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Coping with Sexual Orientation Related Stress: A Weekly Diary Study of Gay Men

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Abstract of the Dissertation

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Research has consistently demonstrated that gay men are at increased risk for internalizing symptoms and disorders compared to heterosexual men. Although sexual orientation-related stress (SORS) has been identified as a risk factor for internalizing disorders among gay men, little is known about how SORS influences mental health. The current study had three main aims: (1) to examine the associations between individual attributes (internalized homonegativity and rejection sensitivity) and coping strategies used in response to SORS (active and disengaged coping); (2) to examine the associations between coping strategies and internalizing symptoms; and (3) to examine coping strategies as mediators of the associations between individual attributes and internalizing symptoms. A sample of 147 gay men completed a baseline questionnaire and weekly questionnaires for the next seven consecutive weeks. In general, results indicated that higher internalized homonegativity and rejection sensitivity were associated with higher disengaged coping, but not active coping. In turn, higher disengaged coping was associated with higher internalizing symptoms and disengaged coping mediated the associations between individual attributes and internalizing symptoms. Associations were evident at the between- and within-person levels, indicating that both average levels and weekly fluctuations in levels are important. Although associations were significant in cross-sectional analyses, they were not significant in prospective analyses. Findings underscore the impact of negative thoughts and feelings about one's sexual orientation on internalizing symptoms. Findings also implicate disengaged coping as a mechanism through which these individual attributes influence internalizing symptoms. Finally, findings demonstrate that gay men's negative thoughts and feelings about their sexual orientation vary from week to week and that this weekly fluctuation has an impact on mental health.

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Acknowledgments

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Introduction

Research has consistently demonstrated that gay men are at increased risk for internalizing symptoms and disorders (i.e., depression and anxiety) compared to heterosexual men. Although sexual orientation-related stress (SORS) has been identified as a risk factor for internalizing disorders among gay men, little is known about *how* SORS influences mental health. The main goal of the current study is to gain a better understanding of how gay men cope with SORS, including individual attributes that may predict the use of different coping strategies in response to SORS and the influence of different coping strategies on internalizing symptoms. The current study will assess gay men's experiences with SORS and their use of different coping strategies on a weekly basis for seven weeks. Individual attributes, including internalized homonegativity and rejection sensitivity, will be examined as predictors of coping responses, given that they have been linked to unassertive interpersonal behavior and internalizing symptoms. Thus, these individual attributes may influence internalizing symptoms by contributing to maladaptive coping in response to SORS. In addition to the seven-week weekly assessments, there was a baseline assessment one week prior to the first weekly assessment. In sum, the current study had three aims: (1) to examine the associations between individual attributes (internalized homonegativity and rejection sensitivity) and coping strategies used in response to SORS (active and disengaged coping); (2) to examine the associations between coping strategies and internalizing symptoms; and (3) to examine the extent to which coping strategies mediate the associations between individual attributes and internalizing symptoms. The current study has the potential to expand our understanding of how gay men cope with SORS in an effort to identify risk and resilience factors related to well-being in this population.

Increased internalizing disorders among gay men

Epidemiological studies have demonstrated that, compared to heterosexual men, gay men are at increased risk for mood and anxiety disorders (e.g., Atkinson et al., 1999; Cochran & Mays, 2000; Fergusson et al., 1999; Sandfort, de Graaf, Bijl, & Schnabel, 2001). For instance, in the California Quality of Life Survey, gay men were 2.2 times more likely to meet criteria for major depressive disorder, 2.3 times more likely to meet criteria for generalized anxiety disorder, and 2.7 times more likely to meet criteria for panic attacks compared to heterosexual men (Cochran & Mays, 2009). Similarly, in the MacArthur Foundation National Survey of Midlife Development in the United States, gay and bisexual men were 3.6 times more likely to meet criteria for major depressive disorder and 5.1 times more likely to meet criteria for panic disorder compared to heterosexual men (Cochran, Sullivan, & Mays, 2003). Using data from the National Epidemiological Survey on Alcohol and Related Conditions, Bostwick, Boyd, Hughes, and McCabe (2010) found that, compared to heterosexual men, gay men had a higher lifetime prevalence of any mood disorder (42.3% versus 19.8% for gay and heterosexual men, respectively) and any anxiety disorder (41.2% versus 18.6% for gay and heterosexual men, respectively); results were similar for past-year prevalence. Notably, the increased prevalence of mood and anxiety disorders among gay men compared to heterosexual men was found regardless of how sexual orientation was operationalized (self-identification, sexual attraction, or sexual behavior), underscoring the robustness of the findings. Finally, in a meta-analysis of the literature on sexual orientation and psychopathology, Meyer (2003) found that the lifetime prevalence of mood disorders was 2.7 times higher for gay men compared to heterosexual men and the lifetime prevalence of anxiety disorders was 2.4 times higher for gay men compared to heterosexual men; again, results were similar for past-year prevalence. Thus, the existing

evidence suggests that gay men are, in fact, at increased risk for mood and anxiety disorders, compared to heterosexual men.

Sexual orientation-related stress as a risk factor for psychopathology

Research has begun to identify the mechanisms that account for these sexual orientation-related mental health disparities. The most prominent theory that has been proposed to explain why sexual minorities are at increased risk for psychological disorders is the minority stress theory (Meyer, 2003). The main tenets of minority stress theory are that sexual minorities experience stress associated with their stigmatized social status (referred to as minority stress) and that such stress accounts for their increased risk for psychological disorders. Meyer (2003) identified several types of SORS, including discrimination, the internalization of negative societal attitudes about non-heterosexual attractions, behaviors, and identities (or internalized homonegativity), and expectations of future rejection based on one's sexual orientation (or rejection sensitivity).

Of particular concern, SORS is a common experience among sexual minorities. Data from a representative sample of sexual minorities in the United States demonstrated that gay men reported high rates of SORS during adulthood, including verbal abuse (63.0%), being threatened with violence (35.4%), property crime (28.1%), and physical violence (24.9%; Herek, 2009). Further, gay men reported the highest rates of SORS compared to other sexual minority groups (lesbians, bisexual women, and bisexual men; Herek, 2009). Similarly, in a large sample of sexual minorities (N = 2,259), Herek, Gillis, and Cogan (1999) found that sexual minority men were significantly more likely than sexual minority women to experience hate crimes, and homosexuals were significantly more likely than bisexuals to experience hate crimes. Thus, in

addition to being a prevalent problem among sexual minorities, SORS is particularly prevalent among gay men.

In a meta-analysis of the literature on victimization among sexual minorities, Katz-Wise and Hyde (2012) aggregated the results of 138 studies with a total of 60,203 participants. In addition to finding a high rate of sexual orientation-related discrimination among sexual minorities (41%), they also found that sexual minorities reported high rates of other types of victimization that may or may not have been related to their sexual orientation, such as verbal harassment (55%), sexual harassment (45%), abuse from family members (28-40% depending on the type of abuse), threats of violence (37%), school victimization (33%), physical assault (28%), and sexual assault (27%). Similar to Herek and colleagues (1999), they found that sexual minority men reported significantly higher rates of several types of victimization compared to sexual minority women. Additionally, across 65 studies with a total of 398,403 participants (13,553 sexual minority and 384,850 heterosexual), they found that sexual minorities reported significantly higher rates of 16 out of 18 types of victimization compared to heterosexuals. Thus, the existing evidence suggests that sexual minorities – particularly men – experience high rates of victimization and that these rates are higher than those for heterosexuals.

In addition to the types of victimization noted above, more recent research has identified that sexual minorities also experience microaggressions, or "…brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups…" (Nadal, 2008, p. 23). Nadal and colleagues (2010) proposed a taxonomy of microaggressions toward lesbian, gay, bisexual, and transgender (LGBT) individuals that included seven categories: (1) Use of heterosexist terminology (e.g., saying "that's so gay"); (2)

Endorsement of heteronormative or gender-conforming culture/behaviors (e.g., telling a gay person to "act straight" in public); (3) Assumption of universal LGBT experience (e.g., assuming all gay men are effeminate); (4) Exoticization (e.g., assuming a bisexual person would want to engage in a threesome); (5) Discomfort/disapproval of LGBT experience (e.g., staring with disgust at a same-sex couple displaying affection in public); (6) Denial of societal heterosexism/transphobia (e.g., telling a gay person he is paranoid for thinking that he is being discriminated against); and (7) Assumption of sexual pathology/abnormality (e.g., assuming all gay men have HIV/AIDS). Given that sexual orientation-related microaggressions are thought to be subtle and commonplace, they may be particularly relevant to the well-being of sexual minorities.

Research has consistently demonstrated the pathogenic effects of SORS on sexual minorities (e.g., D'Augelli, 1992; Díaz, Ayala, Bein, Henne, & Marin, 2001; Herek, Gillis, Cogan, & Glunt, 1997; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Huebner, Rebchook, & Kegeles, 2004; Lewis, Derlega, Berndt, Morris, & Rose, 2001; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Meyer, 1995; Waldo, 1999). For instance, sexual minorities who experienced sexual orientation-based hate crimes experienced greater anxiety, depression, and posttraumatic stress symptoms than those who experienced non-sexual orientation-based crimes and those who did not experience any crimes (Herek et al., 1999). Mays and Cochran (2001) found that, compared to heterosexual men, gay men were significantly more likely to report that discrimination had made life harder and interfered with having a full and productive life. Further, they found that perceived discrimination (both lifetime and day-to-day discrimination) was positively associated with three indicators of mental health problems, including increased odds of having any psychiatric disorder, self-rated "fair" or "poor" current mental health, and high

current psychological distress. Notably, the association between sexual orientation and each indicator of mental health problems was reduced when perceived discrimination was taken into account. Additionally, McLaughlin, Hatzenbuehler, and Keyes (2010) found that, among sexual minorities, there were positive associations between past-year discrimination and the 12-month prevalence rates of seven out of nine psychiatric disorders assessed. None of these associations were significant, but they speculated that this was due to the small sample of sexual minorities, given that past-year discrimination was associated with elevated odds of 12-month mood and anxiety disorders for members of other minority groups (Black, Hispanic, and female individuals). Similar to other types of SORS, research also suggests that sexual orientation-related microaggressions are associated with negative mental health outcomes (Wright & Wegner, 2012).

Although research has consistently found that SORS is associated with mental health problems, studies have typically used cross-sectional designs, precluding the ability to test the extent to which SORS influences changes in mental health over time. In an exception, Rosario, Schrimshaw, Hunter, and Gwadz (2002) examined the extent to which SORS was associated with increases in anxious symptoms, depressive symptoms, and conduct problems over time (six-months and one-year later). They found that SORS was significantly associated with increases in anxious symptoms at the six-month follow-up, but not the one-year follow-up. In contrast, SORS was not significantly associated with depressive symptoms or conduct problems at either follow-up assessment. Thus, they only found partial support for the hypothesis that SORS influences changes in mental health over time. They suggested that the non-significant associations between SORS and both depressive symptoms and conduct problems may have been the result of intervening processes, such as supportive social networks or adaptive coping strategies. Given

that participants were recruited from gay-focused organizations, they may have developed supportive social networks and learned how to manage SORS. This is consistent with the suggestion that lengthy time intervals between assessments of SORS and well-being can underestimate the impact of SORS by failing to capture immediate reactions, instead capturing longer-term coping responses that restore well-being (Herek et al., 1999).

