

ABSTRACT

Title of Document: TWO SIDES OF THE SAME COIN? ASSESSING THE DISTINCTNESS OF STIGMA CONCEALMENT AND DISCLOSURE PROCESSES

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Past scholarship is divided regarding whether stigma concealment and disclosure represent a unidimensional construct. This study used an online survey to investigate the distinctness of these stigma management processes among 298 sexual minority undergraduate and graduate students. The association demonstrated between stigma concealment and disclosure in this investigation suggests that they are related but ultimately distinct aspects of identity management. This finding was reinforced by numerous cases in which these stigma management variables uniquely predicted factors of psychological health (depression and life satisfaction) or aspects of identity adjustment (self-stigma, acceptance concerns, membership esteem, and identity strength). Additionally, as compared to stigma disclosure, stigma concealment was found to be a better predictor of both factors of psychological health and one aspect of identity adjustment (acceptance concerns). The implications of these results are discussed in light of literature on individuals with indiscernible stigmatized identities and may inform clinical practice and future research.

TWO SIDES OF THE SAME COIN? ASSESSING THE DISTINCTNESS OF
STIGMA CONCEALMENT AND DISCLOSURE PROCESSES

By

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Chapter 1: Introduction

In recent decades, there has been a marked increase in scholarship investigating the consequences of possessing a stigmatized trait (e.g., Dovidio, Major, & Crocker, 2000; Frost, 2011; Major & O'Brien, 2005; Meyer, 2003; Pachankis, 2007). A growing portion of this literature examines the experience and well-being of individuals who have stigmatized identities that are not easily detectable by others (e.g., Bosson, Weaver, & Prewitt-Freilino, 2012; Chaudoir & Fisher, 2010; Chaudoir & Quinn, 2010; Frable, Platt, & Hoey, 1998; Pachankis, 2007; Quinn & Chaudoir, 2009; Quinn, 2006; Ragins, 2008; Smart & Wegner, 1999; Stutterheim et al., 2011). Research has underscored the powerful roles that the concealment and disclosure of a marginalized status can play in the everyday life of people with indiscernible stigmatized identities (for a review, see Pachankis, 2007). Despite advances in this area, research has been impeded by inconsistencies in the conceptualization and operationalization of stigma concealment and disclosure constructs. Lack of specificity with regard to defining and measuring these variables have made it difficult to decipher exactly what is known about the concealment or disclosure of indiscernible stigmatized identities and what is needed to advance knowledge regarding these stigma management processes.

A primary goal of this research is to investigate whether two conceptually distinct stigma management constructs—in this case, global disclosure and recent concealment—uniquely or differentially predict psychological outcomes in ways suggested by theory, logic, and related empirical studies on individuals with indiscernible stigmatized identities. This chapter will provide an introduction to concealment and disclosure in the context of stigma, and present a snapshot of what current research suggests about the

ways these variables relate to the psychological well-being and identity adjustment of individuals with indiscernible stigmatized identities.

This section will draw upon research and theory related to various types of indiscernible stigmatized identities, such as having a concealable mental illness, being HIV positive, or living as a transsexual. However, because this thesis will use data from a sample of sexual minority respondents, research pertaining to lesbian, gay, and bisexual (LGB) populations will be emphasized throughout both the introduction and literature review. Studying the experience of LGB people can contribute to knowledge regarding the disclosure and concealment of indiscernible stigmatized identities because (a) it is widely documented that sexual minorities hold an identity that is often stigmatized within the contemporary socio-cultural context of the United States (Balsam & Mohr, 2007; Herek, Chopp, & Strohl, 2007; Meyer, 2003), (b) LGB people encounter ongoing opportunities to reveal and hide their stigmatized group membership (Anderson, Croteau, Chung, & DiStefano, 2001; Beals, Peplau, & Gable, 2009), and (c) a wealth of research suggests that there is a link between sexual minority stigma management and various components of well-being (Beals et al., 2009; Bosson et al., 2012; Cole, Kemeny, Taylor, & Visscher, 1996b; Frost, Parsons, & Nanín, 2007; Jellison & McConnell, 2003; Ragins, Singh, & Cornwell, 2007; Rosario, Schrimshaw, & Hunter, 2009; Selvidge, Matthews, & Bridges, 2008; Talley & Bettencourt, 2011; Ullrich, Lutgendorf, & Stapleton, 2003). Further, as will be evidenced within the literature review, research on the management of sexual minority identity exemplifies the larger conceptual problems and methodological inconsistencies that undermine research on the concealment and disclosure of indiscernible stigmatized identities.

Stigma and the Role of Discernibility

Stigmatization can be understood as the experience of degradation and invalidation faced by individuals who possess (or are believed to possess) an attribute or social identity that is devalued within their specific social context (Crocker, Major, & Steele, 1998). This social devaluing can be based on a number of factors, including attributes related to behavior (e.g., abortion, homosexual sex, crime, pedophilia, immigration), physical appearance (e.g., physical deformities, skin color, height, weight), or group membership (e.g., non-European ethnic ancestry, non-Western religious beliefs, lower social class; Goffman, 1963; Major & O'Brien, 2005). Sometimes these traits can be obvious, as is typically true regarding attributes that rely on visual information such as race, gender, physical disabilities, and physical deformities. Other attributes or group memberships are not necessarily based upon easily perceivable traits, such as immigration status, religion, or sexual orientation. Thus, it can be said that stigmatizing attributes can range from those that are easily perceived by others to those that are quite indiscernible.

Individuals with discernable and indiscernible stigmatized identities have different options at their disposal when navigating the challenges presented by social stigma in everyday life (Miller & Major, 2000; Talley & Bettencourt, 2011). For those who have a stigmatized identity that is obvious to others, there is little they can do to mask their marginalized status in face-to-face social interactions. However, for individuals with concealable stigmatized identities, the experience of social marginalization is contingent upon whether their identity is revealed, discovered, or successfully kept hidden. Many individuals with concealable stigmatized identities can

escape some of the negative consequences of social stigma because of their ability to pass, an experience in which an individual is misperceived as a member of a different, and usually more socially desirable, group than the one to which they belong (Frost, 2011; Goffman, 1963; Jones, Farina, & Markus, 1984).

And yet, those with concealable stigmatized identities face unique experiences regarding the management of their public identity and endure distinct forms of psychological distress that are not present for individuals with conspicuous stigmatized identities (Frale et al., 1998; Frost, 2011; Pachankis, 2007; Quinn, 2006). For example, because individuals with indiscernible stigmatized identities have the option to disclose or conceal in many social situations, they must make ongoing decisions regarding whether to reveal their devalued group membership—not to mention when, why, how, and to whom (Beals et al., 2009; Chaudoir & Quinn, 2010; Goffman, 1963; Pachankis, 2007; Quinn, 2006). Those with more obvious marginalized identities rarely experience this particular cognitive burden (Frost, 2011).

One of the primary relational decisions faced by individuals with concealable stigmatized identities is whether or not to make their private identity known to others. *Stigma management* concerns this decision, referring to the cognitive and interpersonal processes by which individuals regulate the degree their stigmatized group membership is communicated to others (Anderson et al., 2001; Balsam & Mohr, 2007; Beals et al., 2009; Cain, 1991). This process of regulation may differ within persons as they move across contexts (i.e., time and place) and interact with various potential confidants (e.g., family, peers, co-workers, strangers; Mohr & Fassinger, 2000; Moradi, 2009).

One way for an individual to control others' awareness of his or her stigmatized identities is through *stigma disclosure*, which refers to the revealing of a socially devalued identity to others (Chaudoir & Quinn, 2010). The term has been used to describe specific acts of disclosure, one's level of disclosure within a specific social network (e.g., the workplace), or one's tendency to disclose in general (Anderson et al., 2001; Chaudoir & Fisher, 2010; Mohr & Fassinger, 2000; Ragins, 2008). Although much research focuses on direct, verbal disclosure, stigmatized identities can be revealed verbally or nonverbally, overtly or covertly (Carroll & Gilroy, 2000; Goffman, 1959; Lasser & Wicker, 2007).

Stigma concealment is the process of actively hiding a socially marginalized identity (Meyer, 2003; Moradi, 2009; Pachankis, 2007). This stigma management strategy uses effortful control, manifesting in both cognitive (e.g., thought suppression, obsessive self-monitoring; Pachankis, 2007; Smart & Wegner, 1999) and behavioral strategies (e.g., suppressing stigma-implicating mannerisms, subtly steering conversations away from stigma-relevant content, lying about one's stigmatized group membership; Anderson et al., 2001; Lasser & Wicker, 2007).

Conceptualizations and Relations of Stigma Management Variables

Whereas research on concealment and disclosure has shed light on the positive and negative consequences of stigma management, conceptualizations of each construct have varied immensely in the literature. An overview of contemporary research on the topics reveal that questionnaires and instruments designed to measure disclosure and concealment vary considerably with regard to whether the constructs are assumed to be context dependent (Smart & Wegner, 1999), trait-like (Jellison & McConnell, 2003;

Kahn & Hessling, 2001; Mohr & Fassinger, 2000; Ragins et al., 2007) or some combination of the two (Larson & Chastain, 1990; Lasser, Ryser, & Price, 2010). The lack of close attention to such divergences obscures broad understanding of the relations between stigma management strategies and individuals' psychosocial adjustment, because the exact nature of the stigma management variable being discussed is often ambiguous.

Lack of clarity or agreement regarding the relationship between stigma disclosure and concealment is at the root of many of the methodological inconsistencies within the literature. Specifically, researchers have made different assumptions with regard to whether concealment and disclosure are two ends of a single unidimensional scale or simply two constructs that are inversely correlated, but ultimately distinct. Differing assumptions about the dimensionality of stigma concealment and disclosure have led to inconsistent methods of measuring stigma management. For example, researchers who assume that disclosure and concealment are simply the inverse of one another often rely on measures of disclosure as a proxy for concealment (e.g., Beals et al., 2009; Frost et al., 2007; Talley & Bettencourt, 2011). However, research on harboring distressing secrets suggests that, although related, concealment and disclosure are ultimately distinct aspects of information management (Larson & Chastain, 1990). As stigma concealment is a special, identity-based instance of secret-keeping, this research suggests that the concealment and disclosure of invisible stigmatized identities may also represent two distinct constructs.

There are reasons to believe concealment and disclosure are distinct constructs, and thus, should be measured separately. Researchers suggest that both strategies can be

used by the same person across different contexts (Moradi, 2009). However, this does not settle the matter of whether concealment and disclosure represent a unidimensional construct or not. More compelling is the fact that one can construct hypothetical scenarios to illuminate the fact that some individuals demonstrate a low level of concealment and low level of disclosure (or a high level of concealment and high level of disclosure) simultaneously. First, consider an individual who easily passes as non-stigmatized, such as a feminine bisexual woman in a heterosexual marriage. Because of her marriage and her gender-normative traits, she may not need to effortfully hide her sexual minority status (i.e., low concealment). She may also choose to never reveal her bisexual identity (e.g., low disclosure), either because she is uncomfortable with it or because she feels little discomfort in being wrongly assumed to be heterosexual and thus, feels little motivation to actively assert her invisible bisexual identity. This illuminates how levels of global stigma concealment and disclosure are not always oppositely related.

What is more difficult to imagine is one simultaneously concealing and disclosing in a single moment. Can an act, at the same time, contain behaviors that can be both concealing and revealing in nature? To understand how this is possible, consider a gay male who is only out to a select number of confidants and is hypervigilant about keeping this information contained among close friends. Imagine that while at a busy restaurant the individual decides to disclose his sexuality to a new friend. He may find himself lowering his voice, checking for familiar others nearby, or constantly checking the tables nearby to ensure there are no eavesdroppers. Thus, from this example, we see that disclosure and concealment processes can be embedded within a single act. Together,

these two examples contradict the view that the low disclosing individual is necessarily a high concealer, and conversely, that low concealment connotes high disclosure.

The idea that concealment and disclosure may vary independently of one another supports the empirical evidence of Larson and Chastain (1990), which suggests that these constructs are related yet distinct aspects of information management, rather than two ends of a unidimensional construct. In addition to concealment and disclosure being distinct constructs, paying more attention to the way a stigma management variable is conceptualized and measured—for example, general tendency to conceal versus situational concealment—is warranted. Might stigma concealment be a better predictor of some relevant psychosocial outcomes than stigma disclosure? Could stigma disclosure be a better predictor of other aspects of well-being as compared to stigma concealment? And, does it matter how one defines and operationalizes concealment and disclosure (i.e., stable or context dependent) when testing such associations? To date, these questions have not been empirically tested among individuals with indiscernible stigmatized identities.

The Consequences of Stigma Concealment and Disclosure Decisions

Identifying the relationship between stigma concealment and disclosure constructs is not important simply in the name of methodological clarity. Over the past few decades, researchers have become increasingly interested in the various ways stigma-related stressors relate to the well-being of individuals facing social stigma (Crocker et al., 1998; Frost, 2011; Meyer, 2003; Pachankis, 2007). Accompanying this trend has been greater attention to the internal forces at play in the lives of individuals managing concealable stigmatized identities, such as suppression, intrusive thoughts, obsessive rumination, and

fear of discovery (Crocker et al., 1998; Frost, 2011; Pachankis, 2007; Smart & Wegner, 1999). Some scholars have addressed possible consequences associated with the internal processes of stigma management (for a review, see Pachankis, 2007). For example, there is a wealth of evidence suggesting that stigma concealment can negatively affect health and psychological well-being. The burden of hiding a socially stigmatized identity is associated with increased anxiety and depression (Beals et al., 2009; Frost et al., 2007; Larson & Chastain, 1990; Major & Gramzow, 1999; Quinn & Chaudoir, 2009), preoccupation and intrusive thoughts (Major & Gramzow, 1999; Smart & Wegner, 1999), internalized oppression and identity based-shame (Chow & Cheng, 2010), as well as increased physical symptoms (Larson & Chastain, 1990; Quinn & Chaudoir, 2009).

