental health.

Second, the thesis compared childhood bullying between LGBTQ and cisgender heterosexual respondents. Chi-square analysis was again used to determine whether LGBTQ respondents were significantly more likely to have experienced childhood bullying compared to cisgender heterosexual respondents. Cramer’s V was then applied to determine the magnitude of the relationship. Third, the current thesis used chi-square to explore the relationship between positive mental health and childhood bullying, to explore whether LGBTQ and CH adults who reported no experiences of childhood bullying reported a similar percentage of flourishing levels of positive mental health. Cramer’s V was used to establish the strength of the relationship between these two measures, if such a relationship existed. Upon conducting missing-value analysis, the missing data for the first three research questions were found to be missing completely at random, and from such a discovery multiple imputations were used to address the missing values in the first three parts of the analysis.

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<sup>19</sup> Effect size measures the strength or magnitude of the relationship.

Finally, the relationship between positive mental health and childhood bullying among LGBTQ adults was explored in more detail. Using a hierarchical ordinary least squares regression model, the current study looked at the effect of past experiences of childhood bullying on positive mental health among LGBTQ respondents. A hierarchical ordinary linear regression model was used, because it requires a continuous dependent measure (i.e. positive mental health index), and using the hierarchical block enter method allows researchers to test for spurious effects between variables in the regression model (Tabachnick, & Fidell, 2013). An ordinary least squares regression model also allows for the use of both continuous and dummy or discrete independent measures. T-tests were used to determine if there were any significant differences in terms of positive mental health among several demographic variables. The only two demographic variables that demonstrated significant differences on the positive mental health index were age and employment contract. From this information, both variables were used as control variables in the regression model. Three blocks were entered into the regression model in the following order: (1) demographic controls (i.e. age and employment contract), (2) severity of childhood bullying, and (3) supportive LGBTQ environment measures. To account for and address missing values in the analysis, pairwise deletion was then employed in the regression model. Lastly, all analyses were weighted by province using a weighting algorithm in SPSS. For more information on the weighting procedures used in the analysis see Taylor and colleagues' (2015) report on the Every Teacher dataset.

### **Methodological Limitations**

While the importance and novelty of the current research is evident, there are limitations in the data and statistical analysis that must be noted. First, to account for missing values, pairwise

deletion was employed for the linear regression model, and multiple imputations were employed for the three bivariate analyses (for an explanation of pairwise deletion and multiple imputations, see Baraldi, & Enders, 2010; Little, Jorgensen, Lang, & Moore, 2013). Missing values were assumed throughout the analysis, which involves filling gaps in the data using probability statistics. Using missing value procedures to fill in such gaps can invite statistical error or bias; however, it also allows participants with some missing information to remain part of the statistical analysis (for more discussion about missing value analysis, see Tabachnick, & Fidell, 2013). As noted in the literature, it is better to impute or assume missing cases than to remove them completely from the analysis (Janssen, et al., 2010). First, pairwise deletion has its limitations in respect to bias and statistical error, however, unlike other missing value procedures (e.g., listwise deletion) the participants that report missing cases on some of the variables are still included in the final analysis (Baraldi, & Enders, 2010). Further, as argued by other academics, multiple imputations, another method used in the current study, is one of the best methods to use (i.e., “state of the art”) in resolving missing values, and therefore despite its limitations, it is the best available method (Schafer, & Graham, 2002; Janssen, et al., 2010; van der Heijden, Donders, Stijnen, & Moons, 2006).

Second, the level of measurement of the variables limited the data analysis, in that many of the variables used were dummy measures. Therefore, the results do not give as robust a level of statistical information about the relationship between childhood bullying and positive mental health as could have been achieved using higher levels of measurement such as interval or ratio data. For example, the current study used two measures of childhood bullying. The dichotomous childhood bullying measure simply relayed whether or not the respondent had experienced childhood bullying; however, the discrete categorical variable, a measure that is technically a

higher level of order, allowed researchers to further understand the impact of such bullying. Hence, higher levels of measurement allow researchers to get more information, so again, instead of only knowing whether participants had experienced childhood bullying, researchers could also obtain information about how severely such bullying had impacted the participants.

Third, the current sample only looked at Canadian educators. Therefore, although the current study can explore a relationship between enacted stigma and positive mental health among Canadian adults, and more specifically among Canadian education professionals, the current sample is not completely representative of the LGBTQ or the Canadian community as a whole. However, despite the specific sample, in comparing LGBTQ and CH adults, using a sample of educators helps account for other factors such as employment, in that all participants are employed, and further, have similar salaries, although potentially different social locations (e.g., single-parent vs. two parent family).

The sample could also be subject to self-selection or volunteer bias. For instance, the current sample consists of people who agreed or chose themselves to participate in the questionnaire, which can introduce bias in respect to what population of people the current research is analyzing. Further, in regard to the sampling frame, the sample is not a probability sample, because it was collected using non-probability-sampling techniques. However, the demographics of the current sample of Canadian educators closely resemble the demographics of the actual population of Canadian educators (as noted in Taylor, et al., 2015). Hence, one can argue that the sample acts as a probability sample, although any factors or variables affecting whether certain Canadian educators decided to answer the questionnaire are unknown. In other words, there may be patterns of self-selection bias, but unfortunately the current thesis could not compare participants who answered the questionnaire to participants who refused to answer the

questionnaire. Ultimately, despite the limitations of the current sample, as noted by other researchers (Meyer, & Wilson, 2009; Moradi, Mohr, Worthington, & Fassinger, 2009), obtaining a substantive number of LGBTQ and CH individuals in one research sample, particularly within a sample of adults, is a difficult task. Therefore, despite the potential for self-selection bias, as well as the unrepresentative, non-probability sample of Canadian educators, in conducting a preliminary or exploratory study as to extend minority stress theory, the sample employed in the current study represents an adequate sample of professional LGBTQ and heterosexual adults within the Canadian population.

Fourth, although the current thesis is exploring the long-term relationship between childhood bullying and positive mental health, the current data are not longitudinal, and other more recent or past events that can affect one's positive mental health over time have not been taken into consideration. For instance, as noted by Horn, Kosciw, and Russell (2009), LGBTQ individuals negotiate numerous social locations, and are not always "at risk" or "resilient" in every social location. LGBTQ individuals negotiate different social contexts, beyond the workplace or educational system, wherein different forms of enacted stigma or prejudice occur such as in the family or the health-care system (Horn, Kosciw, & Russell, 2009).

Fifth, there are limitations to using self-report measures, especially measures that require participants to recall information from their adolescence. Using such measures can introduce both recall bias and self-report bias into the statistical data. Despite the limitation of self-report bias, the purpose of the current thesis is not to objectively impose, for example, what the researcher believes to be a severe or minimal form of bullying. In other words, whether a minimal impact from bullying resembles hate speech or physical harassment, how participants rate the impact of their experiences of bullying is a subjective decision of the participants

themselves. Therefore, although self-report bias allows participants to, in part, define or impose meaning on the situation, how bullying impacts the participants is not concerned with objective definitions of severe or minimal bullying, but is focused on how those experiences are rated or remembered by participants themselves. Further, in regard to recall bias, although asking participants to remember an event that happened to them potentially over 20 years ago can invite inaccurate reports of what ‘actually’ happened, the current thesis is concerned with how such experiences are affecting the participants today. Therefore, how participants recollect childhood bullying is also an indicator of how those experiences could still be affecting them today. Further, in a similar study exploring the long-term effects of bullying on gay adults, Rivers (2001) asked a sub-sample of respondents to complete the questionnaire at two separate times to test the reliability of the participants’ memories. Rivers (2001) found the memories of the participants were impressively accurate with respect to recalling information about their experiences of bullying in their adolescence, and therefore, the limitations of recall bias did not significantly affect the accuracy of the data. Ultimately, recall bias and self-report bias are notable limitations of the current data, but for the purpose of the current thesis, the accuracy of the story being told is not necessarily the focus, but it is how participants characterize the impact of such experiences or how it is impacting them today that is the important information.



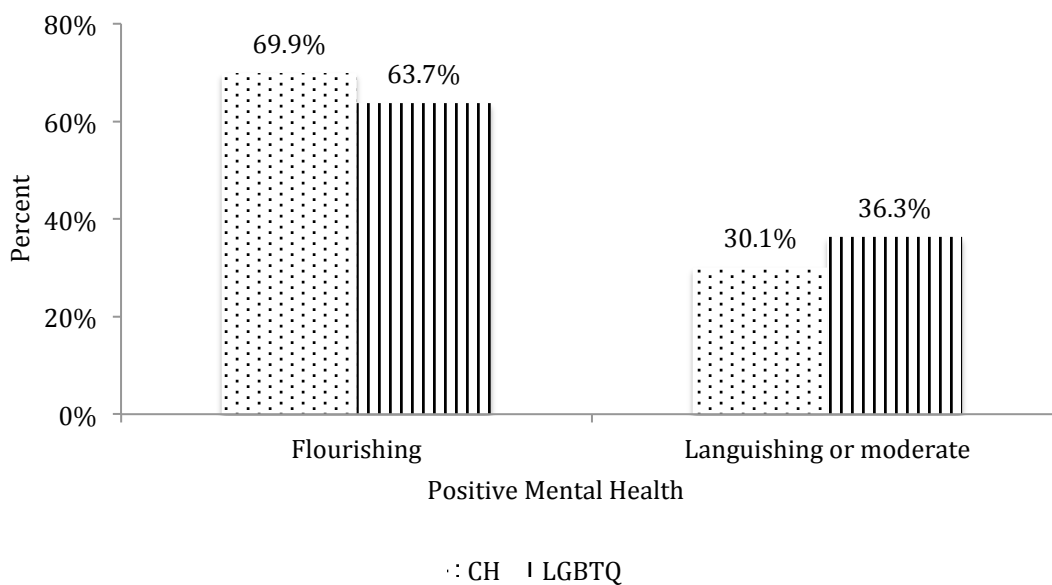
## Chapter 5: Results

### (1) Positive Mental Health: LGBTQ vs. CH

Based on the chi-square analysis, there was a significant association between positive mental health (PMH) and LGBTQ or cisgender heterosexual (CH) identity. More specifically, LGBTQ adults were significantly more likely to have languishing or moderate levels of positive mental health, compared to CH adults (36.3% vs. 30.1%, respectively,  $p < .001$ ); or in other words, CH adults were significantly more likely to report flourishing levels of positive mental health compared to their LGBTQ peers (69.9% vs. 63.7%, respectively,  $p < .001$ ). Therefore, the null hypothesis for the first research question can be rejected, and the research hypothesis can be supported. However, based on the value of Cramer's V ( $\phi_c = .065$ ), the association between LGBTQ/CH identity and positive mental health represented a very weak statistical association (see Figure 2).

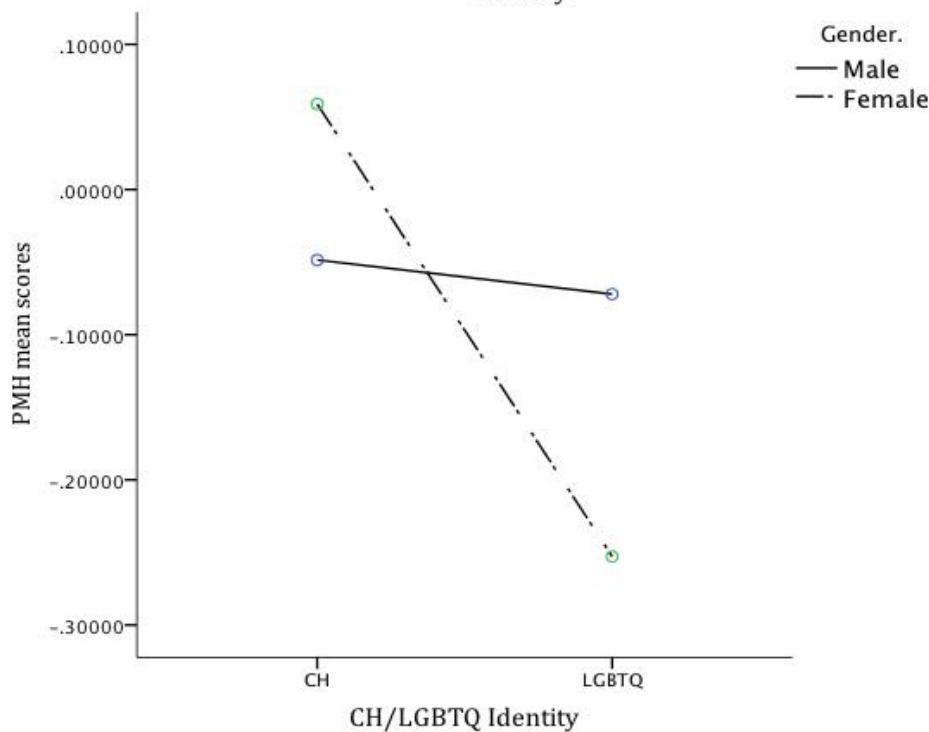
Further, the association between LGBTQ/CH identity and positive mental health was not consistent across genders; in other words, there was a gender interaction effect between LGBTQ/CH identity and positive mental health. Notably, there was no significant difference between LGBTQ and CH males on flourishing versus languishing levels of positive mental health; however such a relationship was significant between female LGBTQ and CH respondents (see Figure 3). Self-identified LGBTQ females, on average, were significantly more likely than CH females to report languishing to moderate levels of positive mental health (33.2% vs. 20.1%,  $p < .001$ ) or lower mean scores on the positive mental health index. However, again, based on Cramer's V ( $\phi_c = .133$ ), such a relationship among female respondents only demonstrated a weak relationship, although a stronger relationship than found in the overall sample.

