Sexual Minority Quality of Life: The Indirect Effect of Public Stigma Through Self-Compassion, Authenticity, and Internalized Stigma

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BRIEF REPORT

Sexual Minority Quality of Life: The Indirect Effect of Public Stigma Through Self-Compassion, Authenticity, and Internalized Stigma

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Sexual minorities experience public stigma because of their identity and may subsequently internalize this stigma (Meyer, 2003). These experiences can lead to negative mental and physical health outcomes and psychosocial problems, such as decreased quality of life (QoL; Frost, 2011; Meyer, 2003). However, limited research with sexual minorities has examined whether public stigma decreases self-acceptance and whether that in turn helps to explain mental health outcomes (Woodford, Kulick, Sinco, & Hong, 2014). The current study explored the mediating role of self-compassion and authenticity between public stigma and QoL in sexual minorities. Rather than focusing on negative health outcomes (such as presence of distress, disability, or disease), QoL looks at the presence of mental health, physical health, and psychosocial resources (e.g., social support and environmental resources). Furthermore, we explored whether the relationship between public stigma and self-compassion and authenticity may be accounted for by internalized stigma.

Stigma can include both public and internalized stigma. Public stigma is perpetrated by others via attitudes and behaviors that are biased against sexual minorities and may lead to internalized stigma, or the application of the negative attitudes or behaviors of others toward the self (Herek, Gillis, & Cogan, 2009). Both public and internalized stigma are associated with a number of negative mental and physical health outcomes, including psychological distress, depression, anxiety, substance abuse disorders, and suicidal ideation (Meyer, 2003) as well as detriments in other QoL indicators, such as decreased relationship quality, lower social status and income, and reduced access to resources such as housing, education, and jobs (see Frost, 2011). Additionally, sexual minorities high in internalized stigma are less likely to disclose their sexual orientation to others (Herek et al., 2009), and this lack of authenticity via concealment has been linked to worse mental health outcomes (Riggle, Rostosky, Black, & Rosenkrantz, 2017). However, additional research is needed to understand the relationship between stigma and QoL in sexual minorities.

Building on research that indicates self-acceptance, or positive evaluations of one’s self and identity, may mediate stigma and negative outcomes in sexual minority college students (Woodford et al., 2014), the current study examined the self-acceptance related constructs of self-compassion and authenticity as mediating mechanisms of the relation between stigma and QoL in a general population of sexual minorities. Self-compassion is positive self-regard, even in suffering, and has three subcomponents: self-kindness (i.e., kindness toward the self, even in difficult times), recognition of a common humanity (i.e., understanding that others have common suffering and shortcomings), and mindfulness (i.e.,
being present in the moment and aware of one’s internal reaction without dismissal or rumination; Neff, 2011). Self-compassion has been identified as a cognitive process that can be used as a healthy coping strategy when dealing with stress (Allen & Leary, 2010), such as stress associated with stigma. Within sexual minorities, higher self-compassion has been linked to higher general well-being (Beard, Eames, & Withers, 2017). Authenticity is an acceptance of one’s identity and an attempt to embrace that identity (Riggle, Mohr, Rostosky, Fingerhut, & Balsam, 2014) and has been linked to higher general psychological well-being in lesbian, gay, and bisexual individuals (Riggle et al., 2017). By understanding indirect links between stigma and QoL, such as self-compassion and authenticity, potential points of intervention may be identified for improving QoL for this population. Thus, we examined a model in which both public and internalized stigma related to QoL through self-compassion and authenticity.

Method

Sample and Procedure

Social media sites (e.g., Twitter, Facebook) and e-mails to lesbian, gay, and bisexual organizations across the United States were used to recruit 435 participants from 2014 to 2015 for an institutional review board–approved study exploring various components of stigma and health in sexual and gender minorities. Only those who identified as a sexual minority, completed all necessary scales for the current analysis, and had no missing data (n = 213) were included in the present research. Participants were mostly White (89.5%) but diverse in terms of sexual orientation (20.5% gay/lesbian, 25% bisexual, 14.1% pansexual, 15.9% asexual, and 24.5% other) and gender (55.5% cisgender female, 15% cisgender male, 14.1% genderqueer, 0.9% intersex, 4.1% transgender male, 2.3% transgender female, and 8.2% other). The mean age was 25.15 years (SD = 8.86) and ranged from 18 to 63 years.

Materials

The self-report questionnaire included demographic items and assessments for stigma, self-compassion, authenticity, and QoL. Race, gender identity, sexual orientation, age, and concealment of sexual orientation identity were treated as potential covariates for the purpose of this study, with dummy variables created for gender (cisgender), race (White), and sexual orientation (gay/lesbian). Perceived public stigma (α = .82) and internalized stigma (α = .73) were measured using the Perceived Stigma Scale (Mickelson, 2001), adapted for sexual orientation. Self-compassion (α = .89) was measured using the Self-Compassion Scale Short Form (Raes, Pommier, Neff, & Van Gucht, 2011). Authenticity (α = .88) was measured using a 5-item subscale of the Lesbian, Gay, Bisexual Positive Identity Measure (Riggle et al., 2014). Finally, QoL was measured using the World Health Organization Brief Quality of Life Scale (Bonomi, Patrick, Bushnell, & Martin, 2000), that consists of four aspects of QoL: physical health (seven items; α = .80), psychological health (six items; α = .84), social relationships (three items; α = .68), and environment/resources (eight items; α = .79).