Although stigma concealment is typically associated with negative outcomes for people with indiscernible stigmatized identities, hiding one's marginalized status can be protective (Schope, 2002; Talley & Bettencourt, 2011). For example, the concealment of a devalued identity can be an effective strategy to keep one's stigmatized identity invisible to unaccepting others, thus decreasing risk of being targeted by prejudice (Cole, Kemeny, & Taylor, 1997; Healy, 1993; Schope, 2002). The concealment of indiscernible stigmatized identities may buffer specific negative interpersonal and systemic effects of social prejudice, which include stereotypes, job and housing discrimination, rejection, and violence (Crocker et al., 1998; Goffman, 1963; Jones et al., 1984; Quinn, 2006).

Similarly, stigma disclosure is also associated with both positive and negative outcomes. The vast majority of studies examining stigma disclosure suggest that revealing one's concealable identity is associated with increased mental and physical health (Beals et al., 2009; Chaudoir & Quinn, 2010; Pachankis, 2007). These benefits of

stigma disclosure have been demonstrated among social groups such as individuals of low socio-economic class (Frable et al., 1998), sexual minority populations (Corrigan & Matthews, 2003), and caretakers of people living with HIV (Mitchell & Knowlton, 2009). However, here again, research suggests that not all disclosures are associated with positive outcomes. Individuals who are particularly sensitive to social rejection or who experience negative reactions from their confidants may not experience the aforementioned benefits of disclosing and may instead experience negative health outcomes (Chaudoir & Fisher, 2010; Cole, Kemeny, Taylor, & Visscher, 1996a; Cole et al., 1996b; Corrigan & Matthews, 2003). Moreover, making a private identity public can increase the risk of prejudice, social isolation, abuse, homelessness, work discrimination, and hate crimes (Herek, 1998; Pachankis, 2007).

Thus, regardless of whether one chooses to disclose or conceal, either stigma management strategy could have positive or negative implications for individuals with indiscernible stigmatized identities (Frost, 2011). Disclosure seems to lead to increased mental health and social connectedness, but also to greater risk for rejection and persecution. Concealment may prevent direct discrimination, but is simultaneously associated with increased social isolation, distress, and mental health problems. Theory focusing on the implications of stigma management has underscored this critical dilemma faced by individuals who hold undetectable, socially devalued identities (Frost, 2011; Meyer, 2003).

Summary of Gaps in Stigma Management Literature

As the literature on stigma has expanded, so has the number of investigations into the psychosocial consequences of managing an indiscernible stigmatized identity.

Research on the concealment and disclosure of an indiscernible stigmatized identity suggests that these variables can predict aspects of well-being and identity adjustment. However, little is known about if and how the link between stigma management and well-being changes depending on the stigma management construct used (e.g., concealment versus non-disclosure) or the stability of the stigma management construct being measured (e.g., trait-like versus context dependent). Thus, it can be concluded that this is a potential area for growth in the literature on the concealment and disclosure of indiscernible stigmatized identities.

One set of questions requiring further attention concerns the relationship between stigma concealment and disclosure constructs. Although research has disentangled the relationship between global disclosure tendencies and global concealment tendencies as it relates to secret-keeping (Larson & Chastain, 1990), whether these constructs remain distinguishable when applied specifically to the concealment and disclosure of an invisible stigmatized identity has not been investigated. Lack of clarity and differing assumptions about the unidimensionality of stigma concealment and disclosure has caused researchers to take different, and at times, contradictory approaches to the conceptualization and measurement of stigma management variables. These conceptual distinctions and methodological differences have been largely ignored in the dissemination of knowledge about stigma management among individuals with indiscernible identities, making it difficult to glean big picture knowledge within this growing area of interest.

Second, little is known about whether various measures of stigma concealment or disclosure uniquely predict relevant psychosocial outcomes above and beyond one

another. Studies rarely include measures of both stigma concealment and disclosure in the same study. Thus, it is unclear whether measures of stigma concealment are better predictors of specific outcomes than stigma disclosure variables (and vice versa). In addition, researchers rarely acknowledge that the particular way they conceptualize and measure a stigma management construct is one of multiple potential ways to measure that variable (e.g., concealment over the past week, concealment in a given situation, global tendency to conceal). Thus, another area of inquiry concerns whether the specific conceptualization and measurement of a stigma management construct accounts for unique variance in its ability to predict various outcomes. There is a need for research investigating the distinct associations of various types of stigma management behaviors as they relate to psychological health (e.g., depression, life satisfaction) and identity-specific adjustment factors (e.g., self-stigma, group identity strength).

An investigation that examines multiple stigma management variables' relations to well-being could help determine whether certain stigma management constructs are better at predicting psychological adjustment factors. This gets to the core of how stigma management influences well-being. Take, for example, the well-documented fact that both concealment and (lack of) disclosure are positively related to depression (Beals et al., 2009; Maas, Wismeijer, Van Assen, & Aquarius, 2012; Ullrich et al., 2003; Wong & Tang, 2004). To learn that concealment is a better predictor of depressive symptoms than disclosure may suggest that the effortful control and cognitive strain involved in concealment are mechanisms through which stigma management related to psychological well-being. On the other hand, evidence that stigma disclosure is a stronger predictor of depression than concealment could move one's attention to particular mechanisms

associated with disclosure (e.g., social support, identity coherence) in mediating the relation between stigma management and mental health.

Research examining the gaps outlined above would build upon the current literature on stigma management and would contribute to the broader understanding of disclosure and concealment among individuals with indiscernible stigmatized identities. The current study will address each of these concerns by investigating the unique associations between specific conceptualizations of stigma management and well-being among sexual minorities. In doing so, this undertaking will offer new insight to the growing literature on stigma management among individuals with indiscernible stigmatized identities.

Chapter 2: Literature Review

The Evolution of Stigma Theory

With linguistic roots in ancient Greece, the term *stigma* was re-popularized in the 1960s by sociologist, Erving Goffman, who defined stigma as an attribute, behavior, or trait that signifies inferiority and effectively reduces an individual “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). Goffman posited that the presence of a socially unfavorable attribute sparks negative interpersonal and institutional social processes—such as demonization, discrimination, and the use of stigma based-slurs for invalidation—each of which hold tangible consequences for the holders of the socially undesirable attributes. Contemporary stigma scholars continue to ground their research within Goffman’s framework (Crocker et al., 1998; Frost, 2011; Major & O’Brien, 2005; Meyer, 2003; Pachankis, 2007).

Today, stigmatization is understood to be a process of degradation and invalidation that targets individuals whom either possess or are believed to possess a social identity that is devalued within a specific social context (Crocker et al., 1998). This conceptualization is the product of the evolution of stigma theory over the past 50 years, with stigma researches both extending and departing from Goffman’s initial framework (Frost, 2011).

One shift concerns which specific part of the stigmatization process is termed stigma. In Goffman’s (1963) framework, stigmas are qualities or characteristics located upon or within an individual—in other words, stigma referred to the social devalued attribute itself. Frost (2011) describes a historical shift in the discourse on stigma that “moved the source of stigma out of the bodies and identities of the stigmatized and

placed the origins of stigma at the societal level” (p. 824). Indeed, today stigma is not the attribute situated within the individual (e.g., same-sex attraction) but rather is understood to be a social process of marginalization (e.g., homophobia) that targets individuals based on such attributes¹ (Frost, 2011; Major & O’Brien, 2005; Ragins, Singh, & Cornwell, 2007).

A related change can be seen in the fact that most contemporary identity theorists emphasize that stigma is a social construction that reflects the norms of a given society (Dovidio et al., 2000; Frost, 2011; Major & O’Brien, 2005). The context-specific nature of stigma is evidenced by the fact that the groups targeted by stigmatization and the intensity of the stigmatization faced, have changed over time and differ between cultures (Jones et al., 1984). One can see the influence of this conceptual shift in the popularization of the phrase *social stigma*, which is often used interchangeably with the term stigma (e.g., Crocker & Major, 1989; Frost, 2011; Major & O’Brien, 2005).

Third, assumptions about the relationship between a social group’s level of normativity and their level of stigmatization has also fallen under dispute (Major & O’Brien, 2005). Goffman (1963) posited that the world was divided into two groups: normals and those with a stigma. He framed stigma as “a special relationship between attribute and stereotype,” claiming that a stigma is an attribute that does not meet others’ normative expectations (Goffman, 1963, p. 4). In departure from this view, researchers today recognize that some social groups that deviate from the norm are not targeted for stigmatization (e.g., the extremely wealthy), whereas some categories that are certainly well represented in society are marginalized (e.g. women; Crocker et al., 1998). Thus, it

¹ In adherence with this shift, this text will avoid referring to individuals in ways that suggest that they own or harbor a stigma (e.g., individuals with an indiscernible stigma), and instead will label them as having an identity that is stigmatized by others (e.g., individuals with an indiscernible stigmatized identity).

is no longer accepted that the normativity of individuals' identities always dictates how much social stigma they face. To the contrary, current stigma discourse identifies social power, not numerical majority, as the defining line between who is targeted by stigma and who is not (Major & O'Brien, 2005).

A final evolution concerns what categories of stigma exist. Goffman (1963) proposed that socially undesirable attributes could be separated into three types: *blemishes of character* (e.g., mental illness, homosexuality, unemployment), *abominations of the body* (e.g., physical deformities, visible manifestations of disease), and *tribal memberships*, which are often transmitted through familial lineages (e.g., non-European ethnic ancestry, non-Western religious beliefs, disgraced family name). Although contemporary scholars continue to acknowledge these three categories of exclusion (e.g., Major & O'Brien, 2005), researchers today note that this typology may be flawed, as there is no evidence that the experience of these stigmas are distinct and some stigmatized identities (e.g., being overweight) can fit into two categories (Crocker et al., 1998). Other researchers have tried to categorize stigmas based on their relationship to various descriptive dimensions (Crocker et al., 1998; Jones et al., 1984). For example, Jones and colleagues (1984) identified six dimensions of stigma, each hypothesized to shape the way that stigma impacts social interactions: course, disruptiveness, aesthetic qualities, origin, peril, and concealability.

The Discernibility of Stigmatized Identities

The frameworks of earlier identity theorists (Goffman, 1963; Jones et al., 1984) make clear that stigmatizing attributes vary with regard to how easily detectable they are by others—and that this level of visibility matters for the experience of the stigmatized

individual. The below excerpt explores how Goffman categorized stigmatized people into two broad categories based on visibility, asking:

Does the stigmatized individual assume his differentness is known about already or is evident on the spot, or does he assume it is neither known about by those present nor immediately perceivable by them? In the first case, one deals with the plight of the discredited, in the second with that of the discreditable. This is an important difference... (Goffman, 1963, p. 4).

Individuals with easily perceivable stigmas have what Goffman (1963) termed *discredited* attributes, and are contemporarily referred to as people with conspicuous or discernable stigmatized identities². This category is generally reserved for categories of difference that are based in physical differences and visible information (e.g., race, sex, weight, height, physical disabilities, disfigurements, etc.). For these individuals, their devalued group membership is obvious in social interactions and immediately undermines their public dignity.

On the other hand, some individuals have *discreditable* attributes, in which their stigmatized group membership is not readily apparent (Goffman, 1963). Such identities, now typically referred to as indiscernible or concealable stigmatized identities, include group affiliations that are not easily detectable, such as may be the case regarding religious affiliations and beliefs (e.g., Muslim, Pagan, Atheist), sexual orientation (e.g.,

² This shift from attributes to identities symbolizes the shift from stigma encompassing “a wide range of imperfections,” including not only social identities (e.g., race, gender, sexual orientation, social class), but also personal factors such as criminal history, literacy, employment, radical political behavior, and addiction (Goffman, 1963, p. 5). Today, stigma theory (Frost, 2011) generally concerns social identities which are the types of attributes that classify groups (based on perceived similarities in appearance, culture, biology, or behavior) and stratify them within a socially constructed hierarchy, offering advantages to certain groups and disadvantaging others. Individuals in marginalized groups often have a sense of group connectedness and shared culture (Frost, 2011), whereas this may not be as common regarding personal characteristics (e.g., literacy) and past occurrences (e.g., criminal history).

gay, lesbian, bisexual), mental health diagnoses (e.g., bipolar disorder, bulimia nervosa), certain physical illnesses (e.g., HIV positive status, breast cancer), and other often indiscernible stigmatizing factors (e.g., being raised working class, being an undocumented immigrant).

One may ask whether individuals with indiscernible stigmatized identities warrant study. Until relatively recently, many researchers assumed that individuals with conspicuous stigmatized identities face greater vulnerability to impaired mental health as compared to those with indiscernible stigmatized identities (Crocker & Major, 1989; Pachankis, 2007). For example, Jones and colleagues (1984) theorized that “individuals who have concealed marks would be better adjusted than people whose blemish is apparent” positing that the ability to pass is an advantage afforded to those with indiscernible stigmatized identities (p. 35). To date, the majority of research on the experience and health outcomes of stigmatized individuals has focused on those with conspicuous identities, such as racial and ethnic minorities (Clark, Anderson, Clark, & Williams, 1999; Crocker et al., 1998; Dion, 2002; Kessler, Mickelson, & Williams, 1999).

Current research, however, suggests that individuals with concealable stigmatized identities experience unique stigma-related stressors as compared to individuals with conspicuous identities (Chaudoir & Quinn, 2010; Crocker et al., 1998; Pachankis, 2007; Quinn, 2006; Ragins, 2008). For example, individuals with indescribable stigmatized identities must make ongoing disclosure decisions including whether to disclose, how to disclose, when to conceal, and how to conceal (Beals et al., 2009; Chaudoir, Fisher, & Simoni, 2011; Pachankis, 2007; Quinn, 2006). They also may naturally encounter

situations in which they must correct or collude with misperceptions, face ongoing risks of having their identity revealed by confidants, and experience negative reactions and a strain on relationships upon disclosure (Pachankis, 2007; Ragins, 2008). Many researchers have also found that individuals with indiscernible stigmatized identities face unique psychological outcomes and have less access to similar others, as compared with individuals with conspicuous stigmatized identities (Frible et al., 1998; Pachankis, 2007; Quinn, 2006; Ragins, 2008).