Figure 2: Positive Mental Health - LGBTQ vs. CH adults



$$\chi^2=10.848, df=1, P<.001, \phi_c=.065$$

Figure 3: Moderating effect of gender on the relationship between PMH and LGBTQ/CH identity



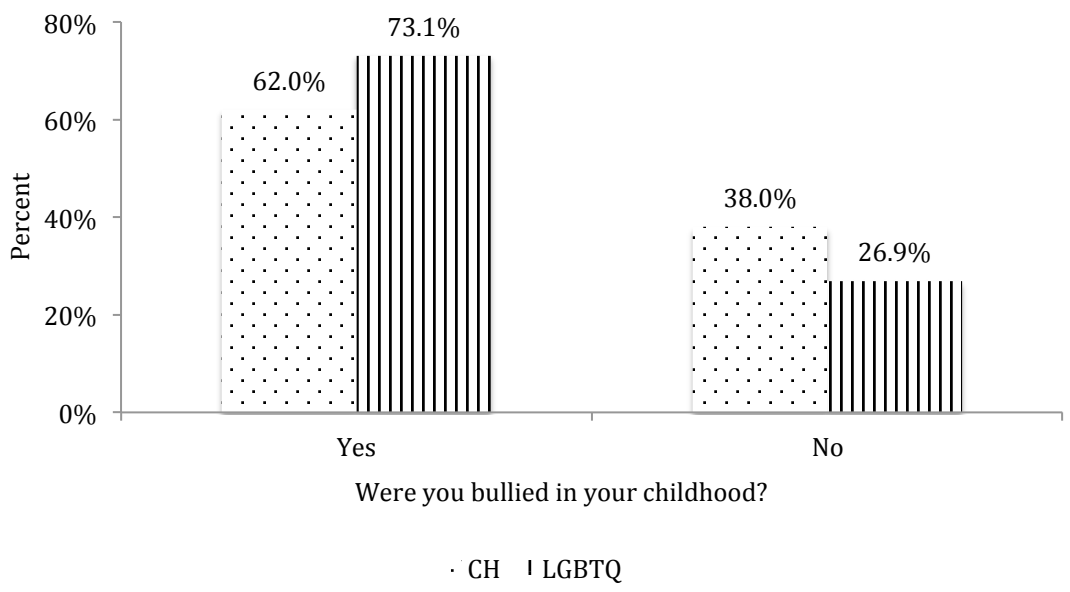
*Note: The vertical axis, namely the PMH mean scores refers to the average score that LGBTQ/CH participants reported on the positive mental health index.*

**(2) Enacted Stigma: LGBTQ vs. CH**

The chi-square analysis indicated that there was a significant difference between LGBTQ and CH adults in terms of childhood bullying. LGBTQ adults were significantly more likely than CH adults to report experiencing in-school bullying in their childhood (73.1% vs. 62.0%,  $p < .001$ ). Therefore, the null hypothesis can be rejected, and the research hypothesis for the second research question can be supported. However, based on the value of Cramer's V ( $\phi_c = .110$ ), the association between LGBTQ/CH identity and in-school childhood bullying represented a very weak statistical association (see Figures 4 and 5).

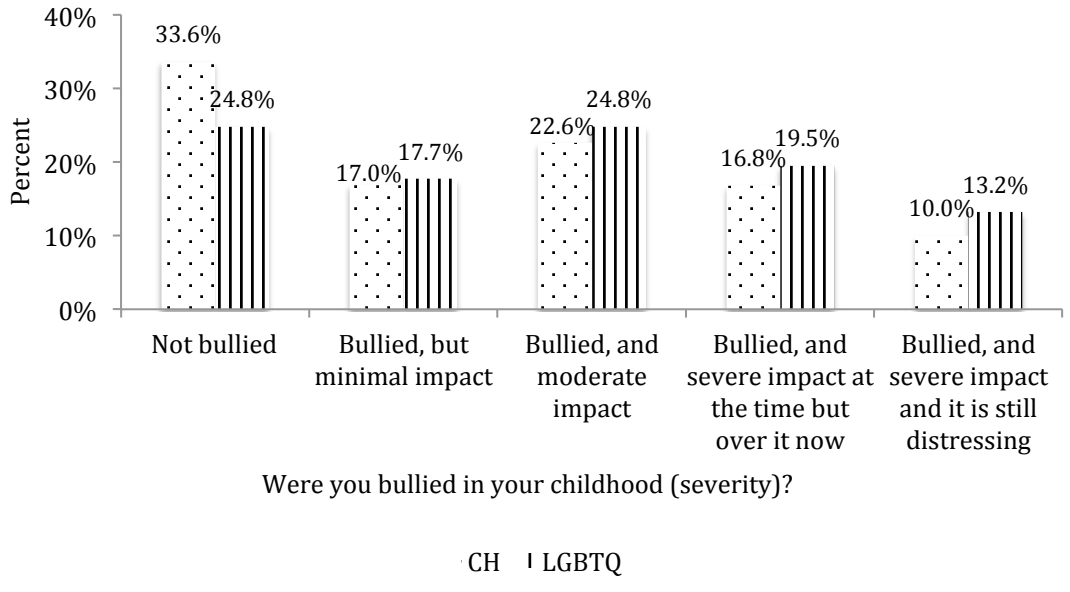
Notably, similar to the first research question, there was a gender interaction effect between CH/LGBTQ identity and childhood bullying (see Figure 6). Specifically, among female participants, there were no significant differences between LGBTQ and CH adults in reporting experiences of childhood bullying. However, among male participants, the relationship found among the overall sample remained, in that LGBTQ male adults, on average, were significantly more likely than CH adults to report childhood bullying (84.6% vs. 72.5%,  $p < .001$ ). Similar to the overall sample, the association between LGBTQ/CH identity and childhood bullying demonstrated a weak statistical association ( $\phi_c = .151$ ).

Figure 4: Childhood Bullying - LGBTQ vs. CH adults



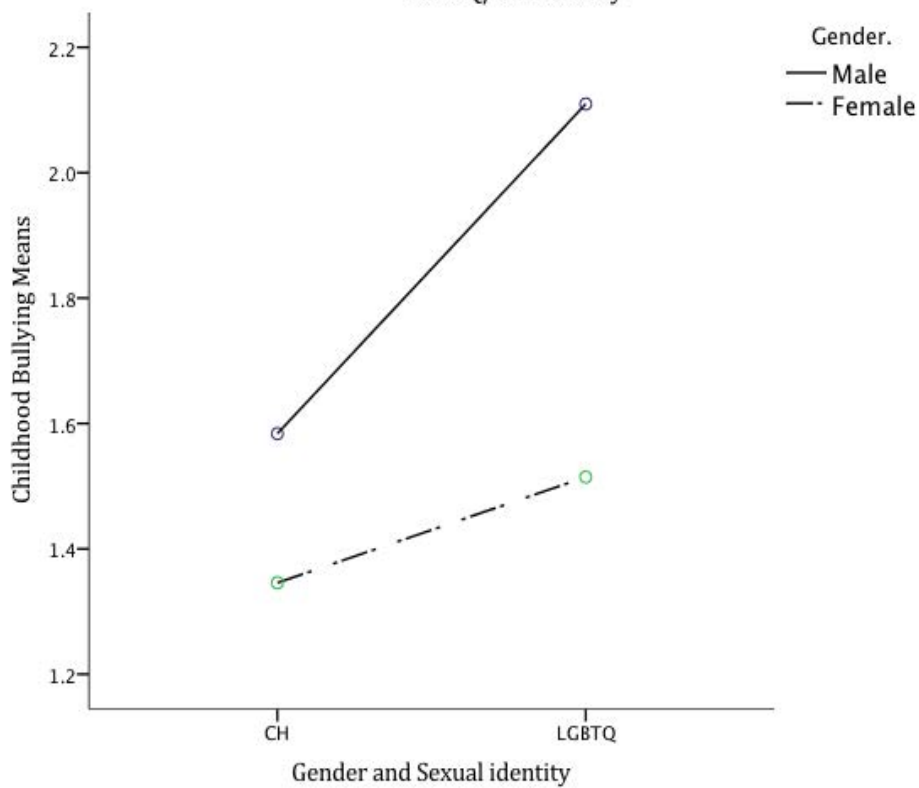
$\chi^2=27.088, df=1, P\leq 0.001, \phi_c=.110$

Figure 5: Childhood Bullying (Severity), LGBTQ vs. CH adults



$\chi^2=25.196, df=4, P\leq 0.001, \phi_c=.117$

Figure 6: Moderating effect of gender on the relationship between Childhood Bullying and LGBTQ/CH identity

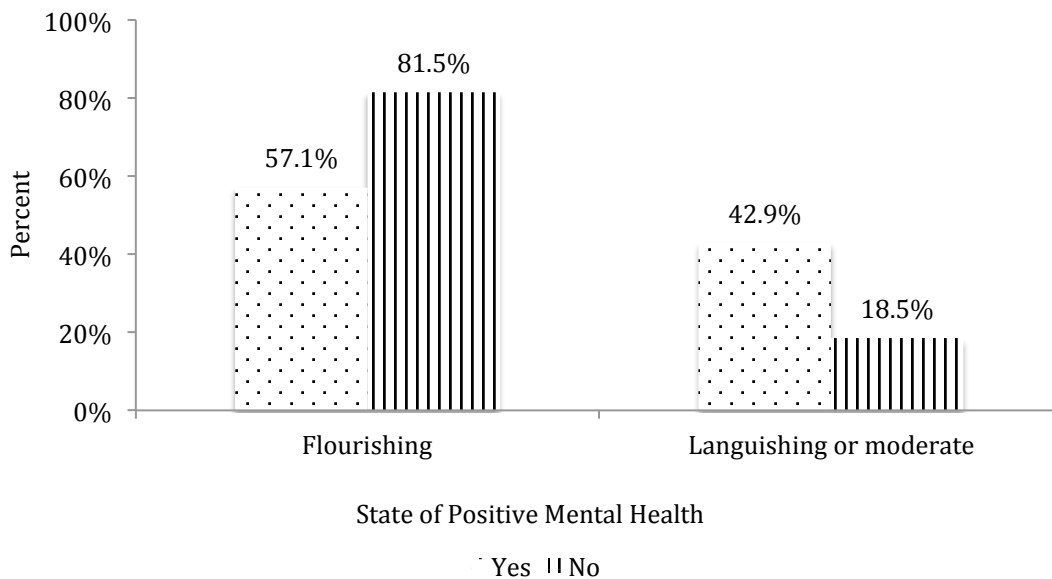


*Note: The vertical axis, namely the childhood bullying mean scores refers to the average score LGBTQ/CH participants noted on the childhood bullying measure.*