To address this issue, Swim and colleagues (Swim et al., 2007; Swim, Johnston, & Pearson, 2009) examined the associations between daily experiences with heterosexist hassles (defined as comments or behaviors that reflect or communicate hostile, denigrating, or stigmatizing attitudes and beliefs about LGB individuals) and psychological well-being using a daily diary design. Swim and colleagues noted that daily diary designs have several advantages when examining experiences with SORS, such as increasing ecological validity, decreasing recall biases, and being less biased toward the over-reporting of severe incidents than recall-based methods. Swim and colleagues found that participants reported an average of two heterosexist hassles over a one-week period, which is consistent with the frequencies reported in other diary studies of everyday SORS (Hyers, 2007; Swim et al., 2001; Swim et al., 2003). Further, they found that more experiences with heterosexist hassles were associated with increased anger and anxious mood, but not depressed mood, and these associations were stronger for sexual minority men compared to women. They suggested that increases in anger subsequent to heterosexist hassles may be due to heterosexist hassles being attributed to social injustice or moral wrongdoing, and increases in anxious mood subsequent to heterosexist hassles may be due to heterosexist hassles being attributed to one's LGB status, which may lead to fear of similar hassles or social rejection in the future on the same basis. In contrast, they suggested that the non-significant association between heterosexist hassles and depressed mood may be due to

heterosexist hassles being attributed to group-related qualities rather than personal qualities, thus being less likely to lead to depression, which is a self-directed emotional state. This is consistent with previous theorizing that different affective responses are a function of different attributions for incidents, and individuals likely make systematically different attributions for hassles they perceive to be discriminatory versus those they do not perceive to be discriminatory (Major, Kaiser, & McCoy, 2003; Schmitt & Branscombe, 2002; Schmitt, Branscombe, & Postmes, 2003).

In sum, research supports the notion that gay men experience high rates of SORS and that such stress is associated with mental health problems, at least in cross-sectional studies. Although there is less research on the longitudinal associations between SORS and mental health problems, the existing research suggests that daily experiences with SORS are associated with increases in anxiety and anger and that non-significant associations over six-month and one-year time periods may reflect intervening processes, such as supportive social networks or adaptive coping strategies.

Mechanisms underlying the associations between sexual orientation-related stress and psychopathology

Despite considerable data to suggest that gay men are at increased risk for psychopathology and that SORS is a robust risk factor for mental health problems, there are two significant gaps in the literature. First, very little is known about how SORS influences mental health. Hatzenbuehler (2009) extended minority stress theory by proposing potential mechanisms to account for the associations between discrimination and negative mental health outcomes, such as general psychological processes (e.g., emotion regulation deficits) and sexual minority-specific processes (e.g., internalized homonegativity). A few studies have begun to provide

support for potential mechanisms underlying the associations between SORS and mental health problems. Feinstein, Goldfried, and Davila (2012) demonstrated that internalized homonegativity and rejection sensitivity both partially mediated the associations between discrimination and both depression and social anxiety symptoms among lesbians and gay men. These findings suggest that discrimination may lead to mental health problems among sexual minorities by increasing negative thoughts about one's own sexual orientation and expectations of rejection based on one's sexual orientation. Further, a daily diary study with 31 LGB individuals found that rumination occurred more on days when SORS was reported and rumination mediated the association between SORS and psychological distress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). Additionally, another study found that rumination mediated the prospective association between implicit anti-gay attitudes and psychological distress (Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phills, 2009).

Second, little attention has been directed at how sexual minorities cope with SORS. Initially, Meyer (2003) proposed that coping could moderate the associations between SORS and mental health problems. More recently, Hatzenbuehler (2009) proposed that coping may be better conceptualized as a mediator of the associations between SORS and mental health problems. He noted that the same variables could be considered moderators or mediators depending on their operationalization, with the crucial distinction that mediators are "…activated, set off, or caused by" stressors (Grant et al., 2003, p. 453). Thus, if coping is operationalized as a trait (e.g., coping styles), then it may be considered a moderator, whereas if coping is operationalized as a response to a specific stressor (e.g., coping strategies used in response to SORS), then it may be considered a mediator. The notion that minority group members can respond to prejudice with coping and resilience was initially proposed by Allport

(1954). Since then, numerous scholars have echoed the sentiment that minority status is associated with important resources that protect minority group members from the adverse mental health consequences of minority stress (Branscombe, Schmitt, & Harvey, 1999; Clark et al., 1999; Crocker & Major, 1989; Kessler, Price, & Wortman, 1985; Miller & Major, 2000; Postmes & Branscombe, 2002; Shade, 1990). In the following sections, I will discuss the role of coping in in the broader literature on stress and mental health as well as specific to sexual minorities.

Coping with stress

Stressors refer to events or conditions that tax or exceed an individual's abilities to manage events or conditions (e.g., Lazarus & Folkman, 1984). In turn, taxing or exceeding an individual's abilities to manage a stressor has the potential to induce mental or somatic illness (Dohrenwend, 2000). Transactional models of stress (e.g., Lazarus & Folkman, 1984) emphasize that cognitive appraisal and coping efforts can influence the effects of an environmental stressor. In these models, coping is conceptualized as constantly changing cognitive and behavioral efforts to manage external and/or internal demands that are appraised as taxing or exceeding one's resources (Lazarus & Folkman, 1984). Importantly, research has demonstrated that coping mediates the associations between stressors and both psychological and physical health (e.g., Pruchno & Resch, 1989; Schroder & Schwarzer, 1998; Holland & Holahan, 2003).

Several taxonomies have been proposed to group individual coping strategies into higher order theoretical constructs (for a review, see Skinner et al., 2003). The two most common taxonomies are problem- versus emotion-focused coping and engagement versus disengagement. In regard to problem- versus emotion-focused coping (Lazarus & Folkman, 1984), problem-focused coping involves actions toward the stressor itself and emotion-focused coping involves

actions toward reducing distress triggered by the stressor. However, problem- and emotion-focused coping are interrelated, such that the same behavior can be categorized as problem- or emotion-focused coping depending on the function. For instance, support seeking can be emotion-focused if the goal is to obtain emotional support or it can be problem-focused if the goal is to obtain advice. Further, effective problem-focused coping reduces the stressor, which in turn reduces the distress triggered by the stressor. Similarly, effective emotion-focused coping reduces the level of distress experienced, which can facilitate engaging in problem-focused coping. Thus, problem- and emotion-focused coping are better thought of as complementary rather than distinct and independent (Lazarus, 2006).

The engagement–disengagement distinction focuses on orientation toward or away from stress, with engagement coping (also referred to as approach or active coping) involving actively dealing with the stressors or related emotions, and disengagement coping (also referred to as avoidance coping) involving escaping the stressors or subsequent emotions (e.g., Moos & Schaefer 1993; Roth & Cohen 1986; Skinner et al. 2003). Of note, engagement includes problem-focused coping strategies and some emotion-focused coping strategies (e.g., support seeking, cognitive restructuring). In contrast, disengagement is typically emotion-focused, because it involves an attempt to escape unpleasant feelings. Despite the goal of escaping distress, disengagement is generally ineffective in reducing distress in the long term, as it does not address the stressor or its impact. Disengagement can also promote a paradoxical increase in intrusive thoughts about the stressor and an increase in negative emotions (Najmi & Wegner, 2008). Finally, some kinds of disengagement can generate additional problems, such as excessive use of alcohol or drugs, which can create further social and health problems. In general, disengagement is associated with negative mental health outcomes and engagement is

associated with improved well-being (Compas, Connor-Smith, Osowiecki, & Welch, 1997; Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). In the proposed study, I will use the engagement and disengagement distinction for two reasons. First, as noted above, problem- and emotion-focused coping strategies can be adaptive or maladaptive depending on the specific strategy, whereas engagement is generally considered adaptive and disengagement is generally considered maladaptive. Second, the limited literature on coping with stress among sexual minorities has tended to use the engagement and disengagement distinction.

Coping with stress among sexual minorities

Research on how sexual minorities cope with stress has conceptualized coping in a variety of ways. First, it has been suggested that sexual minorities cope with stress by seeking support from members of their social networks. Consistent with the broader literature on social support, numerous studies have demonstrated that social support is associated with improved mental health among sexual minorities (e.g., Doty et al., 2010; Sheets & Mohr, 2009; Vincke & Heeringen, 2002; Williams et al., 2005). Second, researchers have proposed that sexual minorities make decisions about whether to conceal or disclose their sexual orientation as a way to protect them from experiencing stress (e.g., discrimination). Although there may be perceived benefits to concealing one's sexual orientation (e.g., minimizing the chances of being rejected or victimized), research has found that concealment is associated with negative mental health outcomes (e.g., D'Amico & Julien, 2012; DiPlacido, 1998; Potoczniak, Aldea, & DeBlaere, 2007; Stall et al., 2001) and difficulty forming a positive sexual minority identity (Frable, Wortman, & Joseph, 1997). These findings are consistent with the broader literature on self-concealment, which finds that self-concealment has deleterious effects on mental health (Larson & Chastain, 1990).

Most relevant to the proposed study, there has also been some research on sexual minorities that has conceptualized coping in ways that are more consistent with the mainstream stress and coping literature, such as coping styles (i.e., traits rather than responses to specific events) and coping strategies used in response to specific stressful experiences (e.g., discrimination). In regard to coping styles, most studies have focused on the associations between coping styles and risky sexual behavior. For instance, Martin, Pryce, and Leeper (2005) found that avoidance coping was positively associated with engaging in unprotected anal intercourse in the past six months among gay men. In contrast, active cognitive and behavioral coping were not associated with unprotected anal intercourse. The association between avoidance coping and risky sexual behavior among gay men has been replicated in numerous studies (e.g., Barrett et al., 1995; Folkman, Chesney, Pollack, & Phillips, 1992; Robins et al., 1994; Semple, Patterson, & Grant, 2000; Williams, Elwood, & Bowen, 2000) and it has been suggested that this association may reflect the use of unprotected anal intercourse as an avoidance strategy (Martin & Knox, 1997).

Less research has focused on how coping styles relate to mental health among sexual minorities. Zea, Reisen, and Poppen (1999) found that higher active coping was associated with higher self-esteem and lower depressive symptoms among lesbians and gay men. In contrast, active coping was not associated with any aspects of collective self-esteem (i.e., the individual's private evaluation of the social group, the individual's beliefs about how others assess the social group, the degree to which membership in the social group is important to the individual's identity, and the individual's sense of worth as a member of the group). Similarly, DeMarco, Ostrow, and DiFranceisco (1999) found that higher involvement-oriented coping was associated with lower depressive symptoms, but only among the most severely depressed men in their

sample (the upper 15%). Nicholson and Long (1990) found that higher avoidant coping was associated with worse mood. Two studies have also found associations between coping and substance use among gay men. Greene and Britton (2012) examined the associations between different types of shame-focused coping and alcohol use disorders, finding that avoidant coping and attack-self coping were positively associated with alcohol use disorders. Similarly, Suprina and colleagues (2010) compared gay men in three groups – those with current alcohol problems, those without current alcohol problems, and alcoholics who were currently abstaining. They found that lower tension control and lower social support were the most significant predictors of current alcohol problems (Suprina, Brack, Chang, & Kim, 2010). Finally, Lehavot (2012) found that higher maladaptive coping and lower adaptive coping were significantly associated with higher depressive symptoms and poorer mental health in a large sample of sexual minority women (N = 1,381). Of note, maladaptive coping had a stronger influence than demographics, social support, and adaptive coping on depressive symptoms and mental health. Further, greater maladaptive coping accounted for increases in depressive symptoms and poorer mental health among bisexual women compared to lesbians. In sum, research suggests that active coping is associated with positive outcomes (e.g., higher self-esteem, lower depressive symptoms), whereas avoidant coping is associated with negative outcomes (e.g., alcohol use disorders, risky sexual behavior), which is consistent with the broader literature on active and avoidant coping.

Further, there has been very little research on individual differences in coping styles among gay men. Nicholson and Long (1990) found that higher internalized homophobia and lower self-esteem predicted greater avoidance coping among HIV-positive gay men; lower internalized homophobia also predicted higher proactive coping. Szymanski and Owens (2008) also found that higher internalized heterosexism was associated with higher avoidance coping

among lesbians. These findings begin to shed light on factors that may influence the ways in which gay men cope with stress. Specifically, gay men who harbor negative feelings toward themselves (in general and specific to their sexual orientation) may be more likely to engage in avoidant coping and less likely to engage in active coping.

Coping with sexual orientation-related stress

A major limitation of the research on how sexual minorities cope with stress is the non-contextual nature of the measurement of stress, which has been acknowledged by other researchers (e.g., David & Knight, 2008). If participants are asked to report on how they cope with stress and the type of stress is not specified, then it remains unclear if they are reporting on how they respond to general life stress or SORS. It is likely that there are differences between how sexual minorities cope with general life stress compared to SORS, given that individuals are likely to make different attributions for stressors they perceive to be discriminatory versus non-discriminatory (Major, Kaiser, & McCoy, 2003; Schmitt & Branscombe, 2002; Schmitt et al., 2003). Despite the high prevalence of SORS reported by gay men, surprisingly little research has focused on how gay men cope with specific incidents of this type of stress.