There is another question as to whether populations with indiscernible stigmatized identities should be studied separately from individuals with conspicuous stigmatized identities. For example, although the literature on stigma (e.g., Chaudoir & Quinn, 2010; Frible et al., 1998; Talley & Bettencourt, 2011) suggests that certain types of identities are inherently concealable (e.g., sexual orientation, learning abilities, religion, mental illness) and others are innately conspicuous (e.g., race, ethnicity, gender, physical disability), this is a false dichotomy. Visibility likely exists on a continuum, differing between group members and changing across settings (Downie, Mageau, Koestner, & Liodden, 2006; Ginsberg, 1996; Shippee, 2011). However, there certainly are types of identities that, on average, are more or less obvious to an observer in an interpersonal interaction (Crocker et al., 1998; Frible et al., 1998; Quinn, 2006). Thus, the division of stigmatized identities into those that are discernible and indiscernible retains utility, giving scholars a way to talk about this difference and to theorize how social stigma impacts individuals differently based on the visibility of their marginalized attributes (Frible et al., 1998; Pachankis, 2007; Quinn, 2006; e.g., Stutterheim et al., 2011).

Finally, there may be a question as to whether individuals with different types of indiscernible identities have enough in common to be considered a single group with regards to concealment and disclosure. For example, some studies test stigma management theories among one subpopulation of individuals with indiscernible identities (e.g., LGB populations), and limit the findings to that particular social group (e.g., Lasser et al., 2010). However, other studies choose to select one or two types of indiscernible stigmatized group identities and generalize findings to all individuals with indiscernible stigmatized identities (e.g., Bosson et al., 2012; Smart & Wegner, 1999). Finally, one can identify studies which mix numerous types of concealable identities together and study them as a single, diverse group (e.g., Chaudoir & Quinn, 2010; Frable et al., 1998). There is not yet sufficient research to determine which format is most appropriate, however, theory suggests that there may be a unifying experience among different types of individuals with indiscernible stigmatized identities (Crocker et al., 1998; Goffman, 1963; Pachankis, 2007; Quinn, 2006) and there is emerging empirical evidence to support this possibility (Bosson et al., 2012; Frable et al., 1998).

The Concealment and Disclosure of Indiscernible Stigmatized Identities

One common way to think about stigma management is to understand it to be a broad, higher order construct composed of two distinct groups of behavioral variables: (a) variables that relate to the revealing of one's stigmatized identity (i.e., disclosure variables) and (b) variables that describe individual's attempts to hide or obscure their stigmatized status (i.e., concealment variables; Anderson et al., 2001; Lasser et al., 2010; Meyer, 2003; Moradi, 2009). Individuals with indiscernible stigmatized identities face ongoing decisions about whether to disclose or conceal their socially devalued group

membership to others (Pachankis, 2007; Quinn, 2006; Ragins, 2008). Stigma researchers have begun to investigate the complex, and sometimes competing, internal motivations that guide stigma management choices (Chaudoir & Fisher, 2010; Chaudoir & Quinn, 2010; Pachankis, 2007). This section will review this literature, exploring *why*, *when*, and *how* individuals with indiscernible stigmatized identities manage their devalued group memberships. Although some scholars have worked to include both concealment and disclosure motivations in a single theory (e.g., Cain, 1991), much research addresses the motives of these stigma management strategies separately. Thus, the context, triggers, and manifestations of stigma concealment and disclosure processes will be reviewed independently.

How, when, and why individuals conceal stigmatized identities.

Why people conceal. Research suggests that there are two primary reasons why people withhold information. The first, and most broadly accepted motivation, is to avoid the negative judgment of others (Hill, Thompson, Cogar, & Denman, 1993; Rodriguez & Kelly, 2006; Vrij, Nunkoosing, Paterson, Oosterwegel, & Soukara, 2002). For example, in a daily diary study by Macdonald and Morley (2001), the more participants anticipated disapproving responses to disclosure, the less likely they were to reveal an emotional event. At times, secret-holders fear that the consequences of revealing will go far beyond mere judgment or disapproval, causing the stigmatized individual to be abandoned, punished, and in some cases, blamed for the stigma (Rodriguez & Kelly, 2006). Secret-keeping can be understood as one of many potential unconscious or conscious behaviors people use to control the opinions others form of them, a process often referred to as impression management or self-presentation (Kelly, 2000; Schlenker & Weigold, 1992).

A second reason that individuals withhold personally distressing information is to avoid feeling personal shame. In a psychotherapy study, Hill and colleagues (1993) suggest that many different types of secrets are kept hidden because of internal reasons, such as a client's feeling of embarrassment or burdensomeness, stating:

Why do clients not reveal their secrets to their therapists? Shame and insecurity seemed to be the primary reasons. The client's reason for not revealing childhood sexual abuse was "embarrassment." The client's reason for not revealing sexual attraction to [the] therapist was "I wish it wasn't so." The gay client said, "I don't want to worry him and cause anxiety." The client who felt therapy was not helping indicated, "I am scared of being rejected" as the reason for not revealing this (Hill et al., 1993, p. 285).

Indeed, many individuals may conceal to avoid negative emotions, such as feeling embarrassed, rejected, or vulnerable (Kahn, Hucke, Bradley, Glinski, & Malak, 2012).

These two related reasons people keep general secrets (i.e., interpersonal fears and intrapersonal shame) parallel the reasons individuals keep stigmatized identities secret. Numerous studies have discussed the interpersonal consequences of stigma for individuals with indiscernible stigmatized identities (Frable et al., 1998; Meyer, 2003; Pachankis, 2007; Quinn, 2006), and this population may opt to keep their marginalized status hidden due to fear of prejudiced judgment and the consequences of such evaluations (Meyer, 2003). For example, in addition to avoiding the homophobic judgment of others, LGB people may opt to conceal their sexual identity to prevent being physically attacked, verbally harassed, losing a close relationship, or being fired from a job (Meyer, 2003; Ragins, Singh, & Cornwell, 2007; Schope, 2002). This effort is not

always in vain, as self-report data suggests that concealment of a sexual minority identity may be an effective strategy to avoid homophobic prejudice and social rejection (Cole et al., 1997; Schope, 2002). This finding has been documented among other individuals with concealable stigmatized identities, such as individuals with disabilities (Olney & Brockelman, 2003) and people living with HIV (Dageid & Duckert, 2008; Hackl, Somlai, Kelly, & Kalichman, 1997). For example, interviews with HIV positive women reveal that they perceive hiding or minimizing their positive HIV status to be a viable means to evade social stigma and maintain support networks (Dageid & Duckert, 2008; Hackl et al., 1997).

Intrapersonal consequences (e.g., embarrassment) have also been explored among individuals with indiscernible stigmatized identities, with much research suggesting that this population may hide their devalued trait to avoid shame and guilt (D'Augelli & Grossman, 2001; Hill et al., 1993; Meyer, 2003; Pachankis, 2007). For example, research suggests that gay men may conceal their sexual orientation to avoid feeling inferior, immoral, shameful, or burdensome (Hill et al., 1993; Shidlo, 1994). Also regarding sexual minority concealment, Cain (1991) posited that gay men may hide their identity due to perceived inappropriateness.

When people conceal. Many individuals with indiscernible stigmatized identities manage their marginalized status differently across contexts, choosing to conceal in some environments, but not conceal in others (Beals et al., 2009; Pachankis, 2007; Quinn, 2006). This begs the question as to when individuals with indiscernible identities opt to actively conceal or disclose their stigmatized status. It may be that the previously mentioned reasons for concealment, such as fear and shame, dictate in which situations

an individual conceals (e.g., when most fearful of consequences, when most ashamed, etc.) and which they do not (Hill et al., 1993; Schope, 2002). However, some research on secrecy suggests that the effort put towards concealment may vary as a function of other factors, such as the significance and psychological closeness of the audience (Kelly, 2000).

Specifically regarding when people hide their stigmatized identities, Pachankis (2007) proposed a theory of concealment, suggesting that three situational factors can trigger stigma management: salience of stigma, threat of discovery, and the consequences of being discovered. The *salience of stigma* refers to how accessible the stigmatized identity is to the stigmatized individual. The salience may be increased by the presence of similar others, by the lack of similar others, or in environments with stigma relevant cues that remind them that they are not in the norm. In Pachankis' theory, *threat of discovery* often occurs in stigma-relevant situations that challenge or bring into question the identity of the stigmatized individual. Finally, the *consequences of being discovered* refers to the individual's assessment of the outcomes of detection (Pachankis, 2007). These perceived outcomes might vary between locations (e.g., home, work, neighborhood, country), among people (e.g., friends, family, strangers, co-workers), and over time (e.g., due to changes in attitudes, advances in legal protections).

To exemplify these situational factors, one can imagine a lesbian woman in her early thirties attending a younger heterosexual sister's wedding. Her lesbian identity may be salient, both because the heterosexuality of her sister is being highlighted and due to stark differences in legal recognition of marriage for same-sex couples. The wedding might trigger concealment due to a high threat of discovery as attending family members

and wedding guests (who assume she is heterosexual) joke that she will be next to get married, pressure her to find a husband and have kids before she gets too old, or express empathy towards her because she does not have a boyfriend. In deciding whether to conceal or reveal her lesbian identity, the individual may weigh a number of consequences including the appropriateness of the environment for such a disclosure, the likelihood of judgment, or a sense of relief from the anxiety associated with concealment.

How people conceal. The final question regarding concealment concerns how one hides his or her marginalized status. Research suggests that stigma concealment involves both behavioral and cognitive components (Pachankis, 2007). With regard to behavioral processes, Griffin (1992) outlined four sexual minority identity management strategies, two of which—passing and covering—relate to concealment. *Passing* involves the active distortion of information in attempt to be perceived as heterosexual. This strategy is understood to be motivated by fear and “involve the greatest sacrifice of sense of self-integrity” (Anderson et al., 2001, p. 245). This construct was differentiated from *covering*, which relied on censoring information that would implicate one as a sexual minority. Here, the emphasis is on omitting the truth (e.g., never talking about sexual attraction at the workplace) rather than fabricating it (e.g., pretending to be sexually attracted to someone of the opposite sex). One can see how these methods of concealment can extend beyond sexual minorities to describe the behaviors used to hide other indiscernible stigmatized group memberships.

Research by Wegner and colleagues (Lane & Wegner, 1995; Smart & Wegner, 1999, 2000) suggests that the behavioral work to conceal is accompanied by a mental process of suppression. In their work, suppression is defined as using cognitive effort “to

keep the thought out of mind in service of trying to maintain the secret” (Smart & Wegner, 1999, p. 475). The authors suggest that, based on the cognitive preoccupation model of secrecy (Lane & Wegner, 1995), suppression should lead to a series of other, more involuntary, internal processes (e.g., intrusive thoughts). These unconscious cognitive processes are said to undermine the attempt at concealment, as well as social functioning and well-being. There are data to support this framework among individuals working to conceal an indiscernible stigmatized identity (Smart & Wegner, 1999).

How, when, and why individuals disclose stigmatized identities.

Why people disclose. Many researchers have worked to identify the various reasons that individuals reveal personal—and at times risky, distressing, or embarrassing—information to others (Creed & Scully, 2000; Law, Martinez, Ruggs, Hebl, & Akers, 2011). Derlega and Grzelak (1979) proposed a theory of disclosure that continues to inform research today. The framework offers five motives for revealing secrets: social validation, relationship development, self-clarification, expression, and social control. Although some scholars note that disclosure can be done to educate or to illuminate inequity (Creed & Scully, 2000; Law, Martinez, Ruggs, Hebl, & Akers, 2011), disclosures tend to be understood to serve a social integration function, such as being seen accurately by others, wanting to enhance the bond of an interpersonal relationship, or aiming to connect with someone who has also revealed a secret (Derlega & Grzelak, 1979).

Based on this understanding of disclosure as a goal-oriented behavior largely concerned with social integration (Derlega & Grzelak, 1979), contemporary researchers have begun to identify motivations for disclosing an indiscernible stigmatized identity to

others (Chaudoir & Quinn, 2010; Ragins, 2008). In one study of men and women living with HIV, participants endorsed catharsis, a duty to inform, the desire to educate, and having a close or supportive relationship as reasons for disclosure. On the other hand, privacy, self-blame, fear of rejection, and protecting the confidant were cited as common reasons for low disclosure. In one study focusing on stigma management and gay identity development, Cain (1991) identified six types of disclosure motivations among a sample of gay men: therapeutic, relationship-building, problem solving, preventative, political, and spontaneous. Other proposed reasons for disclosure include need for belonging, support from similar others, as well as desire for self-verification, which concerns the congruence between public and private identities (Bosson & Weaver, 2012; Ellis & Riggle, 1995; Ragins, 2008).

Chaudoir and Quinn (2010), suggest that nearly all disclosure motivations can be categorized into two types: egosystem motivations, which are self-focused in nature, and ecosystem motivations, which are other-focused. For example, consider two individuals who identify as Jewish, but live in a predominantly Christian and anti-Semitic environment. One may reveal their Jewish identity for self-focused, egosystem motivations by disclosing their stigmatized identity to others in order to reduce the stress associated with hiding. The other individual may disclose his or her Jewish identity for ecosystem motivations, such as revealing to strengthen a connection with a Christian friend or to support someone else facing social stigma. Notably, in the study, other focused motivations were related to better disclosure experiences and higher self-esteem, as compared to self-focused motives.

Finally, individuals may be more apt to disclose if they have had positive disclosure experiences in the past. In a study of individuals with a variety of different concealable stigmatized identities (e.g., mental illnesses, LGB identity, medical conditions, sexual assault history), Chaudoir and Quinn (2010) investigated the association between first disclosure experiences and present-day fear of disclosure. The authors found that positive first disclosure experiences were negatively related to fear of disclosure.

When people disclose. Research suggests that the timing of disclosure is influenced by a number of variables. First, in general, individuals tend to disclose when they anticipate receiving positive or supportive reactions. This relationship has been demonstrated among individuals with mental illnesses (Link, Mirotznik, & Cullen, 1991), women who have had abortions (Major & Gramzow, 1999), gay and lesbian adults (Savin-Williams, 1996), as well as sexual minority youth (Rosario et al., 2009). Second, disclosures are most likely to occur when the stigmatized individual most desires increased feelings of psychological connectedness or is simply overwhelmed with the anxiety associated with concealment (Frable et al., 1998; Frost, 2011). This latter concept has been termed the *fever model of disclosure*, in which, like one's temperature during a fever, anxiety rises over time during concealment until a breaking point in which disclosure occurs, resulting in relief (Stiles, 1987).