### **(3) Enacted Stigma and Positive Mental Health**

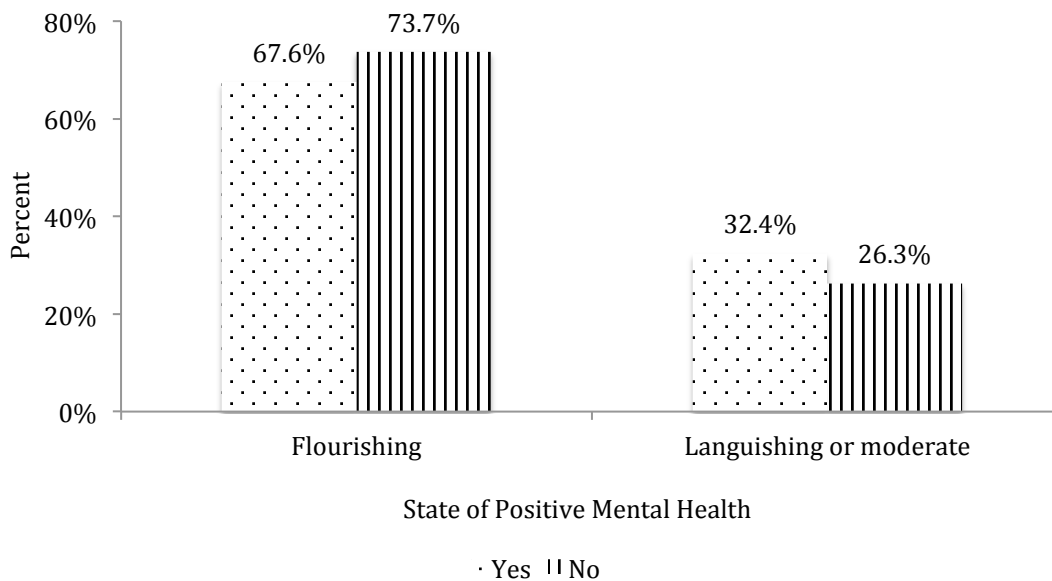
The relationship between childhood bullying and positive mental health among LGBTQ and CH adults was established. Among both LGBTQ and CH adults, respondents who had reported instances of childhood bullying were significantly more likely to report languishing levels of positive mental health than those who indicated no such experiences (42.9% vs. 18.5%,  $p < .001$ ; 32.4% vs. 26.3%,  $p < .001$ , respectfully). The relationship was stronger for LGBTQ than for CH participants. Notably, the difference between bullied and non-bullied participants was statistically very weak among CH adults ( $\phi_c = .096$ ; see Figure 8); however the difference between bullied and non-bullied LGBTQ participants demonstrated a moderate relationship between childhood bullying and positive mental health among LGBTQ adults ( $\phi_c = .231$ ; see Figure 7).

Figure 7: Childhood Bullying (yes/no) and PMH - LGBTQ adults



$\chi^2=31.32$ ,  $df=1$ ,  $P\leq 0.001$ ,  $\phi_c=.231$

Figure 8: Childhood Bullying (yes/no) and PMH - CH adults

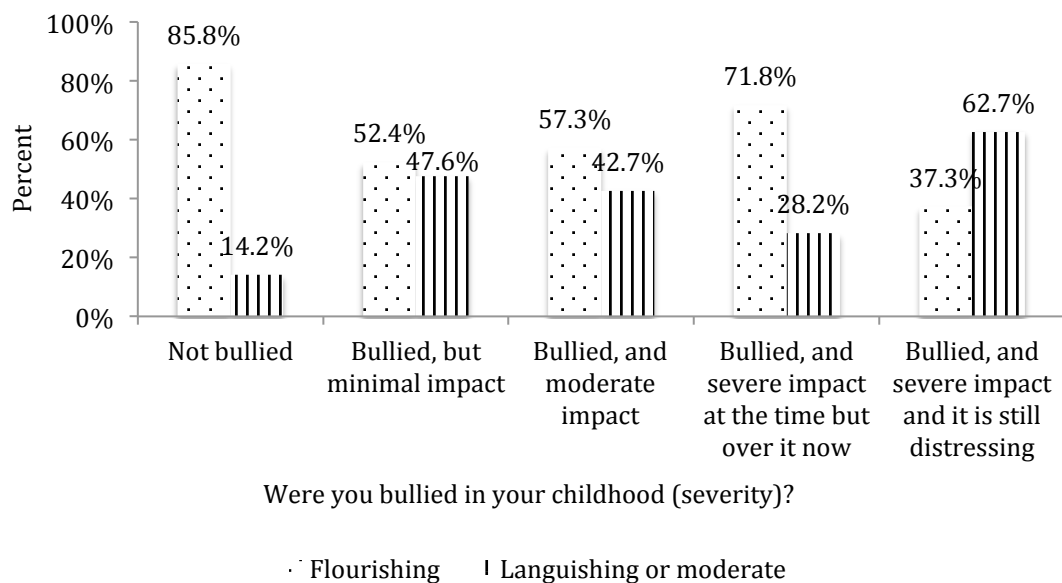


$\chi^2=15.12$ ,  $df=1$ ,  $P\leq 0.001$ ,  $\phi_c=.096$

Notably, using the categorical severity of childhood bullying measure elicited interesting results, and ultimately more information about the relationship between childhood bullying and positive mental health among LGBTQ and CH participants. A relatively consistent percentage of CH adults reported flourishing levels of positive mental health rather than languishing or moderate levels across all childhood bullying severity groups (see Figure 10). Moreover, the only group in which the percentage gap between flourishing versus languishing/moderate CH adults narrowed dramatically was among the ‘severely bullied, and still distressed’ group. In contrast, among LGBTQ adults, the ratio of flourishing versus languishing/moderate respondents varied across groups (see Figure 9). For instance, LGBTQ adults who reported no experiences of childhood bullying were significantly more likely to be flourishing than languishing or moderate (85.8% vs. 14.2%,  $p < .001$ ); however, among respondents who reported they had been severely bullied, but indicated that it was still distressing, LGBTQ adults were more likely to report languishing or moderate levels of positive mental health rather than flourishing levels (62.7% vs. 37.3%,  $p < .001$ ). In comparing LGBTQ to CH adults, the only time both groups precisely resemble one another is in relation to the percentage of flourishing vs. languishing or moderate levels of positive mental health among participants who reported a severe impact from bullying, but were over it (71.8% vs. 28.2%,  $p < .001$ ; 71.2% vs. 28.8%,  $p < .001$ , respectively). Further, LGBTQ adults only report a higher percentage of flourishing respondents than CH adults within the ‘not bullied’ category of childhood bullying (85.8% vs. 76.6%).

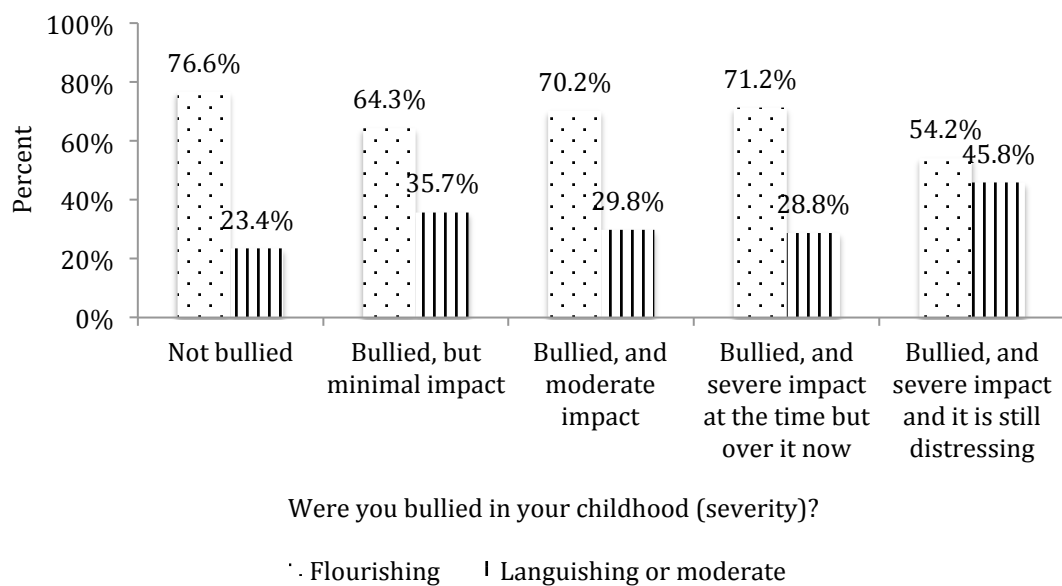


Figure 9: Childhood Bullying (Severity) and PMH - LGBTQ adults



$\chi^2=63.37$ ,  $df=4$ ,  $P<0.001$ ,  $\phi_c=.353$

Figure 10: Childhood Bullying (Severity) and PMH - CH adults



$\chi^2=66.92$ ,  $df=4$ ,  $P<0.001$ ,  $\phi_c=.096$

#### **(4) The Minority Stress Model**

The final hierarchical OLS regression model has been noted in Table 4. In regard to the demographic control variables, employment contract, but not age, is significantly associated with positive mental health. Participants indicating temporary employment contracts were significantly more likely to report higher levels of positive mental health than educators with permanent contracts. Further, in controlling for other mitigating factors, minimal ( $p < .001$ ), moderate ( $p < .01$ ), and severe ( $p < .001$ ), but still distressing categories of childhood bullying were significantly associated with positive mental health, in that compared to respondents that indicated no experiences of childhood bullying, participants that fell into these categories of severity were more likely to report lower levels of positive mental health. Minimal impact from bullying accounted for 30.1%, moderate impact accounted for 15.5%, and ‘severe impact, but still distressing’ accounted for 18.1% of the variance in positive mental health among LGBTQ adults. Notably, the only childhood bullying category that was not significantly associated with positive mental health, was the category “severe impact from bullying, but over it.”

Finally, three of the LGBTQ-supportive climate measures were significant within the final model, including: whether or not participants felt supported in addressing LGBTQ issues in school ( $p < .01$ ); the presence or absence of transphobic harassment policies ( $p < .01$ ); and whether or not a participant had disclosed their LGBTQ identity to another individual ( $p < .001$ ).

Participants who indicated they felt supported in addressing LGBTQ issues in school were significantly more likely to report higher levels of positive mental health than participants who did not feel such support. Further, participants who reported the presence of transphobic harassment policies were significantly more likely to report higher levels of positive mental health than participants who reported no such policies in their workplace. Lastly, LGBTQ adults

who had disclosed their LGBTQ identity were significantly more likely to report higher levels of positive mental health than respondents who had not disclosed such an identity.

Table 4

<i>Overall OLS Regression (PMH)</i>			
<u>Variable list</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Employment Status	-.545	.154	-.172***
Age	.009	.006	.069
Minimal Impact	-.921	.176	-.301***
Moderate Impact	-.396	.154	-.155**
Severe Bullying, But Over it	.084	.160	.030
Severe Impact	-.643	.193	-.181***
LGBTQ Support	.154	.062	.131**
Homophobic Harassment Policies	-.116	.133	-.051
Transphobic Harassment Policies	.449	.141	.185**
Out to anyone at school	.755	.191	.188***
School Safety	.047	.058	.040

*Notes.*  $R^2$  (adj.)=.213 (.190)\*\*\*,  $R$ =.462,  $n$ =523  
 \* $p$  = .05; \*\*  $p$  = .01; \*\*\*  $p$  = .001

Table 5 demonstrates how the original relationship changes after controlling for possible spurious effects. As a note, block 1 refers to the introduction of control demographics; block 2 refers to the introduction of childhood bullying or enacted stigma; and block 3 refers to LGBTQ-supportive climate measures. In observing Table 5, there are no significant changes in regard to the significance of the standardized betas for each independent measure. However, there are significant changes concerning  $R^2$  and  $R$  with subsequent block inputs. With the introduction of the first block in the linear regression model, looking at the adjusted  $R^2$  values, demographic controls only account for 1.1% of the variance of positive mental health ( $p < .05$ ). However, upon the introduction of the severity of childhood bullying measure, the explained variance increases

to 10.5% ( $p < .001$ ). Finally, with the introduction of the third set of variables, namely the social support measures, the model accounts for 19.0% of the variance of positive mental health ( $p < .001$ ).

Table 5

<i>Block Input Analysis of OLS Linear Regression</i>			
	<u>Block 1</u>	<u>Block 2</u>	<u>Block 3</u>
Employment Status	-.120*	-.175**	-.172***
Age	.081	.087	.069
Minimal Impact		-.292***	-.301***
Moderate Impact		-.163**	-.155**
Severe Bullying, But Over it		.020	.030
Severe Impact		-.225***	-.181***
LGBTQ Support			.131**
Homophobic Harassment Policies			-.051
Transphobic Harassment Policies			.185**
Out to anyone at school			.188***
School Safety			.040
<i>Notes.</i> $R^2$ (adj.)=	.016(.011)*	.119(.105)***	.213(.190)***
R=	.128	.345	.462

\* $p = .05$ ; \*\*  $p = .01$ ; \*\*\*  $p = .001$

## Chapter 6: Discussion

According to Schwartz and Meyer (2010), three key pieces of information are required to adequately support minority stress theory, i.e. that a disparity between disadvantaged (e.g., LGBTQ) and advantaged (e.g. cisgender heterosexual or CH) groups exists. First, to imply that there is a mental health disparity between minority and majority groups, Schwartz and Meyer (2010) posit that the disadvantaged group should have a higher prevalence of negative mental health outcomes than their advantaged peers. Second, to maintain the disadvantaged position of the minority group, the minority group should be more likely to experience “prejudice-related stressors” than their advantaged group peers. Third, to solidify the effect of minority stress, there should be a relationship between prejudice-related stressors and negative mental health outcomes among individuals in the disadvantaged group. Schwartz and Meyer (2010) categorize the first two analyses as *between-group analysis*, and the third as *within-group analysis*. Again, they indicate that both forms of analysis should be investigated in order to adequately test minority stress theory. In what follows, each form of analysis and result will be discussed in relation to the four main research questions that have guided the current research.