There is a larger literature on how other minorities (e.g., racial minorities) cope with discrimination compared to sexual minorities. Similar to the broader literature on stress and coping, research on how racial minorities cope with racism has conceptualized coping in a variety of ways, such as problem- versus emotion-focused coping, approach- versus avoidance-coping, and support seeking (for a review, see Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009). In their review, Brondolo and colleagues (2009) concluded that there is only limited evidence that confrontation coping buffers the effects of racism on psychological distress and there is minimal evidence that social support buffers the effects of racism on psychological

distress. However, they limited their review to studies that conceptualized coping as a moderator of the association between racism and psychological distress, noting that mediation models are also plausible. Further, they noted that methodological limitations (e.g., cross-sectional, correlational designs) preclude the ability to draw strong conclusions from the existing literature. Recently, Szymanski and Obiri (2011) found that religious coping mediated the association between racism and psychological distress as well as the association between internalized racism and psychological distress. In contrast, no support was found for the moderating role of religious coping. In sum, research on how racial minorities cope with discrimination suggests that coping strategies may be better conceptualized as mediators than moderators.

Qualitative research has begun to describe the variety of ways that sexual minorities react to and cope with SORS. For instance, Nadal and colleagues (2011) asked 26 LGB individuals how they reacted to and coped with sexual orientation-related microaggressions (Nadal, Wong, Issa, Meterko, Leon, & Wideman, 2011). Two response domains relevant to coping were identified, including behavioral and cognitive reactions. Participants described three types of behavioral reactions to sexual orientation-related microaggressions, including passive coping (e.g., ignoring discriminatory comments, choosing not to be reactive), confrontational coping (e.g., actively speaking up and challenging the people who put them down), and protective coping (e.g., maintaining awareness of surroundings and acting cautiously). Three types of cognitive reactions were also described, including accepting microaggressions as part of life, feeling a need to conform to heterosexual norms, and feeling empowered/resilient. Of note, none of the participants reported that they were always confrontational in response to microaggressions. Instead, consistent with previous theorizing, they made decisions about whether or not to confront the situation by assessing the physical and emotional consequences

(Sue, 2010). Further, Nadal and colleagues (2011) noted that LGB individuals are different in their coping styles and they suggested that the types of reactions to microaggressions may depend on various factors, such as LGB identity, personality type, the context of the situation, and the individual's personal history and experiences. However, they did not assess factors that influenced participants' reactions to microaggressions.

Similarly, McDavitt and colleagues (2008) asked 43 gay and bisexual men how they coped with heterosexism. They found that responses were best categorized through an emotion regulation lens. Consistent with Gross' (1998) model of emotional regulation, participants described different coping strategies that could be categorized as focused on situation selection, situation modification, attention deployment, cognitive change, and response modulation. Participants commonly engaged in situation selection by approaching or avoiding situations based on their anticipated emotional reaction. For instance, participants sought the company of gay-affirmative people (both in person and using the internet). When faced with unavoidable situations, participants engaged in situation modification by attempting to pass as heterosexual (e.g., avoiding the topic of sexual orientation, telling half-truths, keeping a low profile) or covering their sexual orientation. Consistent with the literature on sexual orientation concealment noted above, participants who reported attempting to pass as heterosexual typically felt they were engaging in a protective behavior, but it had negative consequences such as guilt, shame, and frustration. Participants also described trying to modify situations by educating people. In unavoidable situations where they did not think they could modify the situation (e.g., encounters with caregivers), participants reported engaging in attention deployment by listening selectively or ignoring provocations. Similarly, in these situations participants reported engaging in cognitive change, such as reframing experiences and trying to see the other person's perspective.

Finally, participants reported engaging in response modulation to change their emotional experience once it happened in various ways, such as venting, suppressing feelings, and using drugs and alcohol. Of note, nearly all participants talked about using multiple strategies to cope with heterosexism, often in a single situation.

Despite some qualitative research on how sexual minorities cope with SORS, there has been little quantitative research on this topic as well as on how coping with SORS influences mental health. McLaughlin, Hatzenbuehler, and Keyes (2010) used epidemiological data to examine the associations between responses to discrimination and psychiatric disorders among several minority groups (sexual minorities, racial/ethnic minorities, and women). They assessed two types of responses to discrimination – acceptance (accepting it as a fact of life versus trying to do something about it) and disclosure (talking to other people about it versus keeping it to oneself) – and they created four categories of response styles based on whether or not participants endorsed acceptance and disclosure. Among sexual minorities, 45.7% reported not accepting discrimination and disclosing it, 37.8% reported accepting discrimination and disclosing it, 10.6% reporting accepting discrimination and not disclosing it, and 5.9% reported not accepting discrimination and not disclosing it; the order of most to least common response styles was the same for racial/ethnic minorities and women. They were not able to look at the associations between responses to discrimination and psychiatric disorders among sexual minorities due to the small sample, but associations for the other minority groups may shed light on the possible associations between these response styles and psychiatric disorders. In general, not disclosing discrimination (regardless of whether or not individuals accepted it) was associated with increased psychopathology, suggesting that there are psychological benefits to disclosure. Results were less clear in regard to acceptance, with it appearing beneficial in some

instances and problematic in others. This may be due to the vague response options for this variable (accepting it as a fact of life versus trying to do something about it), which could have been interpreted differently by different people.

In a sample of gay and bisexual men, Szymanski (2009) did not find support for social support or avoidant coping as moderators of the association between heterosexism and psychological distress, but she did not test alternate mediation models. Bianchi and colleagues (2004) found that higher sexual orientation-related discrimination was associated with lower active coping, and lower active coping was associated with lower health-promoting behavior (Bianchi, Zea, Poppen, Reisen, & Echeverry, 2004), which provides support for the possibility that coping strategies act as mechanisms through which SORS influences health behavior. Additionally, Szymanski and Owens (2008) tested the extent to which avoidance coping and problem-solving coping mediated or moderated the association between internalized heterosexism and psychological distress among lesbians. They found support for avoidance coping as a mediator, suggesting that lesbians who experience high degrees of internalized heterosexism may be more likely to engage in avoidant coping strategies, which in turn results in poorer mental health. In contrast, they did not find support for problem-solving coping as a mediator or for either type of coping as a moderator. Similarly, Szymanski and Kashubeck-West (2008) found support for social support as a mediator of the association between internalized heterosexism and psychological distress among lesbians and bisexual women. Although these two studies focused on internalized heterosexism rather than SORS, they provide preliminary support for the notion that coping strategies may mediate the associations between dimensions of SORS and mental health.

In sum, several important conclusions can be drawn from the literature on stress and coping among sexual minorities: (1) consistent with the broader literature on stress and coping, an active coping style tends to be associated with improved well-being and an avoidant coping style tends to be associated with negative mental health outcomes; (2) the associations between coping strategies used in response to SORS and mental health outcomes are similar to those between coping styles and mental health outcomes, but few studies have assessed coping in this manner; (3) no studies have examined the associations between coping strategies used in response to SORS and mental health outcomes using daily or weekly diary designs; and (4) little is known about individual differences in coping styles among sexual minorities, although two studies suggest that higher internalized homophobia is associated with higher avoidance coping and lower proactive coping. These conclusions highlight the need for additional research on coping among sexual minorities, particularly research that examines coping strategies used in response to SORS as well as individual differences in coping strategies, which the current proposal will address.

The Current Study

The current study examined a series of hypotheses related to the associations among individual differences (internalized homonegativity and rejection sensitivity), coping strategies (active and disengaged coping), and internalizing symptoms in a sample of gay men using a weekly diary design. Internalized homonegativity and rejection sensitivity were examined as the individual differences, because they have been implicated in the psychological functioning of gay men. Specifically, a meta-analysis demonstrated a significant association between internalized homonegativity and internalizing symptoms (Newcomb & Mustanski, 2010). Although less research has been conducted on rejection sensitivity among gay men, one study

demonstrated a significant association between rejection sensitivity and internalizing symptoms among gay men (Feinstein et al., 2012). Further, although internalized homonegativity and rejection sensitivity are related constructs, they are independent and represent distinct concepts (Feinstein et al., 2012; Pachankis et al., 2008). Thus, the current study examined these as separate individual differences. Additionally, internalizing symptoms were examined as the outcome, because ample research supports gay men's increased risk for internalizing disorders (e.g., Atkinson et al., 1999; Bostwick et al., 2010; Cochran & Mays, 2000b; Cochran & Mays, 2009; Cochran et al., 2003; Fergusson et al., 1999; Meyer, 2003; Sandfort et al., 2001) and previous research supports the notions that both internalized homonegativity and rejection sensitivity are associated with internalizing symptoms (Feinstein et al., 2012; Newcomb & Mustanski, 2010). In contrast, research has yet to examine the association between rejection sensitivity and externalizing symptoms. Further, internalizing symptoms were focused on rather than depressive and anxious symptoms separately, because research suggests that a latent internalizing liability accounts for mood and anxiety disorder comorbidity (Krueger & Markon, 2006; Watson, 2005) and hypotheses for the current study were identical for depressive and anxious symptoms. Finally, a weekly diary design was used in order to increase ecological validity, decrease recall biases, and decrease biases toward the over-reporting of severe incidents. In a daily diary study, Swim and colleagues (2007) found that participants reported an average of two heterosexist hassles over a one-week period. Given that participants are unlikely to experience SORS on a daily basis, a weekly diary design is likely to maximize the chances of participants experiencing SORS between assessments. A weekly diary design also allows for tests of between-person and within-person effects. Between-person effects represent differences

between participants, whereas within-person effects represent weekly fluctuations for individuals.

Hypotheses

1. Between-person effects: Between-person internalized homonegativity and rejection sensitivity will be negatively associated with active coping and positively associated with disengaged coping and internalizing symptoms. Additionally, between-person active coping will be negatively associated with internalizing symptoms and between-person disengaged coping will be positively associated with internalizing symptoms.
2. Within-person effects: Within-person internalized homonegativity and rejection sensitivity will be negatively associated with active coping and positively associated with disengaged coping and internalizing symptoms. Additionally, within-person active coping will be negatively associated with internalizing symptoms and within-person disengaged coping will be positively associated with internalizing symptoms.
3. Between-person mediation effects: Between-person active coping/disengaged coping will mediate the associations between between-person internalized homonegativity/rejection sensitivity and internalizing symptoms.
4. Within-person mediation effects: Within-person active coping/disengaged coping will mediate the associations between within-person internalized homonegativity/rejection sensitivity and internalizing symptoms.

Method

Participants

Participants included 147 self-identified gay men who were recruited from gay men's groups and gay bars in New York City as well as websites (e.g., Craigslist) and LGBT listservs.

All participants were at least 18 years old, self-identified as gay men, lived in a borough of New York City, had regular access to the Internet, could read and write in English, and did not have any reading, vision, or motor problems that would preclude completing online questionnaires. Of the 147 participants, 131 completed all 8 weeks, 9 completed 7 weeks, 2 completed 6 weeks, 1 completed 4 weeks, 2 completed 3 weeks, 1 completed 2 weeks, and 1 completed 1 week. The mean age of the sample was 37.27 years (SD = 11.42; range = 18-65). Approximately two-thirds of the sample identified as White (68.5%) with the rest of the sample identifying as Black (11.0%), Asian (9.6%), Latino (5.5%), or multi-racial (3.4%). Further, 18.8% of the sample identified as Latino. Income ranged from less than $10,000 to more than $150,000; the modal income was $40,000-$49,999. All participants had completed high school; 47.6% had completed a four-year degree, 21.8% had completed a master's degree, and 5.4% had completed a doctoral degree.