Numerous studies have examined when employees disclose mental illnesses (Brohan et al., 2012), transsexual identity (Law et al., 2011), and sexual minority status (Anderson et al., 2001; Creed & Scully, 2000; Griffith & Hebl, 2002; Lance, Anderson, & Croteau, 2010) among co-workers and supervisors. Ragins (2008) theorizes that three

variables serve as antecedents of workplace disclosures: the individual's internal psychological processes, the anticipated consequences of disclosure, and environmental factors. The factors in a work environment that can encourage the disclosure of an indiscernible stigmatized identity include the presence of similar others, the presence of supportive allies, and institutional support (Anderson et al., 2001; Griffith & Hebl, 2002; Lance et al., 2010). Modeling and vicarious reinforcement may also serve a role in encouraging disclosure behaviors (Fantasia, Lombardo, & Wolf, 1976).

How people disclose. Much attention has been paid to the question of how one reveals an indiscernible stigmatized identity. Although most studies of identity disclosure focus on the direct, verbal communication of a stigmatized status, many scholars recognize that some individuals with indiscernible stigmatized identities reveal their marginalized status through indirect or nonverbal means (Carroll & Gilroy, 2000; Healy, 1993; Lasser & Wicker, 2007; Mohr & Fassinger, 2000; Omarzu, 2000). For example, Healy (1993) defined *behavioral language* as "actions which either validate or conceal lesbian identity" (p. 253). Healy and other scholars (e.g., Dindia & Tieu, 1996), cite examples such as hairstyle, form of dress, and wearing gay pride accessories as nonverbal means of intentional disclosure. Written forms of communication, such as an email correspondence or personal letter, may also be acts of disclosure (Omarzu, 2000).

Individuals with indiscernible stigmatized identities may disclose differently across different social domains or with different types of confidants (Mohr & Fassinger, 2000; Ragins, 2008). Believing that disclosure is goal-oriented in nature, Omarzu (2000) suggests that before individuals disclose, they go through a series of disclosure decision-making steps, asking themselves why they are disclosing, what strategy of disclosure to

use to achieve it, and to whom to use the strategy with. The author suggests that how people disclose—with regard to breadth, duration, and depth—may vary as a result of an individual's answers to these questions.

Theories of the management of indiscernible stigmatized identities.

Many frameworks have arisen to explain how, when, and why individuals manage indiscernible stigmatized identities, including impression management (e.g., Goffman, 1959) strategic perception management (e.g., Olney & Brockelman, 2003), visibility management (e.g., Lasser et al., 2010), identity management theory (e.g., Cain, 1991; Cupach & Imahori, 1993), and cognitive theories of secrecy (e.g., Smart & Wegner, 1999). These theories cut across the questions of why, when, and how individuals with indiscernible stigmatized identities conceal and disclose.

Impression management theory (Goffman, 1959) proposes that individuals with concealable stigmatized identities actively regulate their presentation within social interactions to maintain a positive impression among others. The basic premise is that individuals work to achieve congruence between their desired public image and the perceptions of others.

A number of theories have refined or expanded upon this framework (Cupach & Imahori, 1993; Lasser & Wicker, 2007; Pachankis, 2007). First, strategic perception management theory suggests that individuals with indiscernible stigmatized identities must develop protective tactics to vigilantly control their interactions with others, such as tracking whether others detect their stigmatized identity while simultaneously working to guide the interaction to keep their marginalized status hidden (Pachankis, 2007). A related concept is that of visibility management, which refers to “the process by which

individuals regulate the degree to which they disclose traits or characteristics that would otherwise be inconspicuous” (Lasser et al., 2010, p. 416; Lasser & Wicker, 2007).

Visibility management only differs from impression management in that it is specific to individuals with concealable stigmatized identities and has been used frequently with regard to the management of sexual minority status.

Another relevant framework includes the disclosure processes model (Chaudoir & Fisher, 2010). The disclosure processes model theorizes exactly when and why stigma disclosure leads to positive outcomes (Chaudoir & Fisher, 2010). The framework suggests that disclosure goals and avoidance motivation moderate the effect of disclosure on personal, relational, and social contextual outcomes. The disclosure processes model also suggests that the impact of disclosure on these outcomes is mediated by how much the disclosure alleviates inhibition, increases social support, or changes social information about the discloser.

Problems in the Conceptualization and Measurement of Stigma Management

In recent years, researchers have become more interested in assessing the stigma management processes used by individuals with indiscernible stigmatized identities (Pachankis, 2007; Ragins, 2008). As a result, various approaches to measuring stigma concealment and disclosure have emerged (e.g., Anderson et al., 2001; Beals et al., 2009; Chaudoir & Quinn, 2010; Cole et al., 1996b; Jellison & McConnell, 2003; Rosario et al., 2009; Smart & Wegner, 1999). Although this scholarship has offered new insights regarding the costs and benefits of stigma management, the broader meaning of these results is obscured by problems regarding the conceptualization and measurement of stigma management strategies.

One way stigma researchers' measures of stigma management vary is with regard to whether they assess concealment and disclosure constructs as stable, trait-like characteristics (e.g., Mohr & Fassinger, 2000; Talley & Bettencourt, 2011), dynamic and context dependent strategies (e.g., Chaudoir & Quinn, 2010; Smart & Wegner, 1999), or a hybrid approach which blends the two conceptualizations (e.g., Lasser et al., 2010). These different modes of assessing stigma concealment and disclosure could offer a nuanced understanding of these identity management strategies. However, nearly all researchers reviewed in this text failed to: (a) clearly communicate which specific type of stigma management process they measured, (b) acknowledge that the selected conceptualization was one of many possible ways of understanding the construct, or (c) offer their reasoning (e.g., theory, logic) for selecting the particular conceptualization of concealment or disclosure used in the study. Additionally, when drawing upon past literature on concealment among stigmatized individuals, researchers often fail to acknowledge whether or not the studies they are citing measure concealment specifically as it relates to the hiding of a stigmatized identity, such as concealment of sexual minority status (e.g., Jellison & McConnell, 2003) or simply assess stigmatized individuals' broad tendency to conceal secrets (e.g., Potoczniak et al., 2007; Selvidge, Matthews, & Bridges, 2008).

Another problem, which will be the focus of this section, arises from conceptual disagreements about the relationship between concealment and disclosure. On the one hand, there are scholars who measure stigma management in a manner that suggests that concealment and disclosure are distinct constructs (e.g., Moradi, 2009; Potoczniak et al., 2007; Smart & Wegner, 1999). Alternatively, some investigations of concealment and

disclosure suggest that these constructs are not distinct but rather are two ends of a bipolar spectrum (e.g., Beals et al., 2009; Frost et al., 2007; Talley & Bettencourt, 2011). This section will couch this conceptual divide within the larger literature on secrecy, review stigma management literature from both perspectives, and discuss the ways that this split leads to methodological inconsistencies and undermines the empirical integrity of the study of stigma management.

Research on concealment and disclosure as distinct constructs.

Secrecy and emotional disclosure research. A number of researchers have engaged the question of whether concealment and disclosure represent a unidimensional construct. Many of these contributions have come from research on secrecy and emotional disclosure. For example, Pennebaker's work on the healing power of expressing traumatic events has helped shape the way many researchers understand disclosure and concealment today (Pennebaker, Colder, & Sharp, 1990; Pennebaker & O'Heeron, 1984; Pennebaker, 1989, 1997, 2003). Much of this work focuses on the effects of emotional disclosure on long-term health, which is referred to as the *confiding-illness* relationship (Pennebaker, Kiecolt-Glaser, & Glaser, 2004; Pennebaker & O'Heeron, 1984). Additionally, Pennebaker and colleagues (Pennebaker & Chew, 1985; Pennebaker & O'Heeron, 1984) were interested in the *inhibition-disease* link, the relationship between "active holding back of thoughts, emotions, or behaviors" and long-term psychosomatic health problems (Pennebaker et al., 2004, p. 244). This work is an early example of investigating disclosure and concealment separately with regards to their relations to health outcomes.

Citing the work of Pennebaker, the landmark article of Larson and Chastain (1990) was an empirical milestone with regards to the exploration of the relationship between concealment and disclosure constructs (Larson & Chastain, 1990). The authors sought to explore whether these stigma management constructs are conceptually distinct by comparing a new measure of concealment, called the Self-Concealment Scale (SCS; Larson & Chastain, 1990) to an existing measure of disclosure, called the Self-Disclosure Index (SDI; Miller, Berg, & Archer, 1983). Larson and Chastain proposed a new perspective, questioning the then-assumed understanding of the relationship between concealment and disclosure:

One possible relation is that these two constructs are simply the reverse of each other: the self-concealing individual is not disclosing, and the low-disclosure individual is self-concealing. However, the argument made here is that self-concealment, and self-disclosure are two separate and distinct, though related, constructs (Larson & Chastain, 1990).

Indeed, the study data validated this hypothesis. Comparing the predictive abilities of their SCS measure of individuals' tendency to conceal to the SDI measure of individuals' tendency to disclose, the authors found that only the concealment measure was associated with the health outcomes included in the study (i.e., depression, anxiety, physical symptoms). Thus, Larson and Chastain concluded that self-concealment, defined as “a predisposition to *actively* conceal from others personal information that one perceives as distressing or negative [*italics added*],” is separate and distinct from the construct of nondisclosure (Larson & Chastain, 1990, p. 440).

The aforementioned works of Pennebaker and colleagues, as well as that of Larson and Chastain (1990), suggests that concealment requires deliberate, vigilant attention to one's secrets, a process that is different than nondisclosure. Based on their conceptualizations, the primary difference between concealment and nondisclosure may be that only concealment involves effortful control, which is the conscious and intentional regulation of inhibitory and attentional processes (Rothbart & Ahadi, 1994). The idea that cognitive effort differentiates concealment from (a lack of) disclosure has influenced the broader secrecy literature. For example, in an article exploring in which cases disclosing a secret is beneficial versus harmful, Kelly and McKillop (1996) differentiated secrecy (i.e., concealment) from nondisclosure. Citing the work of Larson and Chastain (1990), the authors declare that "secrecy is not merely the opposite of self-disclosure" claiming that the difference is that "keeping a secret is an active process that uses cognitive resources and can be experienced as an emotional burden" (Kelly & McKillop, 1996).

Stigma management research. The concealment of a stigmatized identity is a specific type of secret-keeping (Hill et al., 1993; Major & Gramzow, 1999). As a result, there is some evidence that research on the concealment and disclosure of stigmatized identities has been influenced by the broader literature on secrecy. Consistent with the idea that concealment and disclosure are separate and distinct constructs (Larson & Chastain, 1990), there are studies on individuals with indiscernible stigmatized identities that have empirically supported the assertion that concealment and disclosure are related, yet ultimately distinct, constructs (e.g., Moradi, 2009; Potoczniak et al., 2007). For example, Potoczniak and colleagues (2007) investigated self-concealment as a potential

mediator of the relationship between social anxiety and ego identity among LGB individuals, echoing the premise popularized by Larson and Chastain (1990) by calling concealment “a similar but factorially distinct construct” from disclosure (Potoczniak et al., 2007, p. 451).

Though rare, some researchers of stigma management have offered empirical data regarding the relationship between stigma concealment and disclosure by including both constructs in a single study (e.g., Anderson et al., 2001; Moradi, 2009). For example, Anderson and colleagues (2001) developed a measure, the Workplace Sexual Identity Management Measure (WSIM), which includes both a Covering subscale that uses 8-items to assess sexual orientation concealment behaviors (e.g., “[I] omit names or pronouns when talking about someone I am dating or living with so that my sexual orientation is unclear”) and an 8-item Explicitly Out subscale to measure disclosure (e.g., “[I] tell most or all of my coworkers that I am gay/lesbian/bisexual”). The scale demonstrated a negative correlation between the covering and explicitly out constructs ($r = -.66, p < .05$). This correlation suggests that, though related, concealment and disclosure are not simply two ends of a unidimensional spectrum (Anderson et al., 2001; Tabachnick & Fidell, 2007). Findings by Moradi (2009), who used the subscales to test how sexual orientation disclosure and concealment, respectively, uniquely relate to unit social and task cohesion in military units, reinforced this conclusion by reporting a weaker correlation between the constructs ($r = -.35, p < .05$; Moradi, 2009). The author suggests that “concealment and disclosure strategies are not thought to be opposite ends of a continuum . . .” (Moradi, 2009, p. 515).

Stigma researchers who differentiate high concealment from low disclosure tend to agree with researchers of secret-keeping and emotional disclosure on the grounds for this differentiation. They suggest that, as opposed to nondisclosure, concealment is an active, dynamic process that requires effort (e.g., Pachankis, 2007; Selvidge et al., 2008; Smart & Wegner, 1999) and results in negative cognitive processes (Beals et al., 2009; Maas et al., 2012; Pachankis, 2007; Smart & Wegner, 1999). For example, in an article on psychological well-being in lesbian and bisexual women, Selvidge and colleagues (2008) define concealment as “a vigilant, dynamic process of withholding specific personally salient information from most people in an effort to manage others’ perceptions” (p. 453), going on to suggest that it is “an active process which consumes energy” (p. 464).

Research on concealment and disclosure as indistinct constructs.

Secrecy and emotional disclosure research. There is a second strand of research that treats concealment and disclosure as opposite ends of a single, unidimensional construct. This approach can be identified in the broader literature on secrecy and emotional disclosure. Larson and Chastain (1990) claim that although some early self-disclosure scholars (e.g., Jourard, 1959) pointed to distinctions between concealment and disclosure, the literature on secrecy and emotional disclosure generally did not conceptually differentiate these constructs prior to their study.