### **Positive Mental Health: LGBTQ vs. CH**

Following the first *between-group analysis* suggested by Schwartz and Meyer (2010), results demonstrate that LGBTQ adults are significantly less likely to be flourishing in life, compared to CH adults. Thus, in answering the first research question, the current study found that there is a disparity between CH and LGBTQ adults in relation to positive mental health. This finding is consistent with previous literature, albeit largely in relation to mental health disorders, wherein LGBTQ adults are more likely to report higher levels of mental health disorders or negative

mental health outcomes (e.g., depression) (Bostwick, Boyd, Hughes, & McCabe, 2010; Conron, Mimiaga, & Landers, 2010; Frost, & LeBlanc, 2014; Ward, Dahlhamer, Galinsky, & Joestl, 2014). Some studies have illustrated differences between LGBTQ and CH individuals on indicators of positive mental health – such as self-esteem (e.g. Galliher, Rostosky, & Hughes, 2004; Rivers, & Noret, 2008). For instance, Galliher, Rostosky, and Hughes (2004) found that heterosexual youth were significantly more likely to report higher levels of self-esteem, compared to bisexual youth, although no such disparities emerged in comparing heterosexual and gay-identified adolescents. However, other researchers have reported no such disparities between these two groups on positive mental health indicators (e.g., life satisfaction, self-esteem) (Balsam et al., 2005; Carlson, & Baxter, 1984; McArdle, & Hill, 2009). Notably, there is an absence of studies that have used a robust measure of positive mental health that include indicators of emotional, social, and psychological wellbeing, as suggested by Keyes, to explore such mental health disparities. As such, by using a more robust measure, and not a single indicator of positive mental health, the current study offers an important addition to the academic literature.

Drawing on Goffman's concept of stigma, "homosexuality" is considered a blemish of individual character, which can challenge the mental integrity of an individual who has such a "blemish." Goffman's work on stigmatized identities, however, has been criticized for its sole focus at an individualistic or symbolic interactionist level (Scambler, 2006, 2009; Beatty, & Kirby, 2006). Instead, such disparities should be considered at a structural level wherein the stigma of "homosexuality" or an LGBTQ identity is not talked about as a characteristic blemish of an individual, but rather as a structurally-defined stigma. As argued by Beatty and Kirby (2006), in focusing on the deficiencies of an individual based on their biology or character,

“attention is diverted from the critical role of social structures in the production of stigma” (p. 8). Therefore, such an individual blemish of character should be considered a structurally-defined stigma that has been shaped by a collective conscience, under a Durkheimian lens; or, in Foucauldian terms, a discursive norm that considers heterosexuality and cisgenderism as the norm and an LGBTQ identity as deviant. It is this structural form of stigma or discrimination that has created a disadvantaged position, or an incompatibility with the dominant structure of society, for LGBTQ individuals. As such, the purpose of the current thesis is not to explore the state of positive mental health among individual participants, but rather to explore the structural stigma or prejudice which positions CH individuals in a privileged or advantaged group status, and in turn, assigns LGBTQ individuals to a disadvantaged group within society. According to minority stress theory, such a disadvantaged status can negatively affect one’s ability to think positively and function productively in society.

It is important to point out, however, that even though LGBTQ adults were less likely to be flourishing than CH individuals, the majority of LGBTQ respondents (63.7%) reported that they were flourishing in terms of their positive mental health. Thus, although LGBTQ individuals have to endure a dominant climate of heteronormativity and cisgenderism, most still flourish and thrive emotionally, socially, and psychologically. As Russell (2005) writes in reference to his work on LGBTQ youth, “As researchers, we must be diligent that research does not serve to marginalize or label individual sexual minority youth as unavoidably at risk” (p. 14). As such, the purpose of the current research is not to illustrate that LGBTQ adults are “unavoidably at risk” due to their sexual orientation or gender identity, but to recognize that LGBTQ adults are “at risk” for low levels of positive mental health, as a result of homophobia and transphobia has being ingrained in the dominant structure of society through the process of

discourse and the rise of social norms. While this may be a dominant structure, it is also one that is not rigid, and can therefore be transformed so as to counter homophobia and transphobia.

Further, as noted by Schwartz and Meyer (2010), not all individuals within a disadvantaged group will have mental health disparities relative to their advantaged-group peers. Consistent with such an assertion, a gender-based interaction effect was found in regard to positive mental health and LGBTQ/CH identity in that self-identified LGBTQ women exhibited mental health disparities, compared to their CH female peers; however, between LGBTQ and CH male participants such disparities did not emerge. The literature demonstrates that certain mental health issues are more prevalent among women than men (and vice versa) (e.g. Berghe, Dewaele, Cox, & Vincke, 2010; Galliher, Rostosky, & Hughes, 2004; Pakula, Shoveller, Ratner, & Carpiano, 2016). For instance, Galliher, Rostosky, and Hughes (2004) found that lesbian and bisexual girls reported the poorest mental health outcomes compared to both CH and gay male participants, reporting the lowest levels of self-esteem and highest levels of depressive symptoms. Hence, gender differences can exist within the LGBTQ community in relation to flourishing or languishing levels of positive mental health. Further, Cohen et al. (2016) found, consistent with the current thesis results, that there were greater differences between sexual minority and heterosexual females than heterosexual and gay males on indicators of anxiety and depression, wherein sexual minority females reported the highest scores on each mental health disorder. Few studies, however, have explored within-group differences on a robust measure of positive mental health between LGBTQ and CH individuals, and thus, understanding of gender differences in relation to positive mental health remains limited.

Notably, Schwartz and Meyer (2010) assert that if members of disadvantaged groups exhibit negative mental health disparities compared to their advantaged group peers, further



analysis in regard to how prejudice contributes to mental health disparities among the disadvantaged group is warranted. Thus, based on the results of the between-group analysis (or the first research question), further inquiry into the relationship between positive mental health and prejudice-related stressors among LGBTQ adults, as noted by Schwartz and Meyer (2010), is warranted; thus the exploration of the final three research questions is justified.

### **Enacted Stigma: LGBTQ vs. CH**

The second research question addresses the second form of *between-group analysis* suggested by Schwartz and Meyer (2010). The results of the second research question demonstrate that LGBTQ individuals are more likely to report experiences of childhood bullying, compared to their CH peers. Notably, LGBTQ youth, as found in the literature, are more likely to report in-school bullying or other forms of homophobic or transphobic harassment, in comparison to CH youth (e.g. Kosciw, Greytak, Palmer, & Boesen, 2014; Taylor, & Peter, 2011); therefore, it follows that LGBTQ individuals would be more likely to recall such experiences in adulthood.

Through the development of a collective conscience of heterosexuality and cisgenderism in society, hostile and exclusionary practices towards LGBTQ or perceived LGBTQ individuals have become ingrained in numerous social institutions. The establishment of such a collective conscience positioned LGBTQ or perceived LGBTQ individuals as “deviant” based on religious and conservative morals that consider “homosexuality” a sin. In the past, from such a conception, “homosexuals” in Canada were subject to legal sanctions or punishment for their “abnormalities” as a way to reinforce the heterosexual and cisgender values of society. As noted in the results from the current study an “us vs. them” mentality still emerges between LGBTQ and CH Canadians, wherein LGBTQ youth and adults are still more likely to report experiences

of harassment, victimization, or bullying due to their sexual orientation or gender identity. In other words, despite the de-criminalization of “homosexuality” in Canada, although not subject to legal punishment, LGBTQ individuals are still sanctioned for challenging heteronormativity and cisgenderism in society. By finding that LGBTQ adults are more likely to report past experiences of childhood bullying than their CH peers, the current thesis provides confirmation of such a pattern of homophobia and transphobia in Canadian society.

Like many other social institutions, the education system is based on a structure of heteronormativity and cisgenderism. Numerous studies have demonstrated how schools foster a climate of negativity and exclusion that solidifies the “at risk” status of LGBTQ individuals, through increased levels of bullying, prejudicial speech, or through exclusionary curricula and textbooks. Such a normalization of heterosexuality and cisgenderism has come from a discourse that encourages thoughts and actions that evoke prejudice and discrimination towards LGBTQ individuals. As noted in the literature, homophobic and transphobic discourse is prominent in Canadian and international schools, emanating from teachers, school personnel, and students alike (e.g. Taylor, & Peter, 2011; Kosciw et al., 2013). Such a prominent discourse of prejudice against LGBTQ individuals in Canadian schools can translate into a homophobic or transphobic climate that supports the proliferation of negativity, bullying, and exclusion of LGBTQ youth and adults. As argued by Foucault, discourse has the power to shape or constrain individuals; it has the power to promote certain truths or understandings of the world over others. Therefore, the prominence of homophobic and transphobic discourse in schools can foster a normativity that formulates categories of right and wrong, wherein LGBTQ individuals are again placed in the “wrong” category of sexuality, and in turn, subject to an increased level of prejudice compared to their CH counterparts.

From such a process of normalization and prominence of prejudicial discourse, “homosexuality” has become a stigmatized identity, and as noted by Goffman and other academics, the results of a stigmatized identity can come in three main forms, including enacted stigma, wherein LGBTQ individuals experience first-hand prejudice or discrimination from other people. Notably, to avoid taking an individualistic or interactionist approach, the findings that indicate LGBTQ individuals are more likely to experience prejudice-related stressors than their CH peers should not be regarded as separate incidents of prejudice or bullying, but should be considered as a result of the homophobia and transphobia that remains ingrained in Canadian culture. A culture that still, at times, silently excuses homophobic and/or transphobic bullying, and in turn, places LGBTQ individuals as secondary citizens or at a disadvantage compared to their CH peers. The current study’s results are consistent with minority stress theory, which suggests that minority groups, such as LGBTQ individuals, will be more likely to experience prejudice-related stressors such as homophobic or transphobic bullying that go beyond the general stressors that CH or advantaged group members experience in their everyday lives (Meyer, 2003a).

Finally, despite the relationship between LGBTQ/CH identity and childhood bullying in the overall sample, there was a gender-based interaction term in that male LGBTQ adults were significantly more likely to report experiences of childhood bullying, compared to CH males. However, such a difference between CH and LGBTQ women did not exist. Canadian literature demonstrates that both LGBTQ boys and girls demonstrate disparities in respect to prejudice, discrimination, or harassment, compared to CH boys and girls (e.g., Peter, Taylor, Ristock, & Edkins, 2015; Saewyc, et al., 2007; Taylor, & Peter, 2011). For instance, one Canadian study, the “Every School In Every School” study conducted by Taylor and Peter (2011), demonstrated that

LGBTQ girls were more likely to report verbal and physical harassment in school due to their sexual orientation, compared to LGBTQ and heterosexual boys, as well as heterosexual girls. Similarly, another Canadian study conducted by Saewyc and colleagues (2007) found that there was a greater disparity between bisexual/lesbian and heterosexual girls in respect to physical harassment, wherein bisexual/lesbian girls were more likely to report being physically harassed compared heterosexual girls; a disparity that exceeded the one noted between gay/bisexual and heterosexual boys. Further, Saewyc and colleagues (2007) found, that although the disparity did not exceed the disparity between gay/bisexual and heterosexual boys, lesbian/bisexual girls were more likely to report verbal harassment and being excluded in school, compared to heterosexual girls. Hence, Canadian studies demonstrate that disparities exist between LGBTQ and CH female peers in respect to experiences of in-school bullying or harassment. However, despite being inconsistent with the previous Canadian literature (e.g., Peter, Taylor, Ristock, & Edkins, 2015; Saewyc, et al., 2007; Taylor, & Peter, 2011), the results of the current thesis are consistent with one previous British study conducted by Robinson, Espelage, and Rivers (2013), who found that gay/bisexual boys were more likely to experience victimization in comparison to their male heterosexual counterparts; however, as female participants became older, the victimization rates among lesbian/bisexual and heterosexual girls converged.