Procedures

Participants were recruited in-person at gay men's social groups and at gay bars in boroughs of New York City. At gay men's social groups, study personnel made announcements describing the study and interested individuals were screened in-person for eligibility criteria. At gay bars, study personnel approached men, described the study, and interested individuals were screened in-person for eligibility criteria. Additionally, advertisements were hung at the venues where the gay men's social groups met and at bar gays. The advertisements stated that researchers at Stony Brook University were seeking gay men who were at least 18 years old to participate in a project to help understand the unique experiences of gay men. Advertisements also mentioned that the project involved completing online questionnaires and that participants could receive up to $50 as well as the chance to win an additional $500. Interested individuals

were instructed to contact the study coordinator by phone or email. The study coordinator provided a detailed description of the study procedures and screened interested individuals for eligibility criteria. Eligibility criteria included: at least 18 years old, self-identified as gay men, lived in a borough of New York City, had regular access to the Internet, could read and write in English, and did not have any reading, vision, or motor problems that would preclude completing online questionnaires. Those who met the eligibility criteria were asked to choose the day of the week that they wanted to complete the weekly online questionnaires. Participation began the following week on the day of the week that they chose unless they requested to start on a different week. Participants were informed that they had to complete each week's questionnaires on the same day of the week and that the website that they completed the questionnaires on would record the date and time of their participation. Participants were also informed that they would be compensated $10 for completing the first week's questionnaires, $5 for completing each of the next six weeks' questionnaires, and $10 for the eight week's questionnaires. Thus, participants who completed all eight assessments were compensated $50. Participants were compensated more for the first and last weeks' questionnaires because they were longer. In an effort to increase compliance with the weekly assessments, participants who completed 6 or 7 weeks received one raffle entry for the chance to win an additional $500 at the end of the study. Participants who completed all 8 weeks received two raffle entries.

On the morning of the agreed upon start date, participants were emailed a link to a secure website (using the program PsychData) to complete a battery of baseline questionnaires. The battery of baseline questionnaires included an assessment of demographic information (described below) and additional measures that are not part of the current study. Participants were provided with a unique three-digit identification number, which they were required to enter before

completing any questionnaires. Before viewing the questionnaires, participants were directed to a consent letter, which described the study procedures in writing. In order to participate in the study, participants were required to indicate that they agreed to the content of the consent letter. Those who agreed to participate were directed to the questionnaires. For the next seven consecutive weeks, on the mornings of the agreed upon dates, participants were emailed a link to a secure website to complete the weekly questionnaires and they were reminded of their unique three-digit identification number.

Measures

Demographic information was assessed at baseline (week 1) and all other variables were assessed on a weekly basis for seven consecutive weeks (weeks 2-7).

Demographics. Basic demographic information was assessed at baseline, such as age, gender, race/ethnicity, sexual orientation, income, and education.

Internalized homonegativity (IH). The internalized homonegativity subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS – IH; Mohr & Kendra, 2011) was used to assess negative feelings about one's sexual minority identity. The LGBIS is typically used to assess traits, rather than states, so it was adapted to refer to the past week. For individuals who reported experiencing SORS in the past week, they were asked to rate the extent to which the three statements applied to their experience *since the event that they described.* For those who did not report experiencing SORS in the past week, they were asked to rate the extent to which the three statements applied to their experience *over the course of the past week*. The items included: (1) If it were possible, I would choose to be straight; (2) I wish I were heterosexual; and (3) I believe it is unfair that I am attracted to people of the same-sex. Each item was rated on a 1-6 scale (1 = disagree strongly, 2 = disagree, 3 = disagree somewhat, 4 = agree somewhat, 5 =

agree, 6 = agree strongly). Total scores were calculated by averaging responses to the three items. Total scores could range from 1 to 7, with higher scores indicating more negative feelings about one's sexual minority identity. Mohr and Kendra (2011) reported internal consistencies ranging from .86 to .93 and six-week test-retest reliability of .92.

Rejection sensitivity (RS). Given that existing measures of rejection sensitivity are meant to assess the construct as a trait rather than a state, a measure was developed for the current study to assess weekly fluctuations in rejection sensitivity. The items developed for the current study were modeled after the Gay-Related Rejection Sensitivity Scale (Pachankis et al., 2008) as well as a daily assessment of appearance-related rejection sensitivity (Park & Pinkus, 2009). Park and Pinkus (2009) asked participants to rate one item ("Today, I felt sensitive to rejection based on the way I looked") on a 1-5 scale (1 = not at all, 5 = extremely). That item was adapted in three ways: (1) the time frame was changed from *today* to *since the event that you described* (for those who reported experiencing SORS) or *over the course of the past week* (for those who did not report experiencing SORS); (2) the item referred to sexual orientation rather than appearance; and (3) the word *sensitive* was changed to *worried or anxious* to more closely reflect the conceptualization of the rejection sensitivity construct. Thus, respondents were asked, "How worried or anxious were you about being rejected because of your sexual orientation since the event you described [over the course of the past week]? Respondents were also asked: How likely was it that you would be rejected because of your sexual orientation since the event you described [over the course of the past week]? Items were rated on a 1-5 scale (1 = not at all, 5 = extremely) and total scores were computed by multiplying responses to the items. Total scores could range from 1 to 25, with higher scores indicating higher anxious expectations of rejection.

Sexual orientation-related stress. Participants were provided with a list of eight stressful situations related to one's sexual orientation and they were instructed to indicate which (if any) they had experienced over the past week. The eight situations were taken from the Heterosexist Harassment, Rejection, and Discrimination Scale (Szymanski, 2009) and included: (1) Were you treated unfairly by anyone because of your sexual orientation? (2) Were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because of your sexual orientation? (3) Were you rejected by anyone because of your sexual orientation? (4) Were you verbally insulted because of your sexual orientation or called an anti-gay name like faggot, sissy, or other names? (5) Were you threatened with harm because of your sexual orientation? (6) Were you pushed, shoved, or hit because of your sexual orientation? (7) Did you hear anti-gay remarks directed at you or someone else from anyone? (8) Other. Participants were also provided with a not applicable option if they had not experienced any stressful situations related to their sexual orientation over the past week. If they chose not applicable, then they were not asked the subsequent questions about coping (see below). If they endorsed more than one stressful experience related to their sexual orientation over the past week, then they were asked to identify the one that had the most negative impact on them.

Coping. The Brief Cope (Carver, 1997) was used to assess coping (see the Appendix for the full measure). The Brief Cope is typically used to assess general coping styles, so it was adapted to refer specifically to how participants coped with the SORS that they experienced each week. The Brief Cope assesses 14 coping strategies, including: (1) active coping; (2) planning; (3) positive reframing; (4) acceptance; (5) humor; (6) religion; (7) using emotional support; (8) using instrumental support; (9) self-distraction; (10) denial; (11) venting; (12) substance use; (13) behavioral disengagement; and (14) self-blame. Each of the 14 coping strategies is assessed

with two items for a total of 28 items. Respondents were asked to rate the extent to which they used each of the 28 items in response to the SORS that they experienced each week on a 1-4 scale (1 = I didn't do this at all, 4 = I did this a lot). Carver (1997) reported internal consistencies ranging from .50 to .90, suggesting that all of the subscales met or exceeded the minimally acceptable value of .50 (Nunnally, 1978). Consistent with previous use of this measure (e.g., Meyer, 2001, Lehavot, 2012), subscales were combined into two subscales – Active Coping (including strategies 1-8 listed above) and Disengaged Coping (including strategies 9-14 listed above). Total scores were calculated by averaging responses for the items that assessed Active Coping (AC) and the items that assessed Disengaged Coping (DC). Total scores can range from 1 to 4, with higher scores indicating greater use of each type of coping strategy.

Internalizing symptoms (INT). Internalizing symptoms were assessed with two questions: (1) How depressed did you feel *since the event you described* (for those who reported experiencing SORS) or *over the course of the past week* (for those who did not report experiencing SORS)? and (2) How anxious did you feel *since the event you described* (for those who reported experiencing SORS) or *over the course of the past week* (for those who did not report experiencing SORS)? Items were rated on a 1-5 scale (1 = very slightly or not at all, 2 = a little, 3 = moderately, 4 = quite a bit, and 5 = extremely). Total scores were computed by summing responses to the two questions.

Data Analyses

All analyses were conducted using IBM SPSS Statistics Version 22.

Intercept only models. I estimated separate intercept only models for each variable (IH, RS, AC, DC, and INT). No predictor variables are included in intercept only models, thus they provide an estimate of the average value of the outcome measure, averaged across participants

and time points as well as the between- versus within-person variance decomposition estimates needed to calculate intraclass correlations (ICCs). ICCs represent the amount of total variance accounted for by between-person variability relative to the total (between-person plus within-person) variance. Between-person variability represents how much participants' average levels of the outcome differ from one another, whereas within-person variability represents how much the momentary responses of a participant fluctuate across time points around his mean value.

Cross-sectional associations. I tested the cross-sectional associations between IH/RS and AC/DC/INT. To do so, I computed person-mean centered scores and grand-mean centered scores for IH and RS (see Enders & Tofighi, 2007). Each person-mean centered score was computed by subtracting each weekly observation from a person-level average of their scores across all weeks. In this way, each score reflects deviation from a person's own average across the study. The grand-mean centered scores were computed by subtracting the person-level average from the sample "average of averages." This way, the scores reflect how a person's average level of the construct across all observations deviates from the sample's average. The grand-mean centered person means variables represent the between-person components of each variable and the person-mean centered variables represent the within-person components of each variable. Then, AC, DC, and INT were regressed on IH (in separate analyses) and RS (in separate analyses) to examine their associations. Finally, the analyses were repeated with IH and RS in the same models to test their relative associations. The between-person and within-person components of each variable were entered as fixed effects in all analyses. Models were also tested with the within-person components of each variable entered as random effects. The Bayesian Information Criteria (BIC) was used to compare models with and without random effects. A difference of 2

units in the BIC value is associated with 3:1 posterior odds favoring the superior model (Raftery, 1995). All models reported in the results are without random effects unless otherwise noted.

Prospective associations. Prospective associations were tested in the same way as cross-sectional associations with one exception. Outcome variables at time *t* were regressed on predictor variables at time *t – 1* (i.e., a one-week lag). Doing so pairs outcome variables at each week with predictor variables at the previous week. Thus, results can be interpreted as answering the question, how is AC/DC/INT at each week related to IH/RS at/during the previous week. In these analyses, within-person variability represents the prospective association between the predictor one week and the outcome the next week. Between-person variability is not reported, given that it is redundant with the cross-sectional analyses. Similar to the cross-sectional analyses, the BIC was used to compare models with and without random effects.

Mediation analyses. The Monte Carlo Method for Assessing Mediation (MCMAM; MacKinnon, Lockwood, & Williams, 2004) was used to test the significance of the indirect effects in the mediation analyses. The MCMAM is similar to the parametric bootstrap approach (Efron & Tibshirani, 1986) and it can be used to examine mediation in multilevel models (Bauer, Preacher, & Gil, 2006). The MCMAM assumes that the a and b parameter estimates have normal sampling distributions. Using the inputted parameter estimates and standard errors, random draws from the a and b distributions are simulated and the product of these values is computed. This procedure was repeated 20,000 times and the resulting distribution of the a*b values was used to estimate 95% confidence intervals around the observed values of a*b. Confidence intervals that do not include zero are significant at an alpha level of .05. For the cross-sectional analyses, between-person and within-person mediation effects were tested. In contrast, only

within-person mediation effects were tested for the prospective analyses, given that between-person mediation effects are redundant with the cross-sectional analyses.

Results

Descriptives and Correlations between Predictors

Approximately half of participants experienced SORS at least once over the course of the seven weeks (*n* = 76; 51.7%). Out of a possible seven weeks, 47 participants (32.0%) experienced SORS one week, 13 participants experienced SORS two weeks (8.8%), 9 participants experienced SORS three weeks (6.1%), 4 participants experienced SORS four weeks (2.7%), 1 participant experienced SORS five weeks (0.7%), and 2 participants experienced SORS six weeks (1.4%). Between-person variability in IH was significantly positively associated with between-person variability in RS (estimate = 1.45, SE = .26, $p < .001$). There was also significant positive association between within-person IH and within-person RS (estimate = 1.48, SE = .20, $p < .001$).