Contemporary works that explicitly refute the claim that concealment and disclosure are distinct are rare, but not non-existent. For example, Kahn and colleagues (Kahn & Hessling, 2001; Kahn et al., 2012; Kahn, Lamb, Champion, Eberle, & Schoen, 2002) argue that the distinctness of the constructs depends upon the particular

conceptualization of concealment and disclosure. Specifically, the authors argue that a unidimensional model may be appropriate if one is measuring secrets that are distressing in nature and occurring across time and situations, as opposed to measuring the disclosure of non-distressing secrets or assessing individual acts of disclosure (Kahn & Hessling, 2001). With this thinking in mind, Kahn and Hessling created what they term the Distress Disclosure Index (DDI), a measure created to “measure generalized self-reports of one’s disclosure versus concealment” (Kahn et al., 2012, p. 135). The authors found that the measure was best explained by a unidimensional construct (Kahn & Hessling, 2001), predicting negative psychological and behavioral outcomes (Kahn et al., 2002). This finding challenges the aforementioned conclusions about the dimensionality of concealment and disclosure (Kelly & McKillop, 1996; Larson & Chastain, 1990). From this, one might conclude that whether concealment and disclosure behaviors represent a unidimensional construct depends upon the precise conceptualization (and operationalization) of the stigma management processes.

Stigma management research. Many researchers of stigma management position concealment and disclosure within a unidimensional framework. However, unlike the aforementioned work of Kahn and colleagues, stigma scholars tend to assume, rather than explicitly argue for, a unidimensional conceptualization of stigma concealment and disclosure (e.g., Beals et al., 2009; Frost et al., 2007; Talley & Bettencourt, 2011). This assumption of unidimensionality is not often challenged in stigma management literature. This may be because of the ostensible similarity of concealment and nondisclosure, and a result of the fact that stigma management research has developed somewhat separately

from the larger literature on secrecy and emotional disclosure, where these more scholars more commonly discuss the distinctness of concealment and disclosure.

Although stigma researchers rarely make explicit their belief in unidimensionality, there are many clues within studies that reveal that an investigator ascribes to this belief. First, some empirical articles (e.g., Beals et al., 2009; Talley & Bettencourt, 2011) use concealment as a proxy for nondisclosure (and vice versa), implying that they are perfect opposites. For example, Beals and colleagues (2009) used past research demonstrating a negative relationship between concealment and well-being to back their assertion that disclosure is positively related to well-being. Similarly, Talley and Bettencourt (2011) conducted a study that demonstrated a negative relationship between sexual identity disclosure and depression. The authors used this as grounds to draw a number of conclusions about the positive relationship between concealment and depression (e.g., “individuals who conceal their stigmatized identity and do not endorse problem-solving coping strategies in response to stigma may be especially vulnerable to depression”; p. 2898).

Second, researchers’ measurement of concealment or disclosure often reveals their implicit assumption of unidimensionality. There are numerous examples of empirical articles (e.g., Beals et al., 2009; Frost et al., 2007; Lehavot & Simoni, 2011) in which hypotheses on concealment are not tested by operationalizing the construct in terms of concealment (i.e., effortful hiding), but rather, in terms of nondisclosure (i.e., not revealing). For example, within the methods of a study by Lehavot and Simoni (2011), the authors stated, “*Concealment* was assessed with five items indicating the *degree of disclosure* of sexual orientation to family, heterosexual friends, LGB friends, coworkers,

and health care providers [italics added]” (Lehavot & Simoni, 2011, p. 162). An additional measurement approach that exposes a belief that these constructs are unidimensional is the fact that many studies mix concealment and disclosure items within an instrument without differentiating these concepts into distinct subscales (e.g., Jellison & McConnell, 2003).

Ramifications of divergent stigma management conceptualizations.

Although there has been an increase in scholarship on stigma management among individuals with indiscernible identities, inconsistency with regard to the conceptualization and measurement of stigma management constructs has been present throughout this surge in theoretical and empirical knowledge. The lack of transparency and nuance in defining and assessing concealment and disclosure constructs has negative implications for this area of study.

First, because of the seeming similarity of stigma concealment and stigma nondisclosure, researchers rarely measure both variables within a single empirical study. As a result, little is known about the relationship between concealment and disclosure variables—namely whether they represent two ends of a unidimensional scale or two distinct constructs. Second, as research has grown in the area of stigma management, researchers have begun to draw broad conclusions about the short- and long-term health consequences of stigma management processes (Quinn, 2006). However, again, because so many studies examining stigma management and psychosocial adjustment assume concealment and nondisclosure are the same, only one is included in a given study—thus, it is unclear if certain findings are solely attributable to one stigma management construct or to both. If stigma concealment and disclosure represent two separate stigma

management constructs, then the outcomes to date on stigma management and well-being may be conflating the distinct health correlates of concealment with the distinct health correlates of nondisclosure.

Third, stigma researchers (e.g., Cain, 1991; Healy, 1993; Lasser et al., 2010; Potoczniak et al., 2007) have persistently highlighted the clinical relevance of findings on stigma management. However, the research does not measure concealment or disclosure with sufficient precision to make clear the mechanisms by which stigma disclosure or stigma concealment might relate to psychological health and identity adjustment. Take, for example, the fact that that a single type of stigma management (e.g., concealment) can be measured in different ways (e.g., global tendency to conceal, concealment in a particular situation). Researchers of stigma management have not taken these differences into account in by including these descriptors when reviewing past research on their construct. They also typically have not sufficiently communicated what type of concealment or disclosure they are measuring within their study, leaving it to the readers to discern this information from sample items, if included. Finally, researchers often fail to limit their conclusions about stigma concealment or disclosure to the specific type of concealment or disclosure (e.g., global, situational) they measured.

Defining stigma management terminology.

Stigma concealment and disclosure each represent a range of variables, depending on the context (e.g., work, school, everyday life), duration (e.g., a single act, a broad trait) and other factors (e.g., first disclosures, non-verbal disclosures) that distinguish the construct. Because there are many different ways disclosure and concealment can manifest in everyday life and numerous conceptualizations are present in the existing

literature, it is necessary to make clear exactly what is meant when the terms disclosure and concealment are used in this text. Henceforth, for the purposes of this project, stigma disclosure is defined as the process of *actively* revealing an indiscernible stigmatized identity to one or more others (e.g., coming out to one's parent as bisexual, revealing an undetectable disability within the workplace). Nondisclosure, then, is simply the lack of communication such information. This passive definition is different from concealment, which is defined as *actively* working to hide an indiscernible stigmatized identity from one of more others (e.g., lying about one's religious beliefs, changing pronouns of a significant other to communicate heterosexuality). Nonconcealment simply means that one is not using effortful control to hide their stigmatized identity; notably, this does not necessarily imply disclosure.

These conceptualizations mirror those by numerous researchers (Kelly & McKillop, 1996; Larson & Chastain, 1990; Pennebaker, 1989, 1997), who have concluded that “concealment and disclosure are not opposite ends of a bipolar continuum; concealment involves an active process of inhibition, whereas disclosure involves an active process of confronting distress” (Kahn & Hessling, 2001, p. 42). Also, it is worth noting that in this text, concealment and disclosure are considered two distinct aspects of stigma management.

Because of their relevance to literature on LGB identity management, there are two additional terms that should be defined and contextualized within the larger definitions of stigma concealment and disclosure. *Outness*, which can be defined as the degree to which sexual minority individuals have communicated their sexual orientation to others within their social world, will be considered a global measure of level of sexual

minority identity disclosure (Mohr & Fassinger, 2000). Similarly, *coming out*, which we can define as acknowledging one's own LGB sexual orientation and communicating this sexual minority status to others, will be considered an act of disclosure (Rosario et al., 2009). These LGB-specific conceptualizations are in line with stigma literature on sexual minorities (Frost & Meyer, 2009; Healy, 1993; Mohr & Fassinger, 2000; Rosario et al., 2009; Talley & Bettencourt, 2011).

Each of these terms can be conceptualized and assessed at different levels within a person's everyday life. For example, they can be assessed as global trait-like factors (e.g., tendency to disclose, tendency to conceal, overall outness) or situational, context dependent factors (e.g., first disclosure experiences, concealment over the past two weeks, coming out in the workplace). When relevant, indicators will be included in this text to specify what type of concealment or disclosure is being discussed, with an emphasis on making distinctions between global and situational conceptualizations of these constructs.

The Links Between Stigma Management Processes and Well-Being

One of the most significant new directions in the study of stigma has been the growing number of researchers interested in the links between stigma and physical health or psychological well-being (Major & O'Brien, 2005; Frost, 2011). The aim of this section is to review the literature regarding the positive and negative outcomes of stigma management, especially as it relates to the concealment or disclosure of sexual minority status. The first section will review theoretical perspectives and empirical findings concerning the association between various forms of stigma management and well-being. The second section will focus on the relationship between stigma management and the

two psychological health variables of interest in this study (i.e., depression and life satisfaction). Finally, studies that examine the relationship between stigma management constructs and identity adjustment variables will be reviewed, with a particular emphasis on the identity-related constructs of relevance to this study (i.e., self-stigma, group self-esteem, acceptance concerns, and group identity strength).

The positive and negative consequences of stigma management.

Theoretical perspectives. When the American Psychiatric Association removed homosexuality from the listed disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* in 1974, innate pathology was no longer considered a legitimate rationale to explain the lower levels of psychological health present among sexual minorities as compared to their heterosexual peers (Herek et al., 2007). Thus, historical theories that frame homosexuality as inherently linked to pathology were replaced with contemporary theories that highlight the link between stigma-related factors and well-being among LGB people. For example, some of the theories that have been referred to at earlier points in this literature review regarding how, when, and why individuals with indiscernible stigmatized identities conceal and disclose their marginalized statuses (e.g., preoccupation model of secrecy) also provide explanations for the lower psychosocial functioning among sexual minorities. This section will focus on what these theories and others illuminate about the psychological outcomes of stigma concealment and disclosure.

Many scholars have theorized about the link between stigma management and well-being. For example, some theorists (e.g., Cain, 1991) have used identity management theory to suggest that concealing a stigmatized identity, such as one's

sexual orientation, may pose an obstacle in the formation of a positive overall sense of self. Hetrick and Martin (1987) alluded to this link, declaring that “each successive act of deception, each moment of monitoring which is unconscious and automatic for others, serves to reinforce the belief in one’s difference and inferiority” (p. 35–36). Focusing more on cognitive processes, the preoccupation model of secrecy (Smart & Wegner, 1999, 2000) proposes that a specific series of interconnected mental strategies (e.g., suppression) and unconscious mental processes (e.g., preoccupation, thought intrusion) are involved in managing an indiscernible stigmatized identity. Recent scholarship suggests that identity concealment may be particularly damaging to individuals who tend to ruminate about their stigma, as preoccupation has been theorized to be a toxic element of concealment (Maas et al., 2012).

Pachankis’ (2007) cognitive-behavioral-affective process model, integrates various theories of stigma management, including identity management theory and the preoccupation model of secrecy, to create a larger process model describing the cycle of threats, experiences, and consequences involved in managing a concealable stigmatized identity. The model suggests that situational factors (e.g., threat of discovery, salience of stigma) can activate specific cognitive processes (e.g., preoccupation, vigilance) and affective reactions (e.g., anxiety, depression, shame). These cognitive and affective processes influence one another in a bidirectional manner, and ultimately, impact behavior, causing self-monitoring, isolation, and other negative psychosocial outcomes. Together, the cognitive, affective, and behavioral components influence self-evaluation (e.g., negative view of self, diminished self-efficacy). The behavioral and self-evaluative

components complete the cycle, by influencing future interpersonal situations, such as the decision to disclose or conceal as well as the decision to avoid certain environments.

Two other theories that offer a framework for understanding the outcomes of stigma management include minority stress theory (Meyer, 2003) and the disclosure processes model (Chaudoir & Fisher, 2010). Minority stress theory is a framework that suggests that stigma and discrimination can create a hostile social environment that causes chronically high levels of stress and undermines health among marginalized individuals (Meyer, 2003). In this theory, concealment is considered one of the stigma-related stressors that causes negative psychological health outcomes. For example, considering the experience of sexual minorities, it is argued that “in concealing their sexual orientation LGB people suffer from the health-impairing properties of concealment and lose the ameliorative self-protective effects of being ‘out’” (Meyer, 2003, p. 14). Focusing instead on the outcomes of revealing, the disclosure processes model (Chaudoir & Fisher, 2010) hypothesizes a causal relationship between the goals that precede a disclosure, the quality and content of the disclosure, and the outcome of the disclosure. The model suggests that disclosure can impact long-term outcomes that are individual (i.e., psychological, behavioral, health), dyadic (i.e., trust, liking, intimacy), and contextual in nature (i.e., cultural stigma, norms for disclosure). Specifically, the relationship between disclosures and outcomes are thought to be moderated by the antecedent goals (i.e., approach-focused, avoidance-focused) and mediated by three distinct processes: alleviation of inhibition, social support, and changes in social information.

Identity management theory, preoccupation model of secrecy, cognitive-behavioral-affective process model, minority stress theory, and disclosure processes model have each uniquely contributed to the broader understanding of the consequences of managing a stigmatized identity through concealment or disclosure. Though some more strongly than others, each theory tends to support the basic idea that disclosure supports well-being and concealment undermines health. Although these theories are relevant to the specific experiences of sexual minorities, each are considered relevant to the broader population of people with indiscernible stigmatized identities (Chaudoir et al., 2011; Pachankis, 2007; Smart & Wegner, 1999).

However, each framework makes a distinct contribution to the understanding of the link between stigma management and well-being. For example, the theories differ in the mechanisms theorized to be responsible for the negative impacts of stigma management on health. Identity management theory suggests that stigma management reinforces self-stigma, which impairs positive identity development over time. On the other hand, the preoccupation model of secrecy focuses more on the cognitive burden of concealment and theorizes its immediate effects, as opposed to its long-term impact.

Although the cognitive-behavioral-affective process model and minority stress theory both acknowledge the ways in which concealment can protect stigmatized individuals from negative consequences (e.g., violence, harassment, rejection), both theories focus more heavily upon the multifaceted ways in which concealment undermines psychological functioning. However, they differ in their level of specificity. Minority stress theory is more of a broad, descriptive theoretical framework than a process model. It helps to contextualize stigma management among an array of other

stigma-related stressors that can undermine psychological functioning (e.g., prejudice events, expectations of rejection, self-stigma). The cognitive-behavioral-affective process model, on the other hand, breaks down the various psychological mechanisms that cause consequences—whether positive or negative—for those concealing a stigmatized identity.