One potential explanation for such an interaction could be that society reacts more severely to boys who do not conform to masculine traits or characteristics, compared to girls who do not conform to feminine standards. As such, gay males or self-identified male-to-female transgender individuals may experience more bullying than CH individuals due to gender non-conforming behaviour (Hort, Fagot, & Leinbach, 1990). Another explanation for such a gender effect could be that gay boys are more likely to self-label or to be aware of their gay identity at

an earlier age than girls (D'Augelli, & Hershberger, 1993; Savin-Williams, & Diamond, 2000). Therefore, gay boys are potentially more likely to disclose their gay identity at an earlier time in their life, and as noted in the literature, disclosing one's gay identity earlier can increase the frequency of in-school bullying (D'Augelli, Hershberger, & Pilkington, 1998; D'Augelli, 2003; D'Augelli, & Grossman, 2001; Huebner, Rebchook, & Kegeles, 2004; Kattari, et al., 2016; Rivers, 2001; Swank, Fahs, & Frost, 2013). However, again, despite such a gender-based interaction term in the current study, other studies have found that LGBTQ girls are more likely to report in-school bullying including verbal or physical forms of harassment, compared to both their male and female CH counterparts (Taylor, & Peter, 2011; Peter, Taylor, Ristock, & Edkins, 2015).

Ultimately, the educational system acts as a conductor for homophobic or transphobic discourse and social norms, and from such a school climate, LGBTQ youth are consistently more likely to report bullying, exclusion, or other forms of harassment than their CH peers, which can translate, in turn, to recalling such experiences in adulthood. However, as will be discussed in sections below, the school can also become an arena of transformation, support, and inclusion for LGBTQ youth and adults alike; but for such a change to occur, the homophobia and transphobia ingrained in society's social structure has to be continuously challenged by, for instance, the implementation of LGBTQ-inclusive and supportive policies and practices.

### **Enacted Stigma and Positive Mental Health: LGBTQ vs. CH**

Schwartz and Meyer (2010) further propose that researchers should explore the differences between disadvantaged people who have been exposed to prejudice-related stressors, and people who report little or no exposure to such prejudice (p. 6). The third research question addresses

such an association by exploring the relationship between positive mental health and exposure to enacted stigma, and by showing how such a relationship can differ between LGBTQ and CH adults. In the current thesis, LGBTQ adults who indicated an absence of childhood bullying in their past reported a similar, but slightly higher percentage of flourishing levels of positive mental health, compared to their non-bullied CH counterparts. Hence, following the third research question, LGBTQ adults who report no experiences of childhood bullying maintain similar, and even somewhat higher, levels of positive mental health, compared to non-bullied CH participants. The results are consistent with the previous literature that suggest LGBTQ individuals who report no prejudice-related stressors will resemble CH youth on mental health outcomes (e.g., depression, suicidality) (Bontempo, & D'Augelli, 2002; Birkett, Espelage, & Koenig, 2009), or will score better on mental health outcomes compared to LGBTQ individuals who reported experiencing prejudice-related stressors such as in-school bullying (D'Augelli, & Grossman, 2001).

Further, similar to non-bullied participants, both LGBTQ and CH participants who indicated they had been severely impacted from bullying, but were “over it” resembled non-bullied LGBTQ and CH participants with respect to positive mental health (see Figure 9 and 10). In other words, participants who reported that severe childhood bullying no longer affected them were just as likely to demonstrate a healthy and thriving level of positive mental health.

All in all, as suggested by minority stress theory, LGBTQ individuals experience stressors beyond those that advantaged groups frequently experience in their everyday life. Therefore, when LGBTQ individuals can avoid augmented levels of prejudice-related stressors in their lives, including earlier experiences of minority stress such as childhood bullying, or if they can potentially work through harsh experiences of prejudice when they occur, LGBTQ

adults can resemble their flourishing and thriving CH counterparts. In essence, following Russell's (2005) rationale that research must avoid classifying sexual minority individuals as "unavoidably at risk", the current results demonstrate that LGBTQ individuals are not inescapably at risk for negative mental health outcomes, as consistently noted in the literature. But the "risk" can be, in part, attributed to the increased prevalence of enacted stigma (e.g., childhood bullying) experienced by LGBTQ adults in their youth, or the lack of resources or supports for LGBTQ individuals throughout their lifetime to work past such negative experiences in their childhood.

Further, the results illustrate that there are differences between LGBTQ and CH adults with respect to the strength and nature of the relationship between childhood bullying and positive mental health. The results demonstrate that there is a long-term association between childhood bullying and positive mental health among both LGBTQ and CH adults, wherein bullied participants in comparison to their non-bullied counterparts are more likely to report negative mental health outcomes (i.e., languishing or moderate levels of positive mental health) in adulthood. The results are consistent with the previous literature focusing on the long-term effects of bullying on the mental health of heterosexual (e.g. Schäfer et al., 2004) as well as LGBTQ individuals (e.g. Friedman, et al., 2008; Rivers, 2001, 2004).

However, although the results illustrate that there is a significant relationship between childhood bullying and positive mental health among CH adults, the relationship is not as strong as the one found among LGBTQ Canadians. The strength of the association between bullied and non-bullied LGBTQ adults in regard to flourishing versus languishing or moderate levels of positive mental health was substantially larger than the association noted for CH participants (see Figures 8 and 9). In other words, the results suggest that bullied CH adults are more likely to

report lower levels of positive mental health compared to their non-bullied peers; however, the adverse effect of childhood bullying on LGBTQ adults and their mental health is more severe than that noted by CH adults.

The results indicate that, excluding non-bullied and “severely bullied, but over it” participants, CH adults were substantially more likely to report flourishing levels of positive mental health, compared to their LGBTQ peers on the remainder of the childhood bullying categories (i.e., minimal impact, moderate impact, and ‘severe impact but still distressing’). Further, although CH participants who had reported an impact from childhood bullying, including “a severe impact, but still distressed”, were less likely than non-bullied CH adults to report flourishing levels of positive mental health (54.2% vs. 76.6%, respectively), CH participants who were still distressed from severe experiences of bullying were more likely to report a flourishing state of positive mental health. However, in comparison, LGBTQ adults who were still distressed from severe forms of bullying were more likely to report a languishing or moderate state of positive mental health than flourishing. The current results are consistent with the previous literature that demonstrates how in-school bullying can affect LGBTQ youth more adversely than their heterosexual peers in that bullied LGBTQ youth have been found to report higher scores on negative mental health outcomes such as depression or suicidality, compared to bullied heterosexual youth (Birkett, Espelage, & Koenig, 2009; Bontempo, & d’Augelli, 2002; Collier, van Beusekom, Bos, & Sandfort, 2013; Espelage, Aragon, Birkett, & Koenig, 2008; Gruber, & Fineran, 2008). For example, Birkett, Espelage and Koenig (2009) found that compared to heterosexual youth who reported a high frequency of homophobic teasing, LGB youth who also reported high rates of teasing scored the highest on measures of depression and suicidality. Nevertheless, although LGBTQ adults were more likely to experience childhood



bullying, and were observably more negatively affected by childhood bullying at all severity levels (excluding “a severe impact, but over it” and “not bullied”), it is important to recognize that CH individuals can also be negatively affected by in-school bullying (e.g. Patrick, et al., 2013; Poteat, Scheer, DiGiovanni, & Mereish, 2014).

In general, all human beings experience stressors throughout their lives, both LGBTQ and CH adults alike. However, minority stressors, namely experiences of enacted stigma (e.g., homophobic or transphobic childhood bullying) that minority groups such as LGBTQ individuals experience more frequently in their day to day life, increase the stress levels among minority groups beyond the general stress of their dominant-group peers. This can, as demonstrated in the current thesis and in the previous literature (Felix, Furlong, & Austin, 2009; Swearer, Turner, Givens, & Pollacks, 2008), have harsher effects on LGBTQ individuals and their mental wellbeing than their CH peers. Ultimately, the current thesis suggests (and supports the literature that proposes) that in the absence of prejudice-related stressors, LGBTQ adults can resemble CH adults on mental health outcomes (e.g., positive mental health); however, the presence of such prejudice-related stressors has more of an adverse effect on LGBTQ individuals.

### **The Minority Stress Model**

In answering the final research question, the current study posits that there is a negative association between childhood bullying and positive mental health among LGBTQ adults. The results are consistent with the previous literature that suggest past experiences of bullying or prejudice-related stressors can have long-term negative effects on the mental health of LGBTQ adults – albeit mostly in relation to mental health disorders (e.g. Friedman, et al., 2008; Rivers,

2001, 2004). Previous literature suggests that experiences of enacted stigma are associated with lower levels of positive mental health, although there is absence of research that has explored such effects over time. For instance, consistent with Lyons, Pitts, and Grierson's (2013) study, LGBTQ adults in the current study who had no past experiences of bullying reported higher levels of positive mental health, compared to adults who had such experiences; however, Lyons, Pitts, and Grierson's (2013) study only focused on the short-term effects of enacted stigma (i.e., within one year).

The current thesis illustrates, through the consideration of all the subsequent research questions and corresponding findings, that minority stress theory can be extended to consider the long-term effects of enacted stigma (namely childhood bullying) on the positive mental health of LGBTQ adults. In other words, using the rationale of minority stress theory, when LGBTQ individuals experience minority stressors in their childhood, the negative effect of such experiences can influence their stress levels, and in turn, their positive mental health well into adulthood. Petterson, VanderLaan, and Vasey (2016) concluded from their research that childhood is a critical period of development and growth for individuals, and therefore discrimination experienced in one's childhood can carry over into adulthood, which has been suggested by the current research findings. Consistent with Petterson, VanderLaan, and Vasey's (2016) conclusion, results suggest that experiencing a prejudice-related stressor in childhood can become a form of internalized stigma or minority stressor that persists throughout an individual's life and continuously weighs upon him or her emotionally, psychologically, and socially; or, in other words, such a traumatic event becomes a permanent stressor that negatively affects an LGBTQ individual's state of positive mental health long after the event itself.

One unique aspect of the current study is that the relationship between past experiences of bullying and positive mental health was influenced by the severity of the impact of the bullying on the participant. The severity of bullying ranged from no past experiences of bullying or no impact, minimal impact, moderate impact; severe impact, where the respondent indicated that s/he was “over it”; and severe impact, where the respondent indicated that these past experiences were still distressing to him or her. Surprisingly, the strongest negative association between positive mental health and impact of childhood bullying was not among participants who indicated they had been severely impacted from bullying; but, in comparing bullied to non-bullied participants, LGBTQ adults who reported a minimal impact from bullying demonstrated the strongest negative association with positive mental health. One explanation for such findings, as argued by other researchers, is despite experiencing prejudice or discrimination minority groups, such as LGBTQ individuals, often minimize or dismiss such experiences of prejudice as a minor, non-threatening event (Contrada, et al., 2000).

Research has found such patterns of minimization among LGBTQ individuals and other minority groups (e.g. Adams, Cahill, & Ackerlind, 2005; Ruggiero, 1999; Taylor, Ruggiero, & Louis, 1996). For instance, in one qualitative study, Adams, Cahill, and Ackerlind (2005) found that among a sample of Latino lesbian and gay youth, participants largely minimized the impact of discrimination they had experienced (for similar results, see Taylor, Ruggiero, & Louis, 1996). Some researchers have attributed such a process of minimization among minority groups to a discrepancy between group-related and personal forms of discrimination. As noted by Taylor, Ruggiero, and Louis (1996), as well as Ruggiero (1999), minority group members often acknowledge group discrimination as important and prevalent, however, personal instances of discrimination are minimized and considered unrelated to one’s minority status. In other words,

using the example of LGBTQ individuals, personal accounts of discrimination are seen as unrelated to larger structural issues of homophobia and transphobia ingrained in the dominant culture of society. Hence, LGBTQ individuals recognize the presence of heteronormativity and cisgenderism in society, but when they experience such discrimination themselves they overlook the relationship between these occurrences and such a climate of negativity and exclusion.