Intercept only models

IH. In regard to estimates of fixed effects, the mean level of IH (i.e., the estimated mean of the person means) was 1.58 (SE = .08) on a 1-6 scale. The estimate of the residual (i.e., within-person) variance was .22 (SE = .01) and the estimated variance of the random intercept (i.e., person means) was .95 (SE = .12). The ICC was .81 (= .95 / [.95 + .22]), indicating that 81% of the variability in IH is due to between-person variability and the remaining 19% is due to within-person variability (i.e., fluctuations over time of individuals' scores around their own mean).

RS. The estimated mean level of RS was 3.00 (SE = .28) on a 1-25 scale. The estimate of the residual variance was 8.98 (SE = .44) and the estimated variance of the random intercept was

9.95 (SE = 1.34). The ICC was .53, indicating that 53% of the variability in RS is due to between-person variability and the remaining 47% is due to within-person variability.

AC. The estimated mean level of AC was 1.94 (SE = .06) on a 1-4 scale. The estimate of the residual variance was .16 (SE = .03) and the estimated variance of the random intercept was .12 (SE = .04). The ICC was .43, indicating that 43% of the variability in AC is due to between-person variability and the remaining 57% is due to within-person variability.

DC. The estimated mean level of DC was 1.61 (SE = .06) on a 1-4 scale. The estimate of the residual variance was .16 (SE = .03) and the estimated variance of the random intercept was .14 (SE = .04). The ICC was .47, indicating that 47% of the variability in DC is due to between-person variability and the remaining 53% is due to within-person variability.

INT. The estimated mean level of INT was 1.85 (SE = .06) on a 1-5 scale. The estimate of the residual variance was .42 (SE = .02) and the estimated variance of the random intercept was .44 (SE = .06). The ICC was .51, indicating that 51% of the variability in INT is due to between-person variability and the remaining 49% is due to within-person variability.

In summary, roughly half of the total variances of RS, AC, DC, and INT are due to differences from one person to the next, and the rest is due to week-to-week fluctuation around each person's mean. In contrast, IH is much more "trait-like," with most of the variance being due to individual differences in mean levels and relatively small amounts due to week-to-week fluctuations.

Cross-sectional associations

IH/RS and AC. First, I examined the cross-sectional associations between IH and AC as well as RS and AC in separate models (for results, see Table 1). Between- and within-person variability in IH were not significantly associated with AC. Between-person variability in RS

was not significantly associated with AC. In contrast, within-person variability in RS was significantly positively associated with AC. For each one unit change (e.g., from one week to the next) in RS, there is on average a .03 unit change in AC. Next, I included IH and RS in the same model (for results, see Table 1). The positive association between within-person variability in RS and AC remained significant. Between- and within-person variability in IH as well as between-person variability in RS remained non-significant predictors. This indicates that weekly fluctuations in RS are significantly associated with AC, such that active coping strategies are utilized at a greater rate on weeks when individuals report higher RS than their average levels. Although the positive association between RS and AC was unexpected, it may be due to the significant positive association between AC and DC. In fact, there was a significant positive association between within-person variability in AC and within-person variability in DC (estimate = .50, SE = .08, $p < .001$). Thus, gay men who report engaging in active coping also report engaging in disengaged coping, indicating that they are utilizing multiple coping strategies that range in the extent to which they are active versus disengaged. As such, the positive association between RS and AC may reflect a tendency to utilize coping strategies, both active and disengaged, in response to expectations of rejection.

IH/RS and DC. First, I examined the cross-sectional associations between IH and DC as well as RS and DC in separate models (for results, see Table 2). Between-person variability in IH was significantly positively associated with DC. For each one unit difference between persons in average IH, there is on average a .13 unit difference in the mean level of DC. Within-person variability in IH was also significantly positively associated with DC. Between- and within-person variability in RS were also significantly positively associated with DC. Next, I included IH and RS in the same model (for results, see Table 2). Within-person variability in IH as well as

between- and within-person variability in RS remained significantly positively associated with DC. In contrast, between-person variability in IH was no longer a significant predictor. This indicates that individuals who report higher tendencies to expect to be rejected also report greater use of disengaged coping strategies. Additionally, weekly fluctuations in IH and RS are both significantly associated with DC, such that disengaged coping strategies are utilized at a greater rate on weeks when individuals report higher IH and RS than their average levels.

IH/RS and INT. First, I examined the cross-sectional associations between IH and INT as well as RS and INT in separate models (for results, see Table 3). Results reported for these models include random effects. Between- and within-person variability in IH were not significantly associated with INT. The random effect for within-person variability in IH was significant, indicating that the association between IH and INT varied across participants. Thus, although within-person variability in IH was not significantly associated with INT, this relationship varied across participants. Between- and within-person variability in RS were significantly positively associated with INT. The random effect for within-personal variability in RS was also significant, indicating that the association between RS and INT varied across participants. As such, although within-person variability in RS was significantly positively associated with INT, this relationship varied across participants. Next, I included IH and RS in the same model (for results, see Table 3). Between- and within-person variability in RS remained significantly positively associated with INT and within-person variability in IH became a significant predictor. Between-person variability in IH remained a non-significant predictor. This indicates that within-person variability in IH and RS as well as between-person variability in RS are all significant predictors of INT, but between-person variability in IH is not. Weekly fluctuations in IH and RS are both significantly associated with INT, such that higher

internalizing symptoms are reported on weeks when individuals report higher IH and RS than their average levels. Additionally, regardless of weekly fluctuations, individuals who report higher tendencies to expect to be rejected also report higher internalizing symptoms.

AC/DC and INT. First, I examined the cross-sectional associations between AC and INT as well as DC and INT in separate models (for results, see Table 4). Between-person variability in AC was significantly positively associated with INT. In contrast, within-person variability in AC was not significantly associated with INT. Although the positive association between AC and INT was unexpected, I will present evidence below that it is due to the significant positive association between AC and DC. Between- and within-person variability in DC were significantly positively associated with INT. Next, I included AC and DC in the same model (for results, see Table 4). Between- and within-person variability in DC remained significantly positively associated with INT. Within-person variability in AC remained a non-significant predictor and between-person variability in AC became a non-significant predictor. This indicates that individuals who report higher tendencies to utilize disengaged coping strategies also report higher internalizing symptoms. Additionally, weekly fluctuations in DC are significantly associated with INT, such that higher internalized symptoms are reported on weeks when individuals report utilizing disengaged coping strategies more than their average levels. The findings that between-person and within-person variability in AC were not significant when DC was included in the model supports the notion that the significant positive association between AC and INT in the model without DC can be explained by the significant positive association between AC and DC.

IH/RS/AC/DC and INT. Finally, I included IH, RS, AC, and DC in the same model (for results, see Table 5). Between- and within-person variability in RS were significantly positively

associated with INT. In contrast, between- and within-person variability in IH, AC, and DC were not significant predictors. This indicates that individuals who report higher tendencies to expect to be rejected also report higher internalizing symptoms. Additionally, higher internalizing symptoms are reported on weeks when individuals report higher RS than their average levels. When IH, RS, AC, and DC are considered simultaneously, RS is the only significant predictor of internalizing symptoms.

Cross-sectional mediation analyses

Does AC mediate the associations between IH/RS and INT at the person level?

I examined whether person means of AC mediated the associations between person means of IH and mean INT as well as person means of RS and mean INT in separate models (for results, see Table 6). As noted, between-person variability in IH was not significantly associated with AC. In contrast, between-person variability in AC was significantly positively associated with INT controlling for IH. Given that the predictor variable was not significantly associated with the mediator, between-person AC does not significantly mediate the association between between-person IH and INT. In regard to RS, as noted, between-person variability in RS was not significantly associated with AC. In contrast, between-person variability in AC was significantly positively associated with INT controlling for RS. Again, given that the predictor variable was not significantly associated with the mediator, between-person AC does not significantly mediate the association between between-person RS and INT.

Does DC mediate the associations between IH/RS and INT at the person level?

I examined whether person means of DC mediated the associations between person means of IH and mean INT as well as person means of RS and mean INT in separate models (for results, see Table 7). As noted, between-person variability in IH was significantly positively

associated with DC. Between-person variability in DC was also significantly positively associated with INT controlling for IH. The indirect effect was significant, indicating that between-person DC significantly mediates the association between between-person IH and INT. In regard to RS, as noted, between-person variability in RS was significantly positively associated with DC. Between-person variability in DC was also significantly positively associated with INT controlling for RS. The indirect effect was significant, indicating that between-person DC significantly mediates the association between between-person RS and INT.

Does AC mediate the associations between IH/RS and INT at the weekly level?

I examined whether week-to-week fluctuations of AC mediated the associations between fluctuations of IH and fluctuations of INT as well as between fluctuations of RS and fluctuations of INT in separate models (for results, see Table 8). As noted, within-person variability in IH was not significantly associated with AC. Within-person variability in AC was also not significantly associated with INT controlling for IH. Given that neither of the aforementioned effects were significant, within-person AC does not significantly mediate the association between within-person IH and INT. In regard to RS, as noted, within-person variability in RS was significantly positively associated with AC. In contrast, within-person variability in AC was not significantly associated with INT. Given that the mediator was not significantly associated with the outcome variable, within-person AC does not mediate the association between within-person RS and INT.

Does DC mediate the associations between IH/RS and INT at the weekly level?

I examined whether week-to-week fluctuations of DC mediated the associations between fluctuations of IH and fluctuations of INT as well as between fluctuations of RS and fluctuations of INT in separate models (for results, see Table 9). As noted, within-person variability in IH

was significantly positively associated with DC. Within-person variability in DC was also significantly positively associated with INT. The indirect effect was significant, indicating that within-person DC significantly mediates the association between within-person IH and INT. This indicates that higher internalizing symptoms are reported on weeks when individuals report higher fluctuations in IH and this is due, in part, to higher fluctuations in utilizing disengaged coping strategies. In regard to RS, as noted, within-person variability in RS was significantly positively associated with DC. Within-person variability in DC was also significantly positively associated with INT. The indirect effect was significant, indicating that within-person DC significantly mediates the association between within-person RS and INT. Similar to the aforementioned mediation finding, this indicates that higher internalizing symptoms are reported on weeks when individuals report higher fluctuations in RS and this is due, in part, to higher fluctuations in utilizing disengaged coping strategies more than their average levels.

Prospective associations

IH/RS and AC. First, I examined the prospective associations between IH and AC as well as RS and AC in separate models (for results, see Table 10). Within-person variability in IH and RS one week were not significantly associated with AC the next week. Next, I included IH and RS in the same model and the associations remained non-significant (for results, see Table 10). The cross-sectional association of within-person variability in IH with AC was not significant in the prospective analysis. Thus, although active coping strategies are utilized at a greater rate on weeks when individuals report higher RS than their average levels, this effect is cross-sectional rather than prospective.

IH/RS and DC. First, I examined the prospective associations between IH and DC as well as RS and DC in separate models (for results, see Table 11). Within-person variability in IH and

RS one week were not significantly associated with DC the next week. Next, I included IH and RS in the same model and the associations remained non-significant (for results, see Table 11). The cross-sectional within-person effects for IH and RS were not significant in the prospective analyses. Thus, although disengaged coping strategies are utilized at a greater rate on weeks when individuals report higher IH and RS than their average levels, these effects are cross-sectional rather than prospective.

IH/RS and INT. First, I examined the prospective associations between IH and INT as well as RS and INT in separate models (for results, see Table 12). Within-person variability in IH and RS one week were not significantly associated with INT the next week. Next, I included IH and RS in the same model and the associations remained non-significant (for results, see Table 12). The cross-sectional within-person effects for IH and RS were not significant in the prospective analyses. Thus, although higher internalizing symptoms are reported on weeks when individuals report higher IH and RS than their average levels, these effects are cross-sectional rather than prospective.

AC/DC and INT. First, I examined the prospective associations between AC and INT as well as DC and INT in separate models (for results, see Table 13). Within-person variability in AC one week was significantly negatively associated with their INT the next week. Within-person variability in DC one week was not significantly associated with INT the next week. Next, I included AC and DC in the same model. Within-person variability in AC became a non-significant predictor and within-person variability in DC remained a non-significant predictor. The non-significant cross-sectional within-person effect for AC was significant in the prospective analysis. This indicates that individuals who report higher tendencies to utilize active coping strategies on a given week report lower internalizing symptoms on the subsequent week.

However, this significant prospective association became non-significant when both AC and DC were included in the model.