The disclosure processes model shares the cognitive-behavioral-affective process model's emphasis on causal mechanisms. However, the disclosure processes model focuses on the antecedents and consequences of the identity disclosure, rather than identity concealment. The disclosure processes model highlights the positive impacts of disclosure (e.g., increased support, alleviation of the stress associated with inhibition), which are inversely related to the negative consequences of concealment within minority stress theory (e.g., decreased support, increases anxiety). Therefore, we can understand these various stigma management theories as distinct in that they each offer a unique perspective, but also see them as related to and supportive of one another.

Empirical studies. Mirroring contemporary theory linking stigma and well-being (e.g., Meyer, 2003; Pachankis, 2007), current empirical data suggests that stigma-related stressors account for the majority of disparities in mental health between heterosexual and sexual minority populations (Frost & Meyer, 2009; Frost, 2011; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Mays & Cochran, 2001). A number of studies have tested the outcomes of stigma management among LGB people (Beals et al., 2009; Bosson, Weaver, & Prewitt-Freilino, 2012; Frable et al., 1998; Jellison & McConnell, 2003, 2003; Lasser et al., 2010; Meyer, 2003; Moradi, 2009; Pachankis, 2007; Selvidge et al., 2008; Ullrich, Lutgendorf, & Stapleton, 2003). These investigations have included

sexual minority subpopulations, such as lesbian and bisexual women (Selvidge et al., 2008), sexual minority employees (Croteau, Anderson, & VanderWal, 2008), LGBT military veterans (Moradi, 2009); gay men with HIV (Cole et al., 1996a, 1996b); LGB ethnic minorities (Miller, 2011; Selvidge et al., 2008; Wong & Tang, 2004), and sexual minority youth (Rosario et al., 2009).

Although stigma concealment and disclosure can be defined and measured in many ways, looking broadly at the literature, one can uncover trends in the research on the relations between each construct and various aspects of psychological functioning. Research on sexual minorities has demonstrated that concealment is associated with a myriad of negative well-being outcomes. For example, among LGB populations, stigma concealment variables are related to increased physical health risk (Cole et al., 1996a, 1996b), decreased social support (Pachankis, 2007; Potoczniak et al., 2007), increased depressive symptoms (Frost, Parsons, & Nanín, 2007), a threatened sense of identity coherence (Bosson et al., 2012), increased psychological strain (Ragins et al., 2007), as well as increased self-monitoring and social anxiety (Potoczniak et al., 2007; Selvidge et al., 2008). The relationship between concealment constructs and negative psychosocial outcomes is mirrored in the broader literature on secret-keeping (e.g., Larson & Chastain, 1990) as well as in research on other indiscernible stigmatized traits, such as women who had received abortions (Major & Gramzow, 1999), working class college students (Granfield, 1991), people living with HIV (Maas et al., 2012) and individuals with an eating disorder (Smart & Wegner, 1999).

Although most studies suggest that concealment is linked to negative outcomes, research on the consequences of stigma suggests that, in certain circumstances, one's

decision to actively hide their stigmatized identity can be adaptive. For instance, stigma concealment can be protective against negative consequences, such as discrimination, homelessness, harassment, and violence (Eldridge & Gilbert, 1990; Healy, 1993; Herek, 1998). For example Cole and colleagues (1997) found that among rejection-sensitive gay men, those who did not conceal their sexual orientation demonstrated a significant acceleration to low CD4 T lymphocyte level, times to AIDS diagnosis, and times to HIV-related mortality. The researchers' explanation for this effect is that, among rejection-sensitive participants, the heightened stress caused by a rejection (or the imagined threat of rejection) may influence the sympathetic nervous system function and neuroendocrine activity in a way that undermines immune system function, and thus, facilitates the progression of HIV infection.

Moving to research on the disclosure of an indiscernible stigmatized identity, the literature suggests that revealing one's marginalized status is typically associated with positive health outcomes. For example, among LGB individuals, stigma disclosure is associated with lower rates of avoidant behavior (Rosario et al., 2009), less depressive symptoms (Talley & Bettencourt, 2011; Ullrich et al., 2003); higher self-esteem (Beals et al., 2009; Jellison & McConnell, 2003); increased life satisfaction (Wong & Tang, 2004); greater social support (Beals et al., 2009); greater acceptance of LGB sexual identity (Jellison & McConnell, 2003); and better overall psychological functioning (Elizur & Ziv, 2001; Pachankis, 2007). The seeming benefits of stigma disclosure are reflected within many sexual minority identity development models (e.g., Cass, 1979; Troiden, 1979) that implicitly suggest that coming out as LGB is linked to positive adjustment and healthy identity development (Szymanski, Kashubeck-West, & Meyer, 2008a). This link

has been evidenced among multiple populations of individuals with indiscernible stigmatized identities, including people with HIV and individuals with a mental illness (Bos, Kanner, Muris, Janssen, & Mayer, 2009; Corrigan et al., 2010; Hackl et al., 1997). Despite this trend, scholars have begun to investigate exactly when disclosure is beneficial and when it may undermine well-being. For example, research suggests that disclosure can decrease well-being if the reaction of the confidant is negative (Chaudoir & Quinn, 2010; Kelly & McKillop, 1996). Indeed, in a study by Rosario and colleagues (2009), the number of rejecting reactions to disclosure of sexual minority status was positively associated with substance use, anxious symptomatology, and depressive symptoms among LGB youth. Factors that have been shown to mediate the relationship between disclosure and well-being among sexual minorities include the motivation for the disclosure (Chaudoir & Quinn, 2010), support (Beals et al. 2009; Major et al 1990), sensitivity to rejection (Cole et al., 1997), as well as emotional processing and suppression (Beals et al. 2009).

Based on the literature, it can be said that individuals with indiscernible stigmatized identities face a dilemma regarding the communication of their identity to others. The benefits of disclosing can come at the expense of safety, relationships, and social status. And yet, hiding one's identity is not without potential negative outcomes, as the mental strain and isolation of concealment can undermine one's sense of authenticity, self-esteem, social connectedness, and overall psychological health (Bosson et al., 2012; Pachankis, 2007). Meyer (2003) spoke about this predicament among sexual minorities, claiming, "LGB people engage in identity disclosure and concealment strategies that address fear of discrimination on one hand and a need for self-integrity on the other."

Sexual minority individuals seem to have some awareness of the competing risks and benefits involved in decisions regarding stigma management (Chaudoir & Fisher, 2010). Take, for example, the experience of Tom B., who, when discussing his experience of college, said, “I don’t want anyone to know I’m gay. It’s kind of hard to explain. I want to be gay because I feel that’s what I am, but I don’t want anyone to know... There are so many hateful people out there” (Rhoads, 1994, p. 63). Thus, it can be said that, due to the competing motivations and the potential for strategies to backfire, stigma management decisions are far from simple.

Stigma management and depression. Numerous empirical studies have investigated the relationship between concealment and depression. In the broader literature on secret-keeping, Larson & Chastain (1990) found a moderately strong positive relationship between global tendency to self-conceal and depression among the sample. Small to moderate positive associations between measures of stigma concealment and depression have been demonstrated among many populations, including older adults (Friedlander, Nazem, Fiske, Nadorff, & Smith, 2012), individuals with herpes (Dibble & Swanson, 2000), and HIV-positive individuals (Maas et al., 2012). Numerous studies have uncovered a positive relationship between concealment and depression among sexual minorities (Cole, 2006; Ullrich et al., 2003). For example, Ullrich (2003) demonstrated a moderate correlation between a measure assessing how “in the closet” one is regarding their sexual identity and depression among HIV positive gay men. However, data from lesbians and gay men that participated in a 2-week daily diary study conducted by Beals and colleagues (2009) suggests no significant within person relationship between days in which respondents suppressed thoughts and feelings related

to sexual orientation and respondents' levels of depression. Suppression was measured using two items (e.g., "Today, did you feel as though you had to keep feelings about being gay or lesbian to yourself because they would make other people feel uncomfortable?"; Beals et al., 2009, p. 872). However, it is worth noting that, though related, suppression is not exactly the same as concealment. Both have cognitive-affective processes, but only concealment is typically understood to have a behavioral component (Pachankis, 2007). This fact makes this particular study a somewhat unsatisfactory investigation of concealment and depression.

As compared to studies investigating the link between concealment variables and depression, the associations between stigma disclosure constructs and depression have been more thoroughly researched. Kahn and Garrison (2009) found that depression was negatively associated to both the disclosure of a specific event and one's tendency to self-disclose personally distressing emotions. Specifically regarding sexual orientation, Lehavot and Simoni (2011) found that general level of nondisclosure of sexual orientation was positively related to depression in a sample of lesbian and bisexual women. Similar findings have been reported regarding the association between depression and HIV disclosures (Mitchell & Knowlton, 2009; Venable, Carey, Blair, & Littlewood, 2006; Vyavaharkar et al., 2011), including disclosure of HIV status among HIV positive gay men (Frost, 2007). Although more thoroughly researched than concealment and depression, the relationship between disclosure and depressive symptomology is less conclusive. For example, in a sample of LGB individuals, Frost and Meyer (2009) found that a measure of global outness (i.e., level of LGB disclosure to various groups) was not a significant predictor of depression. Of the many studies on

depression and disclosure among individuals with indiscernible stigmas, the most common result uncovered is a qualified relationship between disclosure and depression (e.g., Bybee, Sullivan, Zielonka, & Moes, 2009; Legate, Ryan, & Weinstein, 2012; Mireshghi & Matsumoto, 2008; Petrak, Doyle, Smith, Skinner, & Hedge, 2001; Talley & Bettencourt, 2011).

Stigma management and life satisfaction. Investigations of the relationships between stigma management strategies and satisfaction with life are sparse, especially regarding the relationship between concealment variables and life satisfaction. A recent study by Friedlander and colleagues (2012) looked at the relation between global tendency to conceal secrets and suicidal behaviors. The researchers reported that the self-concealment measure accounted for significant variation in suicidal behaviors among younger adults in the sample. However, the relationship was not significant among older adults. Kahn and Hessling (2001) tested the relationship between concealment and life satisfaction, demonstrating that baseline reports of concealment predicted an increase in life satisfaction two months later. This result must be taken with caution, as the measure used, the 12-item Distress Disclosure Index (DDI; Kahn & Hessling, 2001), is “related to but slightly different from self-disclosure and self-concealment as they are typically defined” (Kahn & Hessling, 2001, p. 44). Rather, it blends the traditionally distinct definitions in order to allow concealment and disclosure to be measured as a unidimensional stigma management construct.

Comparatively, there is more available research on the relationship between disclosure and life satisfaction. Beals and colleagues (2009) discovered a positive relationship between daily measures of disclosure and daily measures of satisfaction with

life among sexual minorities. Wong and Tang (2004) also found that, among Chinese gay men in Hong Kong, a measure of “readiness and level of disclosure of one’s homosexual sexual orientation” was positively related to life satisfaction (p. 288). Despite the evidence that life satisfaction is related to the disclosure of sexual minority status, some studies have failed to produce this relationship. For example, an assessment of outness at work was not significantly related to life satisfaction in a study of LGB employees (Huffman, Watrous-Rodriguez, & King, 2008). Also, in a study of individuals living with cancer, Park and colleagues (2011) reported no significant relationship between a global measure of disclosure of cancer and life satisfaction. Finally, in a three-wave longitudinal study of individuals living with HIV/AIDs, Greeff and colleagues (2010) found that at time one, global disclosure to friends was positively related to life satisfaction. However, by the final time point, this effect was reversed such that, holding all other variables constant, higher disclosers reported decreased life satisfaction.

Stigma management and identity adjustment variables. Individuals with indiscernible stigmatized identities may have difficulty adjusting to having a marginalized status (Mohr & Kendra, 2011). This may be especially true among individuals who either acquire their stigmatized identity or become aware of their stigmatized group membership after adolescence, which is not uncommon among sexual minorities. Individuals who find themselves in a stigmatized group later in life may be more vulnerable to accepting negative stereotypes about their identity group prior to identifying with that group, providing an additional barrier to positive identity adjustment (Crocker & Major, 1989). In addition to the distress that identity adjustment factors may cause in and of themselves, one’s ability to cope with a stigmatized identity may relate to

broader aspects of psychosocial functioning (Meyer, 2007; Mohr & Kendra, 2011). Some common identity adjustment variables include self-stigma (Szymanski et al., 2008a), acceptance concerns (Mohr & Fassinger, 2000), collective self-esteem (Crocker, Luhtanen, Blaine, & Broadnax, 1994), and identity strength (Phinney, 1992). The relationships between these select identity adjustment constructs and stigma management variables (i.e., concealment and disclosure) will be reviewed below.

One of the most widely researched aspects of identity adjustment is self-stigma. Self-stigma based on one's sexual minority status is often referred to as internalized homophobia, internalized homonegativity, or internalized heterosexism. In an analysis of fourteen studies examining the link between internalized heterosexism and LGB self-disclosure variables, Szymanski and colleagues (2008b) found that the literature consistently demonstrates a negative relationship between disclosure and internalized heterosexism, with an average effect size of .41. Studies conducted since this review generally support a relationship between disclosure of indiscernible stigmatized identities and self-stigma (Buseh, Kelber, Hewitt, Stevens, & Park, 2006; Chow & Cheng, 2010; Frost & Meyer, 2009; Lehavot & Simoni, 2011). Though less thoroughly researched, concealment has been shown to have a positive relationship to self-stigma. Research by Mohr and Kendra (2011) found that internalized homonegativity has a moderately strong negative relationship to concealment motivation in two samples of sexual minority individuals. Some scholars (Cain, 1991; Mohr & Fassinger, 2000) have cautioned against assuming that either low disclosure or high concealment are indicative a negative identity, as these stigma management strategies may be symptoms of perceived external

consequences (e.g., violence, rejection, harassment, etc.) as opposed to reflecting negative internal self-evaluations.