Ruggiero (1999) asserts that minority individuals may not be able to equate events of hate or discrimination represented in the media (e.g., violent anti-LGBTQ hate crimes), to their own personal experiences of hate or discrimination. Therefore, minority group members minimize their experiences of discrimination in comparison, despite the fact that such prejudicial experiences regardless of other instances of hate crimes or heinous acts of discrimination, could potentially weigh on their mental health. As noted by Adams, Cahill, and Ackerlind (2005), minimizing experiences of discrimination can lead to a decrease in the support received to help cope with such prejudice. Thus, if an LGBTQ individual simply underestimates homophobic or transphobic bullying as a “life lesson” or as “just a joke”, the negative implications of such an experience may not be acknowledged and in turn, could affect the mental health of the individual throughout their life. As demonstrated in the literature, subtle forms of discrimination or micro-aggressions that may seem harmless can still have adverse effects on the mental health of minority group members such as LGBTQ individuals (Nadal et al., 2011a, b), and thus, LGBTQ individuals who report minimal impacts from bullying can still be strongly affected by such experiences with respect to their positive mental health.

In essence, minority group members who experience prejudice or discrimination such as homophobic or transphobic bullying, in trying to understand the situation, can potentially minimize the impacts of such bullying on themselves and their state of mental health. Therefore,

in the current study, LGBTQ participants could have minimized their experiences of childhood bullying, and in turn, reduced their ability to obtain resources to appropriately address the negative mental health implications of such experiences of discrimination, despite an indication from the current results that LGBTQ adults who reported the lowest impact from childhood bullying demonstrated the strongest negative long-term relationship between enacted stigma and positive mental health.

Notably, one of the most interesting findings was in relation to the two categories of severe bullying. Respondents who reported a severe impact from childhood bullying, but indicated that they were “over it”, reported no significant differences in terms of positive mental health, compared to non-bullied respondents. However, respondents who had been severely impacted from childhood bullying, and also indicated that they were still distraught from these experiences, were more likely to report lower levels of positive mental health, compared to non-bullied participants. Therefore, despite both groups experiencing a severe impact from bullying in their past, the positive mental health of LGBTQ respondents who reported that these experiences still were distressing for them today, were more negatively affected by past experiences of bullying. The difference between these two groups makes sense, in that for one group the severe impact from childhood bullying is no longer a minority stressor for them, and therefore has no effect on their positive mental health in adulthood; whereas for the other group the severe impact is still a stressor for them, and in turn, can still negatively affect their positive mental health today. As a result, in answering the main research question, past experiences of bullying can affect LGBTQ individuals’ levels of positive mental health in adulthood, however, this relationship can be influenced by the impact of the bullying, and more specifically whether or not the impact of the bullying is still affecting them today.

Ryff, Keyes, and Hughes (2003) assert that the relationship between prejudice and positive mental health is not a linear relationship, in that for some people, experiences of discrimination or prejudice can either fortify or be detrimental to one's sense of positive mental health. For instance, in the current thesis, respondents who reported a severe impact from bullying, but had overcome it, resembled their non-bullied peers in terms of positive mental health. Thus, finding avenues to work through discrimination experienced in childhood can potentially strengthen or encourage growth in the state of positive mental health among LGBTQ adults, suggesting that LGBTQ individuals who have had such traumatic experiences in their childhood can, in fact, "get better". The "It Gets Better" campaign that speaks to LGBTQ youth who have experienced harassment and assures them their lives will improve in adulthood is correct in some respects, but it clearly does not "get better" for all LGBTQ individuals who have experienced harassment. As illustrated in the current thesis, not all LGBTQ individuals can overcome such severe forms of minority stressors in their childhood. Therefore, campaigns such as the "It Gets Better" project should direct their focus not only on inspiring hope in bullied LGBTQ youth, but in providing support and resources for LGBTQ individuals to overcome traumatic experiences in their childhood that could affect their state of positive mental health in the long term. Again, as noted by Petterson, VanderLaan, and Vasey (2016), childhood is an important time for growth and development for all youth, therefore the negative effects of homophobic or transphobic childhood bullying (in the form of negative mental health outcomes or increased stress levels), can carry over into adulthood and inhibit the attainment of flourishing levels of positive mental health among LGBTQ adults.

### **The Minority Stress Model: Control Factors**

In terms of answering the second part of the final research question, there were only four control measures associated with positive mental health among LGBTQ adults. The four control measures included: employment contract, disclosing one's LGBTQ identity ("outness"), support for addressing LGBTQ issues in school, and transphobic harassment policies (homophobic harassment policies were not significant in the final model).

**Demographic controls.** First, among the demographic control measures, only employment contract showed a significant relationship with positive mental health; age did not show a significant association upon introduction into the model. The relationship between employment contract and positive mental health among the current sample is surprising. Based on the literature, one might expect that LGBTQ adults with permanent contracts and job stability would report higher levels of positive mental health, compared to temporary contracts workers (e.g., LaMontagne, Keegel, Louie, & Ostry, 2010; Silla, De Cuyper, Gracia, Peiró, & De Witte, 2009). However, few studies have explored the difference between temporary and permanently-employed LGBTQ adults in terms of mental wellbeing. One study conducted by Wright, Colgan, Creegan, and McKearney (2000) found that LGBTQ workers with temporary employment status were more likely to conceal their LGBTQ identity for fear of employment termination due to their temporary contract (for a discussion of LGB youth career development, see also Schmidt, & Nilsson, 2006). Therefore, a lack of job stability could be a minority stressor that is detrimental to the positive mental health of temporary LGBTQ workers. Ultimately, the expected relationship between employment contract and positive mental health was not found by the current research. One possible explanation could be that LGBTQ educators with permanent

employment contracts become more invested in a school climate permeated with homophobia and transphobia, which can be detrimental to their positive mental health. While in contrast, LGBTQ educators with temporary contracts do not become as invested in a similar work climate of heteronormativity and cisgenderism.

**Outness.** There was a significant relationship between disclosing one's LGBTQ identity and positive mental health among LGBTQ Canadians. Goffman (1963), in talking about stigma, categorizes two forms: visible and concealable. As discussed in the literature, "homosexuality" is considered a concealable form of social stigma (e.g. Beatty, & Kirby, 2006), and in talking about the challenges of managing a spoiled identity, and specifically a concealable stigma, Goffman (1963) wrote:

The issue is not of managing tension generated during social contacts, but rather that of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where. (p. 42; as cited in Beatty, & Kirby, 2006)

Beatty and Kirby (2006) also discuss the hardships of a concealable stigma, and they note that in comparison to visible stigmas such as race or ethnicity (wherein people accept that individuals have no choice in their identity), concealable stigmas, most notably sexual orientation, are mistakenly thought by many to be a choice - which creates an expectation that LGBTQ individuals can become heterosexual if they so choose (for a discussion of concealable stigmas, see also Ragins, 2008). In discussing sexual orientation, Beatty and Kirby (2006) indicate that "homosexuality", due to the majority of people acknowledging their LGBTQ identity later in life, has been considered an "achieved status" or a "choice", and from such a conception, LGBTQ individuals are blamed for challenging the climate of heteronormativity and cisgenderism ingrained within the dominant social structure. Therefore, as noted by Beatty and



Kirby (2006), people with “achieved stigmas” such as HIV/AIDs or the “homosexual identity” are seen as responsible for their own stigma, and are not considered deserving of compassion or support (p. 7). Further, with respect to LGBTQ educators, the literature suggests that the school climate has never been especially inviting or supportive of them (Graydon, 2011; Griffin, & Ouellet, 2003). As noted by Griffin and Ouellet (2003), in the past LGBTQ educators were accused of pushing the “gay agenda”, or were considered perverted or deceitful. Therefore, disclosing one’s LGBTQ identity as an educator in the present day may have additional negative effects on one’s positive mental health, if the reception of one’s LGBTQ identity is not one of support or inclusion.

However, despite the hardships of disclosing a concealable stigma, and the assertion that people who disclose their LGBTQ identity will experience a higher frequency of minority stressors (e.g., D’Augelli, Hershberger, & Pilkington, 1998; D’Augelli, 2003; D’Augelli, & Grossman, 2001), according to minority stress theory (Meyer, 2003a) and the current results, participants who disclosed their LGBTQ identity in the workplace were not worse off in terms of positive mental health. Specifically, respondents who disclosed their LGBTQ identity were significantly more likely to report higher levels of positive mental health than respondents who had not disclosed. The literature is somewhat supportive of this relationship between disclosing one’s LGBTQ identity and mental wellbeing (Durso, & Meyer, 2013; Jordan, & Deleuty, 1998; Morris, Waldo, & Rothblum, 2001; Legate, Ryan, & Weinstein, 2012; Tabaac, Perrin, & Trujillo, 2015). Studies have suggested that LGBTQ individuals who have disclosed their LGBTQ identity will express lower levels of mental health disorders and higher levels of positive mental health (e.g. Feldman, 2012; Jordan, & Deleuty, 1998; Strain, & Shuff, 2010), which is consistent with the current study’s results. For instance, despite consistent findings in

the literature that transgender individuals will report more negative mental health outcomes compared to their CH peers (e.g., Su, et al., 2016), Olson, Durwood, Demeules, and McLaughlin (2016) found that transgender youth who were supported in their transition to their felt gender reported similar levels of depression, and only a slightly higher percentage of anxiety symptoms, compared to their non-transgender counterparts. Further, in one study, transgender youth who reported always living in their felt gender were more likely to report good or excellent mental health compared to transgender youth who reported only sometimes living in their felt gender (Veale, Saewyc, Frohard-Dourlent, Dobson, & Clark, 2015).

Minority stress theory has largely attributed the flourishing levels of mental health found among disclosed LGBTQ individuals to the fact that disclosed LGBTQ youth or adults have more access to social support networks within the LGBTQ community. Wherein, such supports have been associated with mitigating the effect of minority stress on the mental wellbeing of LGBTQ individuals (Doty, Willoughby, Lindahl, & Malik, 2010; Jordan, & Deluty, 1998; Riggle, Whitman, Olson, Rostosky, & Strong, 2008). As noted by Meyer (2003a), using personal coping strategies to overcome a stigmatized identity, such as concealment, are not as beneficial as *minority coping strategies*, which involves disclosing one's LGBTQ identity, and becoming actively involved and supported in the LGBTQ community. Research demonstrates that LGBTQ youth who have disclosed their minority identity and engaged in the LGBTQ community report an increased sense of resilience and positivity in regard to social change (DiFulvio, 2011; Riggle, et al., 2008). As noted in DiFulvio's (2011) qualitative study of a sample of LGBTQ youth, connecting with the LGBTQ community allowed these youth to "reclaim an identity that had been ostracized and stigmatized" (p. 1614). Further, as noted by participants in Riggle and colleagues' (2008) qualitative study, disclosing one's LGBTQ identity was equated to a process

of self-acceptance, a way to be honest and authentic with oneself; or, similar to DiFulvio's (2011) study, a way for LGBTQ individuals to reclaim power over their own identities and to reinforce through resilience and self-acceptance a positive identity, inclusive of their LGBTQ identity. In essence, "coming out" has been largely supported as a factor that fosters positive wellbeing among LGBTQ individuals, and has also been cited as a mechanism of change in respect to the dominant heteronormative and cisgender social structure ingrained in Canada and abroad.

Durkheim (1938) asserts that the normative state of society must be upheld, re-established if it is challenged, and re-instated if the social situation changes; the normative must be maintained at all costs in order to promote the "normal" functioning of society (1938, p. 75). Durkheim (1938) recognizes that criminality or resistance exists in all societies, however he held that such forms of resistance only exist to strengthen support for the dominant culture, not to challenge or change the dominant social structure. However, using a Foucauldian analysis, the dominant culture or discourse that posits heterosexuality and cisgenderism as the moral or normal identity is continuously in competition with a counter-discourse of inclusion and support for the LGBTQ community; a discourse that recognizes LGBTQ individuals as viable and accepted Canadian and global citizens.

Thus, 'out' LGBTQ individuals are creating and becoming part of a new counter-discourse of positivity and inclusion; a discourse that recognizes an LGBTQ identity as not rare or abnormal, but as an identity that a substantial number of individuals in Canada and globally rightfully claim as their own. In other words, despite being just one interaction, disclosing one's LGBTQ identity can promote a discourse that recognizes an LGBTQ identity as a viable and acceptable identity in Canada and abroad. For instance, literature suggests that upon meeting or

socializing with an identified LGBTQ individual, CH individuals' perceptions or opinions about the LGBTQ community improves and becomes more accepting (Herek, 1988; Herek, & Capitanio, 1996; Herek, & Glunt, 1993; Lance, 1987). Therefore, disclosing one's LGBTQ identity helps inhibit the norm of heterosexuality and cisgenderism from being completely re-established or re-invented, and promotes another counter-discourse that LGBTQ individuals exist and are "normal" human beings.