Analysis Plan

Structural equation modeling was conducted. Model fit for the models was determined based on the suggestions for samples of less than 500: a nonsignificant χ², a Comparative Fit Index (CFI) ≥ .95, a root mean square error of approximation (RMSEA) ≤ .06, and a Tucker Lewis Index (TLI) ≥ .90 (Kline, 2016). The N:q rule of 10 participants per parameter tested suggests that 210 participants were needed for the current analyses. Additionally, we calculated bias-corrected 95% confidence intervals (CIs) to test for direct, indirect, and total effects within the model using bootstrapping in SPSS Amos 22.0 (IBM, Armonk, NY). An indirect effect is considered significant if the CI does not include zero.

Results

Prior to main study analyses, bivariate correlations were conducted between main study variables and potential covariates. Significant correlations dictated all covariates be included as initially free to float in the hybrid model. Next, we conducted a confirmatory factor analysis in EQS, testing the latent variable of QoL comprised of physical health, psychological health, social relationships, and environment indicators. The factor model was supported, χ² (1) = 1.79, p = .18; CFI = 0.99; RMSEA = 0.06 (90% CI [.00, .20]). Factor loadings ranged from 0.44 to 0.98 (see Figure 1).

Next, we tested a hybrid model of our main hypothesized model. Our initial model testing potential covariates as free to float indicated these covariate relationships be included in the final hybrid model: gender to QoL and public stigma; age to internalized stigma and QoL-physical; and race to public stigma and QoL-social. Concealment and sexual orientation were dropped, given their overlap with other covariates according to the modification indices. The model was still overidentified.

Results of the hybrid model (with covariate relations) revealed a nonsignificant relation between public stigma and self-compassion. The final trimmed model with this relation removed fit the data, χ² (35) = 54.5, p = .02; CFI = 0.96; RMSEA = 0.05 (90% CI [.02, .08]; TLI = 0.94 (see Figure 1). Whereas the χ² test was significant, this test is sensitive to sample size (see Kline, 2016). The direct effect of public stigma on quality of life was nonsignificant [coefficient = −.056, p = .547]; however, there was a significant indirect effect of public stigma on quality of life through internalized stigma, self-compassion, and authenticity (coefficient = −.154, SE = .059, CI [−.339, −.064]), creating a significant total effect of public stigma on quality of life (coefficient = −.210, SE = .111, CI [−.434, −.016]). Additionally, there was a nonsignificant direct effect of internalized stigma on quality of life (coefficient = .149, p = .156), but there was a significant indirect effect of internalized stigma on quality of life through self-compassion and authenticity (coefficient = −.518, SE = .123, CI [−.818, −.321]), creating a significant total effect of internalized stigma on quality of life (coefficient = −.667, SE = .164, CI [−1.064, −.389]). Authenticity (coefficient = .203, SE = .088, CI [.018, .366]) and self-compassion (coefficient = 1.564, SE = .168, CI [1.236, 1.901]) both had significant direct effects on quality of life.

An alternative model testing whether public stigma was indirectly related to internalized stigma through authenticity and
self-compassion, rather than public stigma being indirectly related to authenticity and self-compassion through internalized stigma, did not fit the data, $\chi^2(38) = 221.52, p < .001$; CFI = 0.65; RMSEA = 0.15 (90% CI [0.13, 0.17]), TLI = .49.

**Discussion**

The current study examined self-compassion and authenticity as mediators between stigma experiences and QoL for sexual minorities. Results indicated that public and internalized stigma did not have direct relationships with quality of life, but that they were indirectly related to quality of life through authenticity and self-compassion. These results highlight that authenticity and self-compassion may help explain why the QoL of sexual minorities is negatively impacted by the experience of stigma.

Our study findings speak to the need for interventions to improve QoL among sexual minorities. One such intervention could reduce public stigma through facilitating intergroup contact between straight individuals and sexual minorities. Additionally, clinical and interpersonal therapies targeted at self-acceptance components, such as self-compassion and authenticity, should be developed to work specifically with sexual minorities. For example, Pachankis (2014) has altered cognitive-behavioral interventions to address stigma experiences of gay and bisexual men. Similar programs should be developed to help increase self-acceptance for all sexual minorities.

Whereas public stigma was unexpectedly related to an increase in authenticity, some literature suggests that people experiencing stigma may engage in meaning making—a process of reframing the cause of the stigma from the self to society that can help reaffirm one’s identity (Frost, 2011). This suggests there may be intermediating processes between stigma and authenticity that need to be explored in more depth to identify points of intervention that can help ensure that sexual minorities have the coping mechanisms needed to reframe negative stigmatizing experiences and reaffirm their identity.

Additionally, although public stigma was not directly related to self-compassion, it was indirectly linked to self-compassion through internalized stigma. The negative relationship between internalized stigma and self-compassion highlights the impact that negative views about one’s self based on identity may have on our ability to practice self-compassion. The exact mechanisms that links self-compassion with different forms of stigma should be explored in future research to more precisely identify areas for intervention.

**Limitations and Future Directions**

The current conclusions are limited by the cross-sectional study design; thus, temporal order cannot be determined. Future research should explore ways to induce self-compassion and authenticity in an experimental setting and should explore best practices for establishing and maintaining sexual minority samples who would be willing and able to participate in longitudinal research. Furthermore, the measure of stigma was limited, and a robust measure of public and internalized stigma is needed. Additionally, it is possible that the model is underspecified and that additional parameters may be influencing these relationships.

Additional limitations surround the sample. We collapsed across sexual orientation, gender, and race, given the sample size and complex model of the current study. However, a more nuanced understanding of stigma’s relationship with QoL and mediators at the intersections of sexual orientation, gender, and race is needed. The lack of racial diversity within the study may be a result of unintentionally selecting online locations that are utilized more by White sexual minorities than by sexual minorities of color. Additional avenues for online data collection should be explored. Analysis using larger samples would permit an examination of how the mediating model fits for different groups of sexual minorities.
References


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