An additional area of identity adjustment relates to acceptance concerns. Research suggests that individuals with indiscernible stigmatized identities vary with regard to how much they fear rejection or judgment from others based on their marginalized status (Mohr & Fassinger, 2000; Pachankis, Goldfried, & Ramrattan, 2008). It is sensible to believe that individuals with high acceptance concerns may hesitate to disclose a potentially stigmatizing trait if the desire to be authentic is overpowered by the desire to be accepted. This idea is supported by Chaudior and Quinn (2010), who found that experiencing acceptance during first disclosure experiences is negatively related to chronic fear of disclosure. Similar logic suggests that concerns about acceptance may be highly correlated with concealing behavior, as many theorists suggest that concealment is often used as a strategy to escape negative judgment (Cole et al., 1996a; Schope, 2002). Indeed, Mohr and Kendra (2011) found that acceptance concerns has a moderate positive relationship to concealment motivation among LGB individuals.

Thirdly, many scholars have become interested in self-esteem among individuals facing stigma (Luhtanen & Crocker, 1992; Major & O'Brien, 2005; Pachankis, 2007). Luhtanen and Crocker (1992) suggest that self-esteem, as it is traditionally studied, represents only a partial view of what comprises an individual's self-concept, arguing that there are also collective, identity-based components to self-esteem. For example, they define membership esteem as an individual's subjective sense of how worthy they are as a member of their social groups. Although there is some empirical data on the relationship between stigma management and self-esteem (Bybee et al., 2009; Eldridge &

Gilbert, 1990; Frable et al., 1998; Stutterheim et al., 2011), little to no research has been conducted on how concealment or disclosure are associated with membership esteem. Nonetheless, one can imagine membership esteem varying as a function of concealment and disclosure variables among individuals with indiscernible stigmatized identities. For example, sexual minorities may receive pressure from LGB people or organizations to come out and be visible members of their community in support of activism and social change (Cain, 1991; Rees-Turyn, 2007), sending explicit or implicit messages that high disclosure is tied to worthiness as a member of the group. Conversely, to conceal one's sexual orientation could be seen as an act of weakness or betrayal to the larger LGB community, fostering low membership self-esteem.

Finally, individuals vary with regard to the strength of their stigmatized identity, as well as the salience of their stigmatized identity within their overall self-concept (Jones et al., 1984; Ragins, 2008). Research suggests that stigma management is related to these identity variables (Law et al., 2011; Mohr & Kendra, 2011; Park et al., 2011). Identity strength can be measured in a number of ways, including how oriented one is to others within their in-group (Phinney, 1992) and how important the identity is to the individual (Mohr & Kendra, 2011). Identity centrality, for example, is the degree to which an aspect of a person's social identity (e.g., sexual orientation) is prioritized within her or his overall sense of self (Mohr & Kendra, 2011). In a study by Law and colleagues (2011) on the workplace experiences of transsexual employees, identity centrality was positively related to degree of disclosure of transgender identity, both at work and outside of their place of employment. Mohr and Kendra (2011) found that identity centrality was

negatively related to concealment motivation in two samples of sexual minority individuals.

Summary of findings on study outcome variables. Research exploring if and how concealment and disclosure constructs relate to the six outcome variables of this study (i.e., depression, life satisfaction, identity strength, self-stigma, acceptance concerns, and membership self-esteem) tends to support the overarching theoretical frameworks concerning the outcomes of stigma management (Cain, 1991; Chaudoir & Fisher, 2010; Goffman, 1963; Meyer, 2003; Pachankis, 2007). Like the majority of theoretical perspectives on stigma management, taken together, the studies reviewed suggest that stigma disclosure generally promotes positive outcomes, whereas stigma concealment generally promotes negative consequences.

Although significant relationships were generally in the hypothesized direction (e.g., concealment is positively related to depression, disclosure is negatively related to depression), not all studies investigating correlations between stigma management constructs and one of the six outcome variables uncovered significant relationships. At this point, there is not sufficient research to know what factors to attribute these contradictory results to. However, they may be related to the aforementioned differences in the measurement of concealment and disclosure across studies or to differences in the sample populations.

The body of research on stigma management and these six outcome variables also highlights the multiple ways in which concealment and disclosure is associated to well-being, including aspects of psychological health (e.g., depression, life satisfaction), self-evaluative factors (e.g., membership esteem, self-stigma), and interpersonal identity

adjustment factors (e.g., acceptance concerns). This is in line with contemporary theoretical perspectives that frame the multifaceted ways stigma management impacts individuals with indiscernible stigmatized identities (Chaudoir & Fisher, 2010; Pachankis, 2007; Ragins, 2008). Based on these findings, there is reason to believe that stigma management accounts for some of the discrepancies in mental health between sexual minorities and their heterosexual peers, which were historically attributed to the innate pathology of homosexuality (Herek et al., 2007).

Although research on both variables has increased in recent decades, this lit review suggests that stigma disclosure has been studied more frequently than stigma concealment regarding relations to these six study variables. Many of the studies that claim to study concealment, instead measure disclosure variables and use this metric as a proxy for concealing behavior. Therefore, one gap in the research on stigma management, psychological health, and identity adjustment is that we know very little about the links between stigma concealment and the six outcome variables included in this study. A second gap concerns the fact that some of the identity adjustment study variables (e.g., membership esteem) have received little to no attention regarding their links to stigma management constructs prior to this investigation.

Chapter 3: Statement of the Problem

In recent decades, research on identity concealment and disclosure among individuals with indiscernible stigmatized identities has expanded considerably. A review of relevant literature on the consequences of stigma concealment and disclosure reveals that both stigma management strategies relate to factors of well-being. However, these findings are obscured by the conflated conceptualizations and imprecise measurement of concealment and disclosure variables throughout stigma management literature. An understanding of how stigma management influences psychological health and identity adjustment requires greater attention to the conceptualization and assessment of disclosure and concealment constructs. Knowledge in this area can be advanced through research exploring how stigma concealment and disclosure variables relate to each other—and to various aspects of psychosocial functioning—when assessed among individuals with indiscernible stigmatized identities.

Literature on secret-keeping has suggested that, though negatively related, concealment and disclosure are not two ends of a bipolar spectrum (Larson & Chastain, 1990). However, it is unclear whether this is true regarding the concealment and disclosure of an indiscernible stigmatized identity. One reason to believe stigma concealment and disclosure do not represent a unidimensional construct is that unique mechanisms are thought to motivate these stigma management strategies. Concealment is theorized to be motivated by various situational factors and environmental triggers (Anderson et al., 2001; Pachankis, 2007). For example, fear of discovery or contextual factors that increase the salience of one's stigma may heighten distress and encourage vigilance about concealment (Pachankis, 2007). Disclosure, on the other hand, tends to be

understood as having a social integration function (Beals et al., 2009). Furthermore, the positive effects of disclosure are presumed to be due, in part, to the stable social integration it provides via other global factors, such as social support and identity centrality (Chaudoir & Quinn, 2010; Ragins, 2008). These differences may lead one to believe that stigma concealment (conceptualized as a situational construct) and disclosure (conceptualized as a global construct) are negatively related, but ultimately separate, constructs.

Hypothesis 1. Stigma concealment will be negatively associated with stigma disclosure; however, the negative association will not be so strong as to suggest a unidimensional construct (i.e., r will be significantly smaller than $-.80$)³.

A different way to evidence the distinctness of concealment and disclosure constructs—and to deepen understanding of identity management processes—is to investigate their unique association with outcome variables they may each be related to. Studying the psychological health outcomes of stigma concealment and disclosure, respectively, is a large part of the stigma management literature (Corrigan & Matthews, 2003; Major & Gramzow, 1999; Meyer, 2003; Pachankis, 2007; Quinn, Kahng, & Crocker, 2004; Ragins, 2008; Smart & Wegner, 2000). Concealment and disclosure have demonstrated opposite associations with many psychological adjustment variables, with greater well-being relating to higher disclosure (Beals et al., 2009; Elizur & Ziv, 2001; Jellison & McConnell, 2003; Rosario et al., 2009; Talley & Bettencourt, 2011; Ullrich et al., 2003) as well as to lower concealment (Bosson et al., 2012; Cole et al., 1996b; Frost et al., 2007; Pachankis, 2007; Potoczniak et al., 2007; Ragins et al., 2007). Despite these

³ In the proposed study, $-.80$ is set as a threshold that can be used to gauge whether the constructs are sufficiently similar to be considered unidimensional or sufficiently dissimilar, and thus, separate constructs. This threshold is based on conventions in regression analysis, wherein predictors correlated $.80$ or more are considered too similar to be considered unique predictors (Tabachnick & Fidell, 2007).

findings, no studies have used distinct measures of concealment and disclosure to examine their unique relationships to psychological health outcomes among individuals with indiscernible stigmatized identities.

There are reasons to believe that, as compared to stigma disclosure, stigma concealment may differentially predict depression and life satisfaction. Unlike nondisclosure, the effortful control required to conceal a stigmatized identity may elevate cognitive strain. Thus, some of the association between stigma concealment and depression or life satisfaction, respectively, may be partially due to the cognitive stress caused by working to keep one's true identity hidden. Second, unlike nondisclosure, which does not inherently involve intentional identity distortion, it has been theorized that the acts of deception involved in stigma concealment may reinforce an individual's sense of being abnormal and inferior (Hetrick & Martin, 1987). These feelings may mediate the relationship between stigma concealment and psychological health. Finally, although fear relates to both stigma concealment and disclosure decisions, fear may play a more central role in concealment strategies (Pachankis, 2007). This fear may explain some of the unique relationship between stigma concealment and depression or life satisfaction, above and beyond that which is explained by stigma disclosure.

There are also reasons to believe disclosure may uniquely predict depression and life satisfaction after controlling for concealment. Disclosure is seen as a goal-oriented behavior and one primary goal seems to be social integration (Chaudoir & Quinn, 2010; Derlega & Grzelak, 1979; Ragins, 2008). For example, disclosure has been linked to many social variables, such as social support (Beals et al., 2009), as well as identity coherence, which concerns how well a person's internal sense of self aligns with how

they are seen by others (Bosson et al., 2012). The ability of disclosure to benefit one's interpersonal experiences (e.g. social support, identity coherence) may account for a unique relationship between stigma disclosure and factors of psychological health, such as depression and life satisfaction.

Hypothesis 2. Levels of stigma concealment and disclosure will each account for unique variance in depression.

Hypothesis 2a. Level of stigma concealment will be positively related to depression, after controlling for stigma disclosure.

Hypothesis 2b. Level of stigma disclosure will be negatively related to depression, after controlling for stigma concealment.

Hypothesis 3. Levels of stigma concealment and disclosure will each account for unique variance in life satisfaction.

Hypothesis 3a. Level of stigma concealment will be negatively related to life satisfaction, after controlling for stigma disclosure.

Hypothesis 3b. Level of stigma disclosure will be positively related to life satisfaction, after controlling for stigma concealment.

If stigma concealment and disclosure each uniquely predict depression and life satisfaction, it is possible that one stigma management strategy might predict a given psychological health outcome better than the other. For example, there are a number of reasons to believe concealment may serve as a better predictor of depression than disclosure. First, there are more mechanisms theoretically linking concealment to pathology (e.g., fear, cognitive strain, reinforcement of a negative identity) than there are linking disclosure to pathology (e.g., lack of social support). Also, although nondisclosure does not always necessitate concealment, logic suggests that concealment seems to require some level of nondisclosure. Thus, stigma concealment may also undermine social support in certain situations or contexts (e.g., the workplace), removing

one of the factors theorized to have an ameliorative impact on the mental health consequences of stigma (Beals et al., 2009; Meyer, 2003). Finally, although theory suggests that high concealers may be more depressed than the general population, it does not necessarily follow that low concealers are better off with regards to depression as compared to society (Cole, 2006; Friedman, Cooper, & Osborne, 2009; Maas et al., 2012; Ullrich et al., 2003). In other words, although concealment may be linked to below average functioning, nonconcealment may not be linked to above average functioning. If this is true, it would follow that concealment may be a better predictor of negative psychological adjustment factors (e.g., depression) than positive psychological adjustment variables (e.g., life satisfaction). On the other hand, disclosure seems to relate more strongly to interpersonal factors (e.g., social support, identity coherence), which may lend themselves to predicting positive psychological adjustment factors (e.g., life satisfaction) better than negative psychological adjustment factors.

Hypothesis 4. Stigma concealment will better predict variables related to negative psychological health, whereas stigma disclosure will better predict positive psychological outcomes.

Hypothesis 4a. Level of stigma concealment will account for significantly more variance in depression than stigma disclosure.

Hypothesis 4b. Level of stigma disclosure will account for significantly more variance in life satisfaction than stigma concealment.

Past research suggests that concealment and disclosure are not only associated with general psychological health variables, but also to how one views and adjusts to his or her marginalized status (Mohr & Fassinger, 2000; Mohr & Kendra, 2011). This study will explore the unique predictive abilities of stigma concealment and disclosure in relation to four identity-specific variables indicating adjustment to one's own sexual minority status:

self-stigma, acceptance concerns, membership self-esteem and identity strength. Thus, a number of hypotheses were devised in which stigma concealment and stigma disclosure are hypothesized to have independent and opposite effects on LGB identity adjustment.

There is reason to believe that stigma concealment will uniquely predict self-stigma after controlling for disclosure. Again, as opposed to the more passive behavior of nondisclosure, concealment is theorized to require active cognitive effort. As actively hiding a stigmatized identity may reinforce its negativity and inferiority within the self-concept of the stigmatized individual, effortful control may account for some of the unique relationship between concealment and self-stigma (Cain, 1991). In addition to concealment increasing self-stigma, one's level of self-stigma may also encourage concealment. The more one loathes their stigmatized identity, the more motivated the individual may be to vigilantly keep it concealed from others in interpersonal contexts. Therefore, stigma concealment and self-stigma may impact one another in a bidirectional manner.