In contrast, concealing one's LGBTQ identity, although related to lower levels of enacted stigma (D'Augelli, Hershberger, & Pilkington, 1998), has also been related to mental health issues or minority stress. Using Goffman's (1963) terminology, LGBTQ individuals who have not yet disclosed their LGBTQ identity have to continuously manage their stigma or "homosexuality", and this can involve monitoring their actions, "passing" as an cisgender heterosexual individual, and living every day in fear that their non-heterosexual or non-cisgender identity will be "outed". These stigma-management practices have been associated with inhibiting positive functioning in the workplace for LGBTQ individuals (as discussed in Lewis, Derlega, Berndt, Morris, & Rose, 2002). For instance, Lewis, Derlega, Berndt, Morris, and Rose (2002) found that concealing one's LGBTQ identity in the workplace was associated with higher levels of stress, and the authors attributed such increased stress levels to participants' fear of being "outed" by other workers or upper management. In contrast, Day and Schoenrade (1997) found that workers who were open about their LGBTQ identity reported greater job satisfaction, a stronger connection with their job, and more trust in management to support their rights (see also Gray, 2013; Griffith, & Hebl, 2002). Therefore, concealing LGBTQ identity can negatively affect a workers' stress level and job satisfaction, which could inhibit the attainment of flourishing levels of positive mental health. Ultimately, minority stress theory posits that aside

from internalized, anticipated, and enacted forms of stigma, concealing one's LGBTQ identity can also act as a secondary minority stressor that can negatively affect one's state of mental health (Meyer, 2003a), or one's ability to thrive emotionally, socially, and psychologically within both the workplace, and the larger society. As Harvey Milk once said, "I would like to see every gay lawyer, every gay architect come out, stand up and let the world know. That would do more to end prejudice overnight than anybody could imagine (cited in Corrigan, & Matthews, 2003, p. 235). However, although disclosing one's LGBTQ identity can act as a protective factor in respect to an LGBTQ individual's positive mental health, other factors, namely the social environment, also need to change in order to allow LGBTQ individuals to flourish and thrive in Canadian society.

**LGBTQ-inclusive and supportive climate measures.** Two LGBTQ-supportive and inclusive climate measures, notably perceived support addressing LGBTQ issues in school and transphobic harassment policies, also acted as protective factors in respect to the positive mental health of LGBTQ adults.

*Harassment Policies.* First, transphobic, but not homophobic harassment policies, were associated with positive mental health. Participants who reported the presence of transphobic harassment policies in their schools were more likely to report higher levels of positive mental health; however, such a relationship did not emerge in the current research with respect to homophobic harassment policies. The literature is quite supportive of the relationship between anti-discrimination policies and the mental wellbeing of LGBTQ individuals. The majority of studies have found that anti-discrimination policies, more commonly anti-homophobia policies,

are beneficial for reducing homophobic and transphobic bullying and language, as well as improving the mental health of LGBTQ students (Birkett, Espelage, & Koenig, 2009; Chesir-Teran, & Hughes, 2009; Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, & Keyes, 2013; Kosciw, et al., 2012; Kosciw, Palmer, Kull, & Greytak, 2013; Peter, Taylor, & Campbell, 2016; Saewyc, Konishi, Rose, & Homma, 2014; Taylor, & Peter, 2011). Some studies have also focused on how anti-discrimination policies allow LGBTQ workers to feel more supported and protected in disclosing their LGBTQ identity in the workplace (e.g., Griffith, & Hebl, 2002; Rostosky, & Riggle, 2002; Wright, Colgan, Cregany, & McKearney, 2006), which has been associated with higher levels of positive mental health among LGBTQ adults.

Few studies have explored the relationship between transphobic harassment policies and the mental wellbeing of LGBTQ educators, most likely due to the fact that transphobic harassment policies implemented to combat harassment related to gender identity or gender expression are not as popular as anti-discrimination policies implemented to address harassment related to sexual orientation. For instance, in the current study, participants were more likely to indicate that their workplace had homophobic rather than transphobic harassment policies implemented in their school (66.4% vs. 50.3%). Such a pattern is fairly consistent with the larger Canadian and global climate, wherein LGB rights are more prominently acknowledged, (e.g., the implementation of same-sex marriage in 2005), and transgender or gender minority rights are only now coming to the forefront of Canadian legislation and policy (e.g., the introduction of Bill C-204 in 2016, in support of the implementation of gender expression and gender identity as a basis for discrimination in the Canadian Human Rights Act, and as a basis for a hate crime in the Criminal Code). Therefore, perhaps the presence of transphobic harassment policies characterizes a climate that is more progressive or supportive of the LGBTQ community,

especially the transgender or gender minority community that is still, at times, marginalized from the larger LGB and CH community. Consistent with such an assertion, Kosciw et al. (2014) found that students who reported comprehensive anti-discrimination policies that included discrimination due to gender identity or expression and sexual orientation (10.1% of the sample), were less likely to report homophobic or transphobic language in school compared to participants who reported generic or incomplete school policies (see also Kosciw, et al., 2012; Russell, Day, Ioverno, & Toomey, 2016).

Numerous studies have explored the effects of homophobic harassment policies on LGBTQ individuals, but few studies have explored the effect of transphobic harassment policies on the wellbeing of LGBTQ students, and more specifically, on the wellbeing of LGBTQ educators. The current study suggests that the presence of anti-transphobic harassment policies, although not necessarily directed at the anti-discrimination of LGBTQ educators themselves, can allow LGBTQ educators to thrive and flourish in a workspace that is more supportive and inclusive for LGBTQ adults and youth alike.

Although, Beatty and Kirby (2006) note, in speaking about people with concealable stigmas in the workplace (e.g., an LGBTQ identity), “These environments [social and cultural environments] are more resistant to change, and therefore change occurs slowly: stigma [e.g., LGBTQ stigma] cannot be simply legislated away” (p. 4). Hence, it is not simply the presence of anti-discrimination policies that can change the school climate for LGBTQ individuals. For instance, as demonstrated in a study by Saewyc, Konishi, Rose, and Homma (2014), recently implemented anti-homophobia policies were not related to decreasing suicidality or discrimination among LGB students, however, policies that had been implemented for a longer period of time (i.e., 3 years or more) were associated with lower levels of suicidality, and for

some participants lower levels of discrimination. Thus, for change to occur in Canadian schools, the climate of heteronormativity and cisgenderism has to be continuously challenged and negated over longer periods of time, and although anti-discrimination policies can be tools for such change, it is only a part of the solution. For instance, despite the de-criminalization of “homosexuality” in Canada, there is still a climate of homophobia and transphobia ingrained in the dominant Canadian culture. Thus, evidently a change in legislation or policy is beneficial, but challenging the dominant structure in society that stigmatizes and places LGBTQ individuals at a disadvantage is, as noted by Beatty and Kirby (2006), “a necessary precondition that sets the stage for improved legal protections” (p. 13). All in all, the presence of transphobic harassment policies promotes a counter-discourse of inclusivity and support for LGBTQ individuals, which can foster a work climate wherein LGBTQ educators can better develop a flourishing state of positive mental health. In other words, knowing there are protections such as anti-discrimination policies in the workplace can reduce work-related stress, especially minority stress, which can positively affect one’s ability to be resilient and flourish in a society that continuously places LGBTQ individuals at a disadvantage relative to their CH peers.

*LGBTQ-support and inclusion.* LGBTQ educators who indicated that they would be supported in addressing LGBTQ issues in school were also more likely to report higher levels of positive mental health, compared to participants who reported they would have no such support. The current findings are consistent with previous studies that illustrate how the presence of LGBTQ-inclusive topics in school has been associated with a more LGBTQ-supportive and inclusive school climate (Kosciw, et al., 2014; Saewyc, & Marshall, 2011; Taylor, & Peter, 2011). For instance, Saewyc and Marshall (2011) found, in conducting a longitudinal study of



students in a Canadian high school, that implementing anti-homophobia and LGBTQ-inclusive education practices in schools, including “The Laramie Project”, a play about the hate-induced murder of Matthew Shepard, a gay student, in Laramie Wyoming in 1998, reduced the prevalence of homophobic attitudes among students who took part in the study. Further, Chesir-Teran and Hughes (2009) found that students who reported inclusive programs in school (such as talking about “homosexuality” in class or having access to library materials), also reported lower levels of victimization and tolerance for harassment directed at LGB students (see also Kosciw, et al., 2014; Taylor, & Peter, 2011). Ultimately, the literature suggests that addressing LGBTQ issues in schools can help challenge the climate of homophobia and transphobia ingrained in school culture.

Further, research has also noted how supportive and inclusive work climates for LGBTQ workers, including educators, can also have positive effects on one’s mental wellbeing. Studies have demonstrated how support for LGBTQ issues or support from co-workers and management can improve LGBTQ adults’ wellbeing and job satisfaction. For instance, Croteau and Lark (1995) found, in studying LGB workers, that 45% of participants reported that support for gay-related issues in the workplace did improve their job satisfaction (see also Huffman, Watrous-Rodriguez, & King, 2008). In talking specifically about educators, LGBTQ educators, especially, can experience increased stress levels in bringing LGBTQ-related materials into the classroom. Educators often indicate that they are afraid to address LGBTQ issues in schools, because of the potential accusation from parents, religious communities, or school administrators that educators who implement LGBTQ-inclusive education are “pushing the gay agenda” (as discussed in Malins, 2016; Martino, & Cumming-Potvin, 2011, 2014). Hence, when LGBTQ educators feel that they have support from administration or co-workers in addressing LGBTQ-related issues in

class, it can reduce the stress they feel in anticipating homophobic or transphobic backlash. Therefore, when LGBTQ workers perceive that they have support from co-workers or upper management whether in relation to gay-related issues or otherwise, LGBTQ individuals are more likely to report higher levels of job and life satisfaction. Thus, a positive, supportive and inclusive workspace can play a substantial part in developing an individual's positive sense of growth, mastery and contribution to society.

All in all, having a more LGBTQ-supportive and -inclusive workspace, characterized by anti-discrimination policies and support for addressing LGBTQ issues, was associated with higher levels of positive mental health among LGBTQ educators. As noted in the literature more generally, gay-supportive or gay-positive work climates have been associated with increased job satisfaction, as well as lower levels of job anxiety and stress (Croteau, & Lark, 1995; Driscoll, Kelley, & Fassinger, 1996; Griffith, & Hebl, 2002). Hence, for all adults, LGBTQ and CH alike, the satisfaction and stress one experiences in the workplace can play a large part in the development of mental health. For many people, the majority of adulthood is spent in the workplace, and if one's work climate is exclusionary and unsupportive of the LGBTQ community, this can reflect negatively on the mental wellbeing of LGBTQ individuals who have to work in such an environment. Working in a LGBTQ-supportive and inclusive climate (whether in the form of policies, or support from co-workers and upper management) that reduces stress and anxiety, and increases the gratification one feels as a worker, can allow LGBTQ individuals to better cope with minority stressors by having visible supports in the workplace that will ensure, that homophobic or transphobic prejudice that does occur in the workplace will be addressed and counteracted wherever possible.

Finally, despite the influence of other environmental indicators of inclusion and support, school safety for LGBTQ individuals was not associated with positive mental health among LGBTQ educators. The literature has suggested that school safety and bullying among LGBTQ youth is a prominent issue in schools, wherein LGBTQ youth who report their schools are unsafe or experience a higher frequency of in-school bullying are more likely to skip school and disengage from the school environment (e.g., Kosciw, et al., 2012, 2014; Peter, Taylor, Ristock, & Edkins, 2015). However, there has been a lack of research that has explored such a relationship among LGBTQ educators. One possible explanation for the lack of a relationship between these variables in the current thesis could be that, although LGBTQ educators report experiences of discrimination and hostility from co-workers and other school personnel (e.g., Ferfolja, 1998; Irwin, 2002), LGBTQ educators have more authority in the school environment. Therefore, LGBTQ educators may not be as vulnerable to high frequencies of homophobic or transphobic bullying, harassment, or victimization that so often promotes insecurities and mental health issues among LGBTQ students.

To conclude, although supportive and inclusive environmental school factors can have a positive effect on the wellbeing of both LGBTQ youth and educators, such factors did not substantially mitigate the long-term effects of enacted stigma on the positive mental health of LGBTQ adults. In other words, the long-term effects of childhood bullying had a greater impact on their positive mental health than protective factors such as anti-discrimination policies. Therefore, despite the presence of protective factors in the workplace, LGBTQ adults who have experienced childhood bullying cannot always overcome such negative experiences from their childhood, regardless of the supportive or inclusive environment they may be in now. Thus, in answering the second half of the final research question, there are notable control factors that can

influence the state of positive mental health among LGBTQ adults. However, such supportive or protective factors did not overcome or even substantially diminish the negative long-term effects of enacted stigma on the positive mental health of LGBTQ adults.