IH/RS/AC/DC and INT. Finally, I included IH, RS, AC, and DC in the same model (for results, see Table 14). None of the associations were significant. The significant cross-sectional association between within-person variability in RS and INT was not significant in the prospective analysis. Thus, although higher internalizing symptoms are reported on weeks when individuals report higher RS than their average levels, this effect is cross-sectional rather than prospective.

Prospective mediation analyses

In regard to within-person effects, IH and RS were not significantly associated with AC, but AC was significantly associated with INT. Given that the predictor variables were not significantly associated with the mediators, mediation was not tested. Finally, IH and RS were not significantly associated with DC and DC was not significantly associated INT. Thus, the predictor variables were not associated with the mediator and the mediator was not associated with the outcome variable, so mediation was not tested.

Discussion

The current study advanced the literature on minority stress, coping, and mental health among gay men by examining associations between coping strategies used in response to sexual orientation-related stress and mental health outcomes using a weekly diary design as well as examining individual differences in coping styles. Approximately half of participants experienced sexual orientation-related stress at least once over the course of the seven weeks. Among those who did, most only experienced it during one week. It is somewhat encouraging that a substantial proportion of gay men in the current sample did not experience any

discrimination. Still, a near equal proportion did, suggesting that gay men continue to be discriminated against despite increasing societal acceptance of sexual minorities. Previous research has demonstrated that sexual orientation-related stress is a common experience among sexual minorities. For instance, in a meta-analysis of 138 studies (N = 60,203), Katz-Wise and Hyde (2012) found that 41% of sexual minorities endorsed sexual orientation-related discrimination. The current finding that 51.7% of gay men experienced discrimination at least once over the course of seven weeks is consistent with this. Swim et al. (2007) examined the frequency of heterosexist hassles experienced by LGB individuals (N = 69) over the course of one week. Heterosexist hassles refer to verbal or behavioral expressions of "…hostile, denigrating, or stigmatizing attitudes and beliefs about [LGB individuals]…" (p. 598). They found that LGB individuals reported an average of 2.03 heterosexist hassles over the course of one week (SD = 1.74, median = 2.00, range = 0-8). Although it is difficult to compare findings across studies that assessed discrimination over different time periods (e.g., one week, seven weeks, past year, lifetime), there is general consensus that a sizable proportion of sexual minorities endorse recent and lifetime experiences of discrimination.

The current findings demonstrated that there was stability over time as well as weekly fluctuation in internalized homonegativity, rejection sensitivity, coping strategies, and internalizing symptoms. Substantial variability in each construct was accounted for by within-person variability (19% for internalized homonegativity, 47% for rejection sensitivity, 57% for active coping, 53% for disengaged coping, and 49% for internalizing symptoms). In other words, 19-57% of the total variability in each construct was accounted for by an individual's fluctuation from his own mean on a given week. Gay men who report high levels of negative thoughts and feelings about their sexual minority identity or high levels of anxious expectations of rejection

tend to do so each week. However, these individuals still exhibit variability in their levels of internalized homonegativity and rejection sensitivity from week to week and this weekly fluctuation has an influence on coping and internalizing symptoms. Similarly, although levels of active and disengaged coping tend to be stable from week to week, there is also weekly fluctuation in the extent to which coping strategies are used and this fluctuation has an influence on internalizing symptoms. In sum, assessing weekly fluctuations in gay men's thoughts and feelings about their sexual minority identities and their use of coping strategies helps to explain their levels of internalizing symptoms.

Predictors of Coping Strategies

In regard to active coping, it was hypothesized that higher internalized homonegativity and rejection sensitivity would be associated with lower active coping. Results did not support these hypotheses. The only significant predictor of active coping was within-person variability in rejection sensitivity and the direction of the association was opposite the predicted direction. Results demonstrated that active coping strategies were utilized more on weeks when individuals reported higher rejection sensitivity than their average levels. Rejection sensitivity was not significantly associated with active coping in the prospective analysis, indicating that this effect is cross-sectional. The unexpected direction of this effect may be due to the fact that active coping and disengaged coping were significantly positively associated. Gay men who report utilizing active coping strategies also report utilizing disengaged coping strategies, suggesting that they are utilizing multiple coping strategies that range in how adaptive they are. Thus, the positive association between within-person variability in rejection sensitivity and active coping may reflect a tendency to utilize coping strategies, both active and disengaged, in response to expectations of rejection. This possibility is consistent with qualitative findings that gay and

bisexual men tend to use multiple strategies to cope with heterosexism in a single situation (McDavitt et al., 2008). The non-significant association between internalized homonegativity and active coping is consistent with Szymanski and Owens' (2008) finding that internalized heterosexism was not associated with problem-solving coping among lesbians. However, it is not consistent with Nicholson and Long's (1990) finding that higher internalized homophobia was associated with lower proactive coping among HIV-positive gay men.

These differences may be the result of different types of samples or different operationalizations of active coping. All participants in Nicholson and Long's (1990) study were HIV-positive, which was not the case for the current study or Szymanski and Owens' (2008) study. Thus, it is possible that internalized homonegativity has a stronger influence on active coping among HIV-positive individuals. Additionally, the current study's measure of active coping was a brief version of the COPE (Carver et al., 1989) and Szymanski and Owens (2008) used three subscales from the COPE to measure problem-solving coping. Thus, it is not surprising that two studies that used similar measures of active coping would both find non-significant associations between internalized homonegativity and active coping. In contrast, Nicholson and Long (1990) used a modified version of the Ways of Coping Scale (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Although speculative, it is possible that the extent to which these different measures emphasized social support as an active coping strategy may have contributed to differences in findings. The modified Ways of Coping Scale that Nicholson and Long (1990) used included six items related to social support (half the measure), whereas the subscales from the COPE that Szymanski and Owens (2008) used did not include any items related to social support and the brief version of the COPE used in the current study included two items related to social support. Thus, it is possible that the greater emphasis

on social support in the modified Ways of Coping Scale contributed to the differences in findings across studies.

In regard to disengaged coping, it was hypothesized that higher internalized homonegativity and higher rejection sensitivity would be associated with higher disengaged coping. In contrast to the findings for active coping, results supported all of the hypotheses. Between-person variability and within-person variability in internalized homonegativity and rejection sensitivity were all significantly associated with disengaged coping. Results demonstrated that individuals who reported more negative thoughts and feelings about their sexual minority status as well as those who reported higher tendencies to expect to be rejected also reported greater use of disengaged coping strategies. These findings are consistent with previous findings that internalized homophobia/heterosexism was positively associated with avoidant coping among gay men (Nicholson & Long, 1990; Szymanski & Carr, 2008) and lesbians (Szymanski & Owens, 2008). Further, disengaged coping strategies were utilized more on weeks when individuals reported higher internalized homonegativity and rejection sensitivity than their average levels. Internalized homonegativity and rejection sensitivity were not significantly associated with disengaged coping in the prospective analyses, indicating that these effects are cross-sectional. When internalized homonegativity and rejection sensitivity were included in the same model, all of the associations remained significant except for the between-person effect of internalized homonegativity. Thus, mean levels of rejection sensitivity as well as weekly fluctuations in internalized homonegativity and rejection sensitivity appear to influence gay men's use of disengaged coping strategies.

Predictors of Internalizing Symptoms

It was hypothesized that higher internalized homonegativity would be associated with higher internalizing symptoms. Results partially supported this hypothesis. Within-person variability in internalized homonegativity was marginally significantly associated with internalizing symptoms, but between-person variability was not. Thus, there was a trend toward higher internalizing symptoms being reported on weeks when individuals reported higher internalized homonegativity than their average levels. Of note, the random effect for within-person variability in internalized homonegativity was also significant, indicating that the association between internalized homonegativity and internalizing symptoms varied across participants. Thus, while the average association was positive, it ranged from negative to positive for individual participants. Within-person variability in internalized homonegativity was not significantly associated with internalizing symptoms in the prospective analysis, indicating that this effect is cross-sectional.

The finding for within-person variability in internalized homonegativity is consistent with minority stress theory (Meyer, 2003) and previous research that has implicated internalized homonegativity in gay men's psychological functioning (Feinstein et al., 2012; Newcomb & Mustanski, 2010). Further, this finding extends previous research by demonstrating that gay men's negative thoughts and feelings about their sexual minority identity fluctuate from week to week and these fluctuations influence their mental health. It is noteworthy that 81% of the variability in internalized homonegativity was accounted for by between-person variability, but this variability was not significantly associated with internalizing symptoms. In contrast, even though only 19% of the variability in internalized homonegativity was accounted for by within-person variability, this variability *was* significantly associated with internalizing symptoms. In sum, these findings suggest that weekly fluctuations in internalized homonegativity have a

stronger influence on internalizing symptoms than average levels. Further, the significant variability across participants in the association between internalized homonegativity and internalizing symptoms suggests that internalized homonegativity may lead to increased internalizing symptoms for some people, but decreased internalizing symptoms for other people. It is counterintuitive to consider the possibility that internalized homonegativity would be associated with decreased internalizing symptoms for some people. Although speculative, it is possible that some people who harbor negative thoughts and feelings about their sexual orientation push themselves to excel in other areas of their lives, which leads to better mental health. Consistent with this possibility, Pachankis and Hatzenbuehler (2013) found that young sexual minority men reported deriving their self-worth from achievement-oriented domains, such as academics, appearance, and competition, more so than heterosexual men. Additionally, those who concealed their sexual orientation for longer invested more of their self-worth in these domains. Thus, if internalized homonegativity has positive consequences for some people, it may be a consequence of the ways in which those people cope with their negative thoughts and feelings about their sexual orientation. It will be important for future research to consider both the potential benefits and consequences of internalized homonegativity, and to identify the circumstances under which internalized homonegativity is adaptive versus maladaptive.

It was also hypothesized that higher rejection sensitivity would be associated with higher internalizing symptoms. Results supported this hypothesis. Between-person and within-person variability in rejection sensitivity were significantly associated with internalizing symptoms. This demonstrates that gay men who reported higher tendencies to expect to be rejected also reported higher internalizing symptoms. Further, higher internalizing symptoms were reported on weeks when individuals reported higher rejection sensitivity than their average levels. The

random effect for within-personal variability in rejection sensitivity was also significant, indicating that the association between rejection sensitivity and internalizing symptoms varied across participants. Thus, while the average association was positive, it ranged from negative to positive for individual participants. Within-person variability in rejection sensitivity was not significantly associated with internalizing symptoms in the prospective analysis, indicating that this effect is cross-sectional.

These findings are also consistent with minority stress theory (Meyer, 2003) and previous research that has implicated rejection sensitivity in gay men's psychological functioning (Feinstein et al., 2012). Additionally, these findings extend previous research by demonstrating that gay men's anxious expectations of rejection fluctuate from week to week and these fluctuations influence their mental health. In a daily diary study, Swim and colleagues (Swim et al., 2007; Swim, Johnston, & Pearson, 2009) found that more experiences with heterosexist hassles were associated with increases in anxious mood. They suggested that this might be due to fear of similar hassles or social rejection in the future. Although the current study did not specifically test this hypothesis, the findings lend support to the notion that increases in expectations of rejection contribute to increases in anxious mood. Further, the significant variability across participants in the association between rejection sensitivity and internalizing symptoms suggests that rejection sensitivity may lead to increased internalizing symptoms for some people, but decreased internalizing symptoms for other people. It is again counterintuitive to consider the possibility that rejection sensitivity would be associated with decreased internalizing symptoms for some people. Although speculative, it is possible that some people who anxiously expect to be rejected because of their sexual orientation choose to place themselves in environments that they know are going to be supportive of their sexual orientation,

thus surrounding themselves with supportive people. It will be important for future research to consider both the potential benefits and consequences of rejection sensitivity, and to identify the circumstances under which rejection sensitivity is adaptive versus maladaptive.

It was also hypothesized that lower active coping would be associated with higher internalizing symptoms. Results did not support this hypothesis. Within-person variability in active coping was not significantly associated with internalizing symptoms. In contrast, between-person variability in active coping was, but the direction of the association was opposite the predicted direction. Gay men who reported higher tendencies to use active coping strategies also reported higher internalizing symptoms. Similar to the unexpected positive association between rejection sensitivity and active coping, this finding may be due to the significant positive association between active and disengaged coping. In other words, the positive association between between-person variability in active coping and internalizing symptoms may reflect the use of multiple coping strategies in response to discrimination, which contributed to internalizing symptoms even though some of the coping strategies may have been adaptive. Consistent with this possibility, between-person variability in active coping became non-significant when disengaged coping was included in the model. This is inconsistent with previous findings that higher active coping was associated with lower depressive symptoms (DeMarco, Ostrow, & DiFranceisco, 1999; Lehavot, 2012; Zea, Reisen, & Poppen, 1999) and lower psychological distress (Szymanski & Henrichs-Beck, 2014) among sexual minorities. However, Lehavot (2012) found that maladaptive coping had a stronger influence on depressive symptoms than adaptive coping. Although speculative, it is possible that when adaptive and maladaptive coping strategies are used in response to the same situation, the use of maladaptive coping strategies determines the extent to which depressive symptoms will be experienced. This possibility is

consistent with the current finding that active coping became non-significant when disengaged coping was included in the model. The cross-sectional between-person effect for active coping was not significant in the prospective analysis, whereas the non-significant within-person effect for active coping *was* significant in the prospective analysis. This suggests that individuals who report higher tendencies to utilize active coping strategies on a given week report lower internalizing symptoms on the subsequent week. However, this significant prospective association became non-significant when both active coping and disengaged coping were included in the model.

Finally, it was hypothesized that higher disengaged coping would be associated with higher internalizing symptoms. Between-person and within-person variability in disengaged coping were significantly associated with internalizing symptoms. This demonstrates that individuals who reported higher tendencies to utilize disengaged coping strategies also reported higher internalizing symptoms. Additionally, higher internalizing symptoms were reported on weeks when individuals reported utilizing disengaged coping strategies more than their average levels. These findings are consistent with studies that have demonstrated that higher avoidant coping was associated with worse mood (Nicholson & Long, 1990), higher depressive symptoms (Lehavot, 2012), and higher psychological distress (Szymanski & Henrichs-Beck, 2014) among sexual minorities. The cross-sectional between-person effect for disengaged coping was not significant in the prospective analyses, indicating that this effect is cross-sectional.

Mediation Analyses

It was hypothesized that both active and disengaged coping would mediate the association between internalized homonegativity and internalizing symptoms as well as the association between rejection sensitivity and internalizing symptoms. Results supported the

hypotheses for disengaged coping, but not for active coping. Between-person disengaged coping significantly mediated the associations between between-person variability in internalized homonegativity/rejection sensitivity and internalizing symptoms. This suggests that gay men who reported more negative thoughts and feelings about their sexual minority status as well as those who reported higher tendencies to expect to be rejected also reported higher internalizing symptoms due, in part, to their tendency to use disengaged coping strategies in response to discrimination. Additionally, within-person variability in disengaged coping significantly mediated the associations between within-person variability in internalized homonegativity/rejection sensitivity and internalizing symptoms. Thus, higher internalizing symptoms were reported on weeks when individuals reported higher internalized homonegativity and rejection sensitivity than their average levels and this was due, in part, to utilizing disengaged coping strategies more than their average levels. Thus, internalized homonegativity and rejection sensitivity influence internalizing symptoms in part by contributing to maladaptive coping in response to discrimination.

These findings are consistent with Hatzenbuehler (2009), who proposed that coping might mediate the associations between discrimination and mental health problems. Additionally, these findings are consistent with previous research that has demonstrated that maladaptive coping mediated the associations between discrimination and psychological distress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009), implicit anti-gay attitudes and psychological distress (Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phills, 2009), and internalized homophobia/heterosexism and psychological distress (Kaysen et al., 2014; Szymanski & Henrichs-Beck, 2014; Szymanski & Owens, 2008) among sexual minorities. Further, consistent with the current findings, previous research has demonstrated that adaptive

coping did not mediate the associations between internalized heterosexism and psychological distress among sexual minority women (Szymanski & Henrichs-Beck, 2014; Szymanski & Owens, 2008). In sum, consistent with previous research, findings suggest that maladaptive coping styles are more important than adaptive coping styles in predicting mental health outcomes (Clarke & Goosen, 2009; Dyson & Renk 2006; Felsten, 1998; Lehavot, 2012; Szymanski & Henrichs-Beck; 2014; Szymanski & Obiri, 2011; Szymanski & Owens 2009).

Although disengaged coping significantly mediated the associations between internalized homonegativity/rejection sensitivity and internalizing symptoms in the cross-sectional analyses, it did not significantly mediate these associations in the prospective analyses. In other words, the associations between internalized homonegativitiy/rejection sensitivity and the current week's internalizing symptoms are due, in part, to disengaged coping, but this does not extend to the next week's internalizing symptoms. Thus, the associations among internalized homonegativity/rejection sensitivity, coping, and internalizing symptoms may be short-lived. It will be important for future research to examine these associations using a daily diary design in order to assess their temporal order over shorter time intervals. However, Swim and colleagues (2007) found that sexual minorities reported an average of two heterosexist hassles over a one-week period, indicating that sexual minorities are unlikely to experience discrimination on a daily basis. It is possible that using a daily diary design with a sample that is at higher risk for frequent discrimination (e.g., sexual minorities in rural areas) will allow for more powered tests of daily associations.

Parallels with Other Minority Groups

The current findings are also consistent with findings from studies on other minority groups. For instance, research has consistently demonstrated that internalized racism is

associated with negative mental health outcomes among African Americans (Carter, 1991; Jones et al., 2007; Szymanski & Gupta, 2009; Szymanski & Obiri, 2011; Tomes, Brown, Semenya, & Simpson, 1990; Vandiver, Cross, Worrell, & Fhagen-Smith, 2002; Williams & Williams-Morris, 2000). Research has also demonstrated that rejection sensitivity is associated with negative mental health outcomes among women (London et al., 2012), Asian-Americans (Chan & Mendoza-Denton, 2008), and African-Americans (Mendoza-Denton et al., 2002). Finally, Szymanski and Obiri (2011) found that negative religious coping (but not positive religious coping) partially mediated the relationship between internalized racism and psychological distress among African Americans. In sum, research has demonstrated that internalized negative attitudes, anxious expectations of rejection, and maladaptive coping are associated with negative mental health outcomes across a variety of minority groups. The parallels between the current findings and the literature on other minority groups suggest that there are similar risk factors for psychopathology across different minority groups. However, it is also important to consider the differences between minority groups that can influence coping and mental health. As an example, sexual minorities make decisions about whether to conceal or disclose their sexual orientation as a way to cope discrimination. In turn, sexual orientation concealment is associated with negative mental health outcomes (e.g., D'Amico & Julien, 2012; DiPlacido, 1998; Potoczniak, Aldea, & DeBlaere, 2007; Stall et al., 2001). Thus, sexual orientation concealment is a unique risk factor for psychopathology among sexual minorities. It will be important for future research to simultaneously examine general coping strategies as well as those that are unique for sexual minorities in order to understand their relative impacts on mental health.

Clinical Implications

The current findings expand our understanding of how gay men cope with sexual orientation-related stress and elucidate risk and resilience factors related to well-being in this population. Given that gay men are at increased risk for mood and anxiety disorders compared to heterosexual men (e.g., Atkinson et al., 1999; Cochran & Mays, 2000; Fergusson et al., 1999; Sandfort, de Graaf, Bijl, & Schnabel, 2001), it is important to identify risk factors for internalizing disorders in this population. Doing so has the potential to influence the development of effective prevention and intervention programs that address the unique stressors that gay men experience and their subsequent mental health difficulties. Findings underscore the roles of internalized homonegativity and rejection sensitivity in how gay men cope with discrimination as well as their mental health. Whether or not someone experiences discrimination is largely out of one's control, but negative thoughts and feelings about one's sexual minority identity and anxious expectations of rejection can be reduced through clinical interventions, such as cognitive-behavioral therapy (CBT). Cognitive techniques from CBT can be used to help clients develop and utilize more realistic ways of thinking about the self and others, such as how they feel about their sexual orientation and the accuracy of their expectations of rejection. Additionally, behavioral techniques from CBT, such as exposure, can be used to help clients tolerate their anxiety in situations that trigger expectations of rejection. While internalized homonegativity and rejection sensitivity are generally associated with negative outcomes, findings also suggest that they may be associated with decreased internalizing symptoms for some people. As such, it is important that clinicians not only assess negative thoughts and feelings about one's sexual orientation, but also the extent to which they vary and influence mental health for each individual client.

Findings also emphasize the negative consequences of utilizing maladaptive coping strategies in response to sexual orientation-related stress. If gay men are aware of the possibility that certain coping strategies are likely to increase their distress, they may be less likely to utilize those strategies. Clinicians can work with gay men to develop alternative ways of coping with discrimination that are not going to maintain and exacerbate distress. Of note, when internalized homonegativity, rejection sensitivity, active coping, and disengaged coping were all entered in the same model as predictors of internalizing symptoms, the only significant effects that remained were for between-person and within-person variability in rejection sensitivity. This suggests that weekly fluctuations and average levels of rejection sensitivity may have a stronger influence on internalizing symptoms than internalized homonegativity and coping strategies. Anxious expectations of rejection may be particularly important treatment targets for gay men who are experiencing internalizing problems. As such, teaching gay men how to identify these expectations and their consequences, as well as helping them cope with them in more effective ways, may lower risk for feelings of depression and anxiety.

Scholars have described the potential benefits of providing CBT in the context of an LGB-affirmative therapeutic environment to address the unique stressors experienced by sexual minorities (Balsam, Martell, & Safren, 2006; Martell, 2008; Martell, Safren, & Prince, 2004; Safren, Hollander, Hart, & Heimberg, 2001; Safren & Rogers, 2001; Walsh & Hope, 2010). Recently, Pachankis (2014) developed a cognitive-behavioral intervention to address the effects of minority stress on mental health and risky sexual behavior among gay and bisexual men. The intervention – Effective Skills to Empower Effective Men (ESTEEM) – was developed by adapting the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2011) to address the unique stressors that gay and bisexual men experience. Specifically,

ESTEEM sought to improve coping with minority stress, reduce depression and anxiety, and reduce risky sexual behavior. It attempted to do so using techniques to achieve six goals: (1) normalize the consequences of minority stress; (2) challenge negative thoughts stemming from minority stress; (3) empower assertive communication; (4) validate gay and bisexual men's unique strengths; (5) affirm healthy expressions of sexuality; and (6) facilitate supportive relationships. The efficacy of ESTEEM is currently being tested in a randomized controlled trial.

Limitations, Strengths, and Future Directions

The current findings should be interpreted in light of several limitations. First, the mean levels of minority stress and internalizing symptoms were relatively low, suggesting that the sample was relatively well adjusted and minimally symptomatic. The low levels of minority stress may be due to participants living in a large urban area. It remains unclear if findings would generalize to gay men who endorse higher levels of minority stress and internalizing symptoms. However, it is noteworthy that most hypotheses were supported despite relatively low levels of minority stress and internalizing symptoms, and it is likely that similar findings would emerge in a more severe sample. To examine the generalizability of the current findings, future studies could focus on samples of gay men who are at higher risk for minority stress and internalizing symptoms, such as those who live in rural areas or those who endorse specific risk factors (e.g., parental rejection).

Second, although the total sample size was 147, the analytic sample size was reduced to 76 for cross-sectional analyses that included coping variables, because only 76 participants endorsed at least one week of discrimination and coping questions were only asked if participants endorsed experiencing discrimination. Further, the analytic sample size was reduced to 29 for prospective analyses that included coping, because at least two weeks of coping data

were required to be included in these analyses. It will be important for future research to use larger samples to increase statistical power, especially for within-person analyses. Future studies could also focus on micro-aggressions in addition to explicit experiences of discrimination. A focus on micro-aggressions is likely to lead to higher rates of endorsement, given that micro-aggressions are subtler and, as such, tend to be more frequent than explicit instances of discrimination.