### **Recommendations for Future Research, Policy, and Practice**

Future research should explore the long-term relationship between enacted stigma and positive mental health in the LGBTQ community more thoroughly. This relationship should be explored using a more representative sample of LGBTQ adults, or should be explored using other samples of LGBTQ adults in Canada or in other countries. For instance, instead of exploring such a relationship among a sample of Canadian education professionals, looking at how childhood experiences of enacted stigma affect a more general sample of LGBTQ Canadians in respect to their positive mental health may offer different results than found in the current research.

Further, exploring how other LGBTQ professionals or labourers in Canada (e.g., doctors, lawyers) can be affected by prejudice in their youth could also illustrate a different long-term association between enacted stigma and positive mental health within the minority stress model.

A representative sample could also include a more diverse sample of LGBTQ Canadians that allows researchers to explore intersectional experiences within the LGBTQ community. For example, exploring gender differences more thoroughly in relation to positive mental health, enacted stigma, and the relationship between these two measures could fill important gaps in the literature that could influence policy or practice. For example, exploring the minority stress model in relation to LGBTQ gender differences could offer further information about what resources or supports that bullied LGBTQ girls versus boys may require to truly “get over” prejudice in their youth. Obtaining a diverse sample of LGBTQ Canadians is a difficult task, but

perhaps future research could use a purposive sampling method as to increase the sample size of specific groups, such as rural, racialized, religious, or other diverse groups members within the LGBTQ community in Canada.

Future research should also attempt to understand what factors moderate or alleviate the stress associated with childhood bullying or other instances of enacted stigma experienced in one's youth among LGBTQ adults, and in turn, explore how this can affect their positive mental health. Similarly, research should also explore what the differences are between LGBTQ adults who indicate they are over their past experiences of bullying, and respondents who indicate these experiences are still upsetting for them. Research should look to understand what helps LGBTQ youth and adults recover or come to terms with their past experiences of bullying as to not allow it to affect their mental health or wellbeing in the future. For instance, through a qualitative study, researchers could further understand how LGBTQ individuals cope with or "get over" minority stress experienced in their youth. Previous qualitative studies have evaluated how expressive writing exercises (e.g., writing about their experiences of discrimination) can help LGBTQ individuals cope with minority stress (Crowley, 2014; Lewis, et al., 2005; Pachankis, & Goldfried, 2010), hence future research can explore how other coping methods or exercises may be more or less efficient compared to previously explored coping methods, such as expressive writing techniques.

Also, researchers could further explore if LGBTQ-inclusive or supportive factors within an individuals' workplace or other social institution (e.g., hospitals) can mitigate the long-term effects of enacted stigma on the positive mental health of LGBTQ individuals. In addition, future studies, again, through a qualitative study, could explore how and why LGBTQ individuals minimize experiences of prejudice and discrimination in their youth, even though it may still

negatively affect their mental wellbeing in adulthood. Ultimately, more research should explore the minority stress model in respect to the long-term relationship between enacted stigma and positive mental health, as well as other control factors (e.g., severity of bullying, LGBTQ-supportive and inclusive measures; coping strategies) that can potentially mitigate or influence such a relationship.

Finally, in compliance with the dual-continuum model of mental health suggested by Corey Keyes, comprised of both mental illness and mental wellbeing, future studies should use measures of both mental illness and positive mental health to explore whether the full dual-continuum model of mental health is associated with enacted stigma or minority stress among LGBTQ individuals. Further, more research should explore the state of positive mental health of the LGBTQ community, using more complete measures of positive mental health (e.g., Keyes' Mental Health Continuum Short-Form). Research should focus on what allows LGBTQ individuals to flourish as human beings, specifically as human beings a part of minority group, because LGBTQ individuals can flourish and be successful despite experiencing prejudice and discrimination. Understanding how LGBTQ individuals can flourish within a world that continuously places them at disadvantaged is an important research topic to explore as to better understand how to promote flourishing levels of positive mental health among the LGBTQ community and potentially other minority or stigmatized groups.

In terms of recommendations for policy and practice, anti-LGBTQ bullying needs to be sufficiently addressed in Canadian schools and in the broader society. As noted previously, LGBTQ youth experience more bullying than their heterosexual peers, and in turn, LGBTQ youth experience the consequences of bullying more than their heterosexual peers (e.g. Taylor, & Peter, 2011). Fostering an LGBTQ-inclusive school environment can help eradicate homophobia

and transphobia, resulting in a related reduction of anti-LGBTQ discrimination, harassment, and in-school victimization. Research suggests encouraging positive LGBTQ-inclusive and supportive environments through implementing Gay-Straight Alliances (Toomey, Ryan, Diaz, & Russell, 2011), inclusive curriculums (Taylor, & Peter, 2011), and bullying and anti-harassment policies (Russell, et al., 2011), as well as encouraging educators to be supportive of LGBTQ students (Kosciw, & Diaz, 2008). However, as argued by Malins (2016), the onus is not solely on educators to implement LGBTQ-inclusive education in schools; support networks involving principals, school boards, and other school personnel need to be implemented to support educators in using education to promote change and social justice. Perceived support for addressing LGBTQ issues in schools can allow LGBTQ educators to be more confidently engaged in a counter-discourse that recognizes the importance of acknowledging LGBTQ issues in Canadian schools through inclusive curriculums, anti-homophobia or anti-transphobia days or activities, or other LGBTQ-inclusive practices, policies, or programs. Therefore, as demonstrated through the implementation of inclusive and supportive practices, the norms of heterosexuality and cisgenderism can be challenged, homophobia and transphobia can be resisted, and through a new counter-discourse of inclusivity and support, a climate of acceptance, not tolerance or rejection, for the LGBTQ community can emerge in Canada and abroad.

Furthermore, the current study suggests that LGBTQ adults who have experienced bullying in the past can continue to experience the consequences of such experiences on their mental wellbeing into adulthood. Anti-LGBTQ bullying in schools is not only a problem that affects LGBTQ youth's mental health, it is also an issue that is starting to affect LGBTQ individuals in their adulthood. Therefore, using campaigns such as the "Its Gets Better" project to encourage LGBTQ youth to "keep going" or to "not give up" may have short-term effects in

increasing the morale of bullied LGBTQ youth, both at the time it occurs and also well into their adulthood. Thinking about how social services, supportive resources, and society as a whole can help LGBTQ adults move past these discriminatory experiences in their childhood, can ultimately help these individuals lead healthier, happier lives. However, addressing the issue of anti-LGBTQ bullying, as well as homophobic/transphobic social environments, before it creates negative, longstanding effects on LGBTQ youth's mental wellbeing, is one of the most important goals for school policies and the larger Canadian society to address.

### **Limitations**

While the importance and novelty of the research findings is evident, there is one main gap or limitation in the previous literature that the current study could not address. Although the current thesis explored intersectionality in regard to gender, other experiences of intersectionality within the LGBTQ community could not be explored. The sample was too small to divide by race/ethnicity, sexual orientation (e.g., bisexual vs. gay/lesbian) or gender identity (e.g., cisgender vs. transgender, gender non-conforming), to name a few. Bowleg (2008) suggests that intersectionality should not take an additive approach, but should consider intersectional identities as a cohesive whole. In other words, one identity should not be pitted or ranked against another (e.g., African American vs. lesbian, vs. female). Regrettably, due to the post-positivist orientation of data collection and research questions within quantitative research, as Bowleg (2008) indicates, it is difficult to ask questions about intersectionality that are not additive in nature (e.g. What is your gender, race/ethnicity, age, etc.). Bowleg (2008) ultimately questions the compatibility of quantitative research and intersectionality. Unfortunately, the current thesis could not address such a limitation. The current project did explore interaction terms, namely in



regard to gender; as Bowleg (2008) writes, “One of the foundations of intersectionality research is the premise that multiple factors uniquely combine to define an individual’s experience. For this reason, investigation of statistical interaction in quantitative intersectionality research is both vital and necessary (p. 319). However, again, Bowleg (2008) calls for new tools for intersectional analysis, namely statistical tools that go beyond testing for interaction effects, and that are personalized for intersectional research.

Hence, the current thesis recognizes the importance of addressing intersectional experiences within the LGBTQ community, and that using the umbrella term LGBTQ does not explore all of the unique experiences within such a community. For instance, one group of people who are largely overshadowed in the LGBTQ-grouping is transgender adults and youth (Dargie, Blair, Pukall, & Coyle, 2014). Transgender individuals are situated in a different social location, where at times they cannot be seamlessly compared or grouped with LGB youth or adults in talking about minority stress or mental health. Putting transgender individuals under the umbrella of LGBTQ can conceal how transgender adults and youth have been found to be more susceptible to prejudice, mental health issues, and lack of social support (Dargie et al., 2014; Kattari, et al., 2016). In the current study, a very small percentage of respondents identified as transgender or gender free, and therefore, the results may not be representative of the experiences of transgender or genderless Canadians within the minority stress model. Such an assertion can also be extended in talking about racial minority LGBTQ adults or rural participants in the current study. Ultimately, intersectionality could not be fully addressed for all demographics, and therefore, future research should address the limitations of intersectionality in relation to quantitative research, as well as further explore the relationship between childhood bullying and positive mental health among a more diverse and intersectional sample of LGBTQ Canadians.

## **Concluding Remarks**

The majority of research has focused on the prevalence of mental health disparities among LGBTQ individuals. However, few researchers have explored the state of positive mental health among LGBTQ youth or adults. As noted by Keyes, positive mental health is important for people to flourish, lead productive lives, and as demonstrated in the literature, it can act as a protective factor with respect to mental health issues. Further, academics have focused on the short-term effects of prejudice rather than exploring the long-term effects of prejudice such as childhood bullying on the positive mental health of LGBTQ adults. Based on the gaps in the literature and the importance of positive mental health in promoting resilience among LGBTQ individuals, the current research project looked to fill a prominent gap in the literature, in respect to the long-term effect of childhood bullying on the positive mental health of LGBTQ individuals in adulthood. Notably, the current thesis addressed two gaps in respect to minority stress theory: (1) minority stress theory can be extended to consider the long-term effects of enacted stigma on the mental health of LGBTQ individuals, and further, (2) minority stress theory can also be used to consider the relationship between enacted stigma and positive mental health. The current thesis has its limitations, however the results illustrate that the topic of the current thesis is a worthy topic to address in the literature, in that there does seem to be a connection between early experiences of childhood bullying and positive mental health among LGBTQ Canadians. Hence, again, through the validation of the four main hypotheses, minority stress theory can be extended to consider the long-term effects of childhood bullying on the positive mental health of LGBTQ adults.

Further, although the “It Gets Better” campaign posits that it can “get better” for LGBTQ youth who have experienced harassment, the current thesis research found that working in an

LGBTQ-positive climate did not mitigate or overcome the long-term negative effects of minority stressors still weighing on the mental wellbeing of these individuals. As illustrated by Saewyc, Konishi, Rose and Homma (2014), it may take more time for inclusive or supportive policies and practices to positively affect the mental health of LGBTQ individuals. Thus, maybe as these protective factors become more consistently and effectively implemented in numerous social institutions in Canada and globally (e.g., schools, hospitals), they will have a greater positive effect on the mental wellbeing of LGBTQ individuals, one that exceeds the detrimental effect that minority stress can have on an LGBTQ individual's state of positive mental health.

The climate of heteronormativity and cisgenderism, or the stigmatized identity associated with the LGBTQ community, has become ingrained in society through the rise of social norms and discursive practices that have developed over a long period of time. Therefore, the transformation or transcendence of such a climate of exclusion and hostility towards the LGBTQ community will be gradual and, at times, experience numerous impasses. As demonstrated in the current thesis, LGBTQ adults can develop a flourishing state of positive mental health; they can be resilient and successful despite experiencing traumatic experiences in their childhood, or despite being a part of a socially disadvantaged or stigmatized group in society. However, it is not enough to tell these individuals that it will “get better”, and it is not enough to simply give hope; change must be enacted. Hence, although it will be a gradual process of change and acceptance, the LGBTQ community and its allies must attempt to overcome the climate of homophobia and transphobia ingrained in Canadian society and abroad. Humanity must strengthen the counter-discourse of inclusion, support and acceptance for the LGBTQ community, so that LGBTQ youth no longer have to be told to “hold on” or that “it does get better” in adulthood, because it will already “be better” in their youth.

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