Third, the measure of internalized homonegativity was adapted for the weekly diary design and the measures of weekly rejection sensitivity and internalizing symptoms were developed for the current study. Although findings suggest that these measures captured weekly fluctuations in minority stress and internalizing symptoms, it will be important for future research to replicate the current findings. The measure of coping strategies also aggregated multiple coping strategies into the broad categories of active and disengaged coping and it is possible that specific coping strategies have different associations with minority stress and internalizing symptoms. The aggregate approach used in the current study is consistent with previous research, but researchers are encouraged to examine the differential effectiveness of specific coping strategies in response to SORS.

Fourth, given that stress and symptoms were both assessed at the same time, it is unclear if stress preceded symptoms. To address this limitation, participants were instructed to report their symptoms *since* the stressful event that they endorsed. Still, it is possible that their symptom reports were influenced by their symptoms before the stressful event as well. It will be important for future research to consider the extent to which internalizing symptoms influence perceptions of discrimination and coping strategies used in response to discrimination. Fifth, numerous hypotheses were tested in the current study and a statistical correction for multiple

analyses was not used. As such, the chances of obtaining false-positive results (type I errors) are increased. Finally, approximately two-thirds of the sample identified as White, all participants had completed high school, and approximately three-quarters of the sample had completed a four-year college degree or higher. It will be important for future research to replicate the current findings in more diverse samples, including more ethnic/racial minorities, less educated individuals, and individuals who identify as bisexual or alternate sexual orientations (e.g., queer). It will also be important for future studies to follow participants for longer periods of time in order to gain a better understanding of how fluctuations in minority stress and coping influence internalizing symptoms over extended periods of time (e.g., one year).

Despite limitations, the current study had several strengths. The use of a weekly diary design has advantages over cross-sectional studies and longitudinal studies with long follow-up periods, including increasing ecological validity, decreasing recall biases, and decreasing biases toward the over-reporting of severe incidents. Additionally, it allows for tests of between-person and within-person effects, which separates the overall effects into the parts accounted for by differences between people and the parts accounted for by an individual's fluctuation from his own mean on a given week.

In conclusion, the current study demonstrates that negative thoughts and feelings about one's sexual orientation as well as expectations of rejection are associated with increased use of maladaptive coping strategies in response to sexual orientation-related stress. In turn, maladaptive coping is associated with increased internalizing symptoms. Additionally, the current study demonstrates that internalized homonegativity, rejection sensitivity, and use of maladaptive coping strategies fluctuate from week to week, and this weekly fluctuation has a significant impact on gay men's mental health.

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Table 1

Cross-sectional associations between IH/RS and AC.

Predictor	Estimate	95% CI	SE	P
	IH predicting AC			
Between-person variability in IH	.03	-.07, .13	.05	.576
Within-person variability in IH	.08	-.02, .18	.05	.108
	RS predicting AC			
Between-person variability in RS	.02	-.01, .04	.01	.153
Within-person variability in RS	.03	.02, .05	.01	.000
	IH and RS predicting AC			
Between-person variability in IH	-.05	-.17, .07	.06	.422
Within-person variability in IH	.04	-.06, .14	.05	.427
Between-person variability in RS	.02	-.01, .05	.01	.104
Within-person variability in RS	.03	.01, .05	.01	.000

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 140.

Table 2

Cross-sectional associations between IH/RS and DC.

Predictor	Estimate	95% CI	SE	p
	IH predicting DC			
Between-person variability in IH	.13	.03, .23	.05	.009
Within-person variability in IH	.21	.12, .30	.05	.000
	RS predicting DC			
Between-person variability in RS	.05	.02, .07	.01	.000
Within-person variability in RS	.04	.02, .05	.01	.000
	IH and RS predicting DC			
Between-person variability in IH	.02	-.08, .13	.05	.696
Within-person variability in IH	.17	.09, .26	.04	.000
Between-person variability in RS	.04	.02, .07	.01	.001
Within-person variability in RS	.03	.02, .04	.01	.000

Note. IH = internalized homonegativity; RS = rejection sensitivity; DC = disengaged coping; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 139.

Table 3

Cross-sectional associations between IH/RS and INT.

Predictor	Estimate	95% CI	SE	p
	IH predicting INT			
Between-person variability in IH	.10	-.02, .22	.06	.103
Within-person variability in IH (fixed effect)	.14	-.01, .30	.08	.064
Within-person variability in IH (random effect)	.10	.04, .25	.05	.037
	RS predicting INT			
Between-person variability in RS	.08	.05, .12	.02	.000
Within-person variability in RS (fixed effect)	.03	.01, .05	.01	.014
Within-person variability in RS (random effect)	.003	.001, .01	.001	.016
	IH and RS predicting INT			
Between-person variability in IH	-.03	-.15, .09	.06	.618
Within-person variability in IH	.13	.03, .22	.05	.008
Between-person variability in RS	.09	.05, .12	.02	.000
Within-person variability in RS	.04	.02, .05	.01	.000

Note. IH = internalized homonegativity; RS = rejection sensitivity; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 144; N (events) = 965-967.

Table 4

Cross-sectional associations between AC/DC and INT.

Predictor	Estimate	95% CI	SE	p
	AC predicting INT			
Between-person variability in AC	.82	.38, 1.27	.22	.000
Within-person variability in AC	.43	-.10, .96	.27	.108
	DC predicting INT			
Between-person variability in DC	1.11	.70, 1.53	.21	.000
Within-person variability in DC	.95	.49, 1.41	.23	.000
	AC and DC predicting INT			
Between-person variability in AC	.36	-.11, .83	.24	.134
Within-person variability in AC	-.08	-.64, .47	.28	.768
Between-person variability in DC	.93	.45, 1.41	.24	.000
Within-person variability in DC	.98	.46, 1.51	.26	.000

Note. AC = active coping; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 139-140.

Table 5

Cross-sectional associations between IH/RS/AC/DC and INT.

Predictor	Estimate	95% CI	SE	p
	IH, RS, AC, and DC predicting INT			
Between-person variability in IH	-.002	-.22, .22	.11	.983
Within-person variability in IH	.15	-.04, .33	.09	.123
Between-person variability in RS	.07	.01, .12	.03	.020
Within-person variability in RS	.07	.04, .10	.02	.000
Between-person variability in AC	.44	-.04, .91	.24	.070
Within-person variability in AC	-.36	-.86, .14	.25	.152
Between-person variability in DC	.42	-.14, .98	.28	.137
Within-person variability in DC	.50	-.03, 1.04	.27	.065

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 139.

Table 6

Does AC mediate the associations between IH/RS and INT at the person level?

Predictor	Estimate	95% CI	SE	p
	Does AC mediate the association between IH and INT at the person level?			
Between-person variability in IH predicting AC	.03	-.07, .13	.05	.576
Between-person variability in AC predicting INT controlling for IH	.78	.35, 1.20	.21	.000
Indirect effect of IH on INT via AC	.02	-.06, .11		
	Does AC mediate the association between RS and INT at the person level?			
Between-person variability in RS predicting AC	.02	-.01, .04	.01	.153
Between-person variability in AC predicting INT controlling for RS	.62	.21, 1.04	.21	.004
Indirect effect of RS on INT via AC	.01	-.004, .03		

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 140.

Table 7

Does DC mediate the associations between IH/RS and INT at the person level?

Predictor	Estimate	95% CI	SE	p
	Does DC mediate the association between IH and INT at the person level?			
Between-person variability in IH predicting DC	.13	.03, .23	.05	.009
Between-person variability in DC predicting INT controlling for IH	.99	.55, 1.42	.22	.000
Indirect effect of IH on INT via DC	.13	.03, .26		
	Does DC mediate the association between RS and INT at the person level?			
Between-person variability in RS predicting DC	.05	.02, .07	.01	.000
Between-person variability in DC predicting INT controlling for RS	.72	.24, 1.20	.24	.004
Indirect effect of RS on INT via DC	.04	.01, .06		

Note. IH = internalized homonegativity; RS = rejection sensitivity; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 139.

Table 8

Does AC mediate the associations between IH/RS and INT at the weekly level?

Predictor	Estimate	95% CI	SE	p
	Does AC mediate the association between IH and INT at the weekly level?			
Within-person variability in IH predicting AC	.08	-.02, .18	.05	.108
Within-person variability in AC predicting INT controlling for IH	.30	-.21, .81	.26	.25
Indirect effect of IH on INT via AC	.02	-.02, .09		
	Does AC mediate the association between RS and INT at the weekly level?			
Within-person variability in RS predicting AC	.03	.02, .05	.01	.000
Within-person variability in AC predicting INT controlling for RS	-.15	-.64, .33	.24	.54
Indirect effect of RS on INT via AC	-.004	-.02, .01		

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 140.

Table 9

Does DC mediate the associations between IH/RS and INT at the weekly level?

Predictor	Estimate	95% CI	SE	p
	Does DC mediate the association between IH and INT at the weekly level?			
Within-person variability in IH predicting DC	.21	.12, .30	.05	.000
Within-person variability in DC predicting INT controlling for IH	.79	.29, 1.30	.26	.003
Indirect effect of IH on INT via DC	.17	.05, .31		
	Does DC mediate the association between RS and INT at the weekly level?			
Within-person variability in RS predicting DC	.04	.02, .05	.01	.000
Within-person variability in DC predicting INT controlling for RS	.53	.05, 1.00	.24	.03
Indirect effect of RS on INT via DC	.02	.002, .04		

Note. IH = internalized homonegativity; RS = rejection sensitivity; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 76; N (events) = 139.

Table 10

Prospective associations between IH/RS and AC.

Predictor	Estimate	95% CI	SE	p
	IH predicting AC			
Within-person variability in IH	-.05	-.16, .06	.06	.35
	RS predicting AC			
Within-person variability in RS	.004	-.01, .02	.01	.63
	IH and RS predicting AC			
Within-person variability in IH	-.05	-.17, .06	.06	.37
Within-person variability in RS	.004	-.01, .02	.01	.63

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; CI = confidence interval; SE = standard error; N (participants) = 31; N (events) = 106.

Table 11

Propsective associations between IH/RS and DC.

Predictor	Estimate	95% CI	SE	P
	IH predicting DC			
Within-person variability in IH	.03	-.11, .17	.07	.69
	RS predicting DC			
Within-person variability in RS	.01	-.01, .03	.01	.35
	IH and RS predicting DC			
Within-person variability in IH	.05	-.09, .19	.07	.51
Within-person variability in RS	.01	-.01, .03	.01	.36

Note. IH = internalized homonegativity; RS = rejection sensitivity; DC = disengaged coping; CI = confidence interval; SE = standard error; N (participants) = 31; N (events) = 105.

Table 12

Prospective associations between IH/RS and INT.

Predictor	Estimate	95% CI	SE	P
	IH predicting INT			
Within-person variability in IH	-.02	-.12, .08	.05	.68
	RS predicting INT			
Within-person variability in RS	.01	-.01, .02	.01	.38
	IH and RS predicting INT			
Within-person variability in IH	-.04	-.14, .07	.05	.50
Within-person variability in RS	.01	-.01, .03	.01	.32

Note. IH = internalized homonegativity; RS = rejection sensitivity; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 143; N (events) = 822-825.

Table 13

Prospective associations between AC/DC and INT.

Predictor	Estimate	95% CI	SE	p
	AC predicting INT			
Within-person variability in AC	-.65	-1.26, -.04	.31	.04
	DC predicting INT			
Within-person variability in DC	-.45	-.97, .08	.26	.09
	AC and DC predicting INT			
Within-person variability in AC	-.27	-.95, .41	.34	.44
Within-person variability in DC	-.34	-.93, .24	.29	.25

Note. AC = active coping; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 31; N (events) = 105-106.

Table 14

Prospective associations between IH/RS/AC/DC and INT.

Predictor	Estimate	95% CI	SE	p
	IH, RS, AC, and DC predicting INT			
Within-person variability in IH	-.20	-.46, .05	.13	.12
Within-person variability in RS	.02	-.02, .06	.02	.30
Within-person variability in AC	-.26	-.98, .45	.36	.46
Within-person variability in DC	-.38	-1.05, .29	.34	.26

Note. IH = internalized homonegativity; RS = rejection sensitivity; AC = active coping; DC = disengaged coping; INT = internalizing symptoms; CI = confidence interval; SE = standard error; N (participants) = 31; N (events) = 105.