Fear may be a mechanism in the link between disclosure and self-stigma as well. However, unlike the fear that motivates concealment, the fear of post-disclosure rejection may be less related to immediate and situational consequences (e.g., harassment, violence, ostracism), but rather a function of the perceived negative long-term consequences of revealing a stigmatized identity to significant people, such as losing the support of an important family member or causing tension in a close friendship (Szymanski et al., 2008b). Individuals with high levels of self-stigma may feel uncomfortable sharing an identity that they feel is negative, abnormal, or inferior with people they care about. It seems that different types of fear may mediate the relationships

between disclosure and self-stigma (i.e., fear of long-term social consequences) versus concealment and self-disclosure (i.e., fear of short-term situational consequences). Thus, both stigma management variables may be unique predictors of self-stigma.

Hypothesis 5. Levels of stigma concealment and disclosure will each account for unique variance in self-stigma.

Hypothesis 5a. Level of stigma concealment will be positively related to self-stigma, after controlling for stigma disclosure.

Hypothesis 5b. Level of stigma disclosure will be negatively related to self-stigma, after controlling for stigma concealment.

Again, there is a question as to whether stigma concealment or disclosure may better predict self-stigma. Although both stigma concealment and disclosure are hypothesized to have unique relationships to self-stigma, it makes intuitive sense that actively hiding one's marginalized status (i.e., concealment) is more indicative self-stigma than simply staying silent about it (i.e., nondisclosure). Anderson et al. (2001) spoke to this, arguing that passing (e.g., fabricating information to be perceived as heterosexual) undermined self-integrity more acutely than covering (e.g., censoring information in order to avoid being seen as a sexual minority). Furthermore, it has been demonstrated that concealing a stigmatized aspect of oneself may facilitate identity ambivalence, characterized by a varying view of oneself across contexts (Granfield, 1991; Pachankis, 2007). Identity ambivalence may cause one to feel fraudulent, guilty, or that they are betraying their social group—each of which may increase negative self-evaluations (Pachankis, 2007). Finally, as previously mentioned, there is reason to believe that only the relationship between self-stigma and concealment may work in a bidirectional, reinforcing manner in which self-stigma makes one more vigilant about

concealment, and in turn, concealment sends implicit messages of inferiority to the concealer, deepening his or her sense of self-stigma.

Hypothesis 6. Level of stigma concealment will account for significantly more variance in self-stigma than stigma disclosure.

As previously stated, fear may motivate concealment and hinder disclosure—through what exactly is feared may be distinct in each case. It may be that the decision to conceal varies as a function of perceived consequences in the moment (e.g., harassment, violence, embarrassment), whereas one's level of overall disclosure, theorized to be a goal-oriented behavior with a social integration function, may take the long-term considerations of important relationships into account. With this in mind, one can construct a rationale that concealment and disclosure have unique relationships to acceptance concerns. For example, among individuals whose fear is based in immediate environmental threats, stigma concealment might predict acceptance concerns above and beyond disclosure. On the other hand, among individuals who have acceptance concerns related solely to important, ongoing relationships (e.g., parents, co-workers, friends), stigma disclosure might uniquely predict acceptance concerns. The distinct relationships may also be explained by the particular conceptualizations of concealment and disclosure used in this study. One might expect that, in this study, concealment would uniquely predict situational fears because the measure used examines concealment behavior in a particular context (i.e., within the last two weeks). In a similar vein, broader concerns with acceptance may be uniquely predicted by the global measure of disclosure used in this study.

Hypothesis 7. Levels of identity concealment and disclosure will each account for unique variance in acceptance concerns.

Hypothesis 7a. Level of stigma concealment will be positively related to acceptance concerns, after controlling for stigma disclosure.

Hypothesis 7b. Level of stigma disclosure will be negatively related to acceptance concerns, after controlling for stigma concealment.

Membership self-esteem refers to how much individuals consider themselves to be worthwhile members of their social group. It is expected that membership self-esteem will relate to stigma management variables, as it has been noted that there are implicit expectations in the LGB community regarding stigma management. However, concealment and disclosure may uniquely predict membership self-esteem because they act via distinct mechanisms. The mechanism through which concealment impacts membership self-esteem may be sense of community betrayal. For example, regarding concealment, those who hide their sexual minority status may be made to feel that they are cowards or are betraying other LGB people because they are keeping their identity secret (Hegna, 2007). It is also likely that individuals' level of outness (i.e., disclosure) may impact their internal sense of worth to the larger LGB community. Many LGB people are praised for coming out under difficult circumstances or face expectations that they talk openly about their sexual identity, educate others on homophobia, and serve as an out and proud role model for others in the LGB community (Cain, 1991; Rees-Turyn, 2007). Here the relationship between disclosure and membership esteem may not relate to one's sense of betrayal, but rather, to one's sense of whether their visibility as a sexual minority is adequate.

Hypothesis 8. Levels of identity concealment and disclosure will each account for unique variance in membership self-esteem.

Hypothesis 8a. Level of stigma concealment will be negatively related to membership self-esteem, after controlling for stigma disclosure.

Hypothesis 8b. Level of stigma disclosure will be positively related to membership self-esteem, after controlling for stigma concealment.

It is logical to assume that the stronger one's identity is, the less likely one would be to desire to hide it and the more difficulty the individual would have successfully hiding it. However, the relationship between concealment and identity strength may also work in the other direction, in that hiding an identity may keep an individual from engaging in tasks and activities that would strengthen their stigmatized identity. For example, one can imagine that a LGB individual intent on keeping their sexual minority status a secret may avoid going to gay pride events, associating with LGB individuals, or researching LGB history out of fear of discovery.

Conversely, the stronger the stigmatized identity, the more the individual may feel compelled to disclose it, integrate it into their public network, and achieve coherence between their public and private identities. Also, taking the critical step beyond nonconcealment to make one's identity visible, may increase access to similar others, effectively increasing identity strength (Frable et al., 1998). Therefore, there may be a unique, bidirectional relationship between disclosure and identity strength, above and beyond that which is accounted for by concealment.

Hypothesis 9. Levels of stigma concealment and disclosure will each account for unique variance in identity strength.

Hypothesis 9a. Level of stigma concealment will be negatively related to orientation to identity strength, after controlling for stigma disclosure.

Hypothesis 9b. Level of stigma disclosure will be positively related to orientation to identity strength, after controlling for stigma concealment.

The above hypotheses test the distinctness of stigma concealment and disclosure by examining their association to one another and their unique ability to predict four identity

adjustment outcomes. Hypotheses were offered regarding whether stigma concealment or disclosure better predicts three of the outcome variables: depression, life satisfaction, and self-stigma. These constructs were selected to be explored in this manner because theory, reason, or past research supported such hypotheses with these variables. It is unclear, however, if stigma concealment or disclosure might better predict acceptance concerns, membership self-esteem, or identity strength. Thus, the following research questions have been created to explore whether one stigma management strategy accounts for significantly more variance in one of more of these identity adjustment variables.

Research Question 1. Does stigma concealment or disclosure account for significantly more variance in acceptance concerns, membership self-esteem, or identity strength?

Research Question 1a. Does stigma concealment or disclosure account for significantly more variance in acceptance concerns?

Research Question 1b. Does stigma concealment or disclosure account for significantly more variance in membership self-esteem?

Research Question 1c. Does stigma concealment or disclosure account for significantly more variance in identity strength?

It is worth noting that the difference between two dependent *r*s computed to test *Hypotheses 4a, 4b, and 6* as well as *Research Question 1a, 1b, and 1c* may be minute, even if significant, bringing into question the practical significance of the findings. However, uncovering even a small statistical difference in correlation between stigma concealment and disclosure, respectively, on the various outcomes variables (e.g., depression, life satisfaction, self-stigma) can be understood as significant for two interrelated reasons. First, finding that these variables have unique predictive abilities would provide additional evidence for or against the larger hypothesis that stigma concealment and disclosure are related, but ultimately distinct constructs. There are is

also a practical benefit of such analyses, as even a small significant difference in predictive ability can help clarify the mechanisms by which stigma management relates to psychological health and identity adjustment, informing clinical theory regarding how to best support LGB people navigating stigma-related stressors. For example, finding a small but significant difference in the constructs ability to predict depression and life satisfaction can help clinicians working with LGB clients determine whether the focus of treatment should be on bolstering identity integration by increasing outness or on reducing the hypervigilance associated active concealment.

Chapter 4: Methods

Participants

This study relies upon an archival data set. The sample consists of 298 LGB college students. Regarding sexual orientation, the sample includes 86 respondents identifying as lesbian (28.9%), 109 identifying as gay (36.6%), and 103 identifying as bisexual (34.6%). The study sample is composed of 126 male participants (42.3%), 165 female participants (55.4%), and 7 respondents identifying as transgender or selecting “Other” from the list of response items (2.3%). Participants include both graduate students (31.9%) and undergraduate students (68.1%) from 26 different colleges and universities. The ages of the participants in the sample range from 18 to 52 ($M = 23.2$, $SD = 5.6$). With regard to race/ethnicity, the representation is follows (categories are not mutually exclusive): 14 African American/Black (4.7%); 17 Asian American/Pacific Islander (5.7%); 24 Latino/Hispanic (8.1%); 5 Native American/American Indian (1.7%); 250 White/Caucasian (83.9%); and 11 selecting “Other” (3.7%).

Measures

Stigma concealment.

The 6-item Sexual Orientation Concealment Scale (SOCS; Blair, 2006) was used to assess the degree to which respondents actively concealed their sexual minority status among others within the two weeks preceding the completion of the measure. To complete this instrument, participants respond to the items (e.g., “In the last 2 weeks, I have concealed my sexual orientation by telling someone that I was straight or denying that I was LGB”) on a 5-point rating scale ranging from 1 (*not at all*) to 5 (*all the time*).

An unpublished exploratory factor analysis was used to develop the SOCS and to support the unidimensional structure of the measure (Blair, 2006). In this study, the scale demonstrated adequate internal consistency among sexual minority populations (Cronbach's $\alpha = .78$). The SOCS has been shown to be positively correlated with general tendency to self-conceal, anxiety, and internalized homonegativity (Blair, 2006).

Stigma disclosure.

The 11-item Outness Inventory (OI; Mohr & Fassinger, 2000) was used to measure the degree to which participants had disclosed their sexual minority status in various domains of their lives. In this instrument, respondents are asked how open they are with regard to their sexual orientation to 11 socially relevant categories of individuals, including family members (e.g., mother, father, siblings), religious contacts (e.g., religious leaders, members of my religious community), and everyday relations (e.g., coworkers, friends, strangers). Respondents may select 0 (*not applicable*) if there is no such person or group of people in their life that fit the description of a given item. Otherwise, participants provide responses on a fully anchored 7-point rating scale ranging from 1 (*does not know*) to 7 (*definitely knows and openly talked about*), allowing them to not only indicate who knows about their sexual orientation but also how openly it is discussed. In this study, the OI is being used to distinguish respondent's level of disclosure in this study. It is not necessary or useful for the purposes of this study to evaluate how much others know about the respondent's sexual orientation regardless of disclosure. Thus, scores were recoded so that item responses with the same level of disclosure that are only differentiated based on others' awareness of the respondent's sexual identity will be collapsed. For example, the response item four, "person *probably*

knows about your sexual orientation status, but it is *rarely* talked about” and response item five, “person *definitely* knows about your sexual orientation status, but it is *rarely* talked about” will be combined because both delineate that disclosing behavior was rare (emphasis added; Mohr & Fassinger, 2000)⁴. Results from exploratory and confirmatory factor analyses indicated that the measure can be scored for overall outness, as well as for three subscales: Out to Family, Out to Religion, and Out to World. These domain-specific subscales demonstrated Cronbach’s alpha coefficients of .74, .97, and .79, respectively (Mohr & Fassinger, 2000). The overall outness score computed for this study will be calculated by taking the average of the Out to Family, Out to World, and Out to Religion subscales. This approach has been utilized in past studies of sexual minority populations, within which Cronbach’s alphas ranged from .81 to .87 (Balsam & Mohr, 2007; Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Balsam & Szymanski, 2005). The subscales of the OI have demonstrated significant correlations to identification with lesbian and gay communities, phase of identity development, measures of concealment motivation, and time spent in the coming out process (Mohr & Fassinger, 2000).

Depression.

The 20-item Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to measure depression during the week prior to completing the instrument. Responses to statements related to depressive symptomology (e.g., “My sleep was restless”) were rated on a 4-point rating scale ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*). The CES-D has achieved Cronbach’s alpha

⁴ Specifically, participants selecting response items one, two, and three on a given item will be merged to reflect no disclosure. Similarly, response items four and five will be merged to denote rare disclosure. See items in Appendix B for details.

coefficients ranging from .85 to .90 among populations differing in different age, race, and gender (Knight, Williams, McGee, & Olaman, 1997; Radloff, 1977; Roberts, Vernon, & Rhoades, 1989). Among LGB samples, the measure has yielded adequate Cronbach's alpha coefficients, ranging from .81 to .95 (Beals et al., 2009; Frost & Meyer, 2009; Quinn & Chaudoir, 2009; Talley & Bettencourt, 2011). The CES-D is one of the most widely utilized and empirically validated measures of depression (Shafer, 2006), with validity having been confirmed via concurrent clinical and self-report criteria, in addition to measures of construct validity (Radloff, 1977). Among sexual minority populations, the CES-D has demonstrated correlations with a number of constructs, including perceived stigma and avoidant coping (Talley & Bettencourt, 2011), internalized homophobia, relationship strain, and sex problems (Frost & Meyer, 2009), as well as perceived social support and suppression (Beals et al., 2009).

Life satisfaction.

The 5-item Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) was used to evaluate global life satisfaction for this study. Participants filling out the scale were asked to rate how satisfied they are with their life by responding to statements (e.g., "In most ways, my life is close to my ideal") on a fully anchored 7-point rating scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The original investigation of the psychometric properties of the SWLS (Diener et al., 1985), as well as studies conducted since its creation (Lewis, Shevlin, Bunting, & Joseph, 1995; Mohr & Kendra, 2011; Vassar, 2008), have reported moderately strong internal consistency with Cronbach's alpha coefficients above .80. In the instrument development study, scores on the SWLS also suggest good levels of test-retest reliability (.82). The measure has been

used among LGB populations with similar results (Balsam & Mohr, 2007; Halpin & Allen, 2004). For example, Balsam and Mohr (2007) reported a Cronbach's alpha estimate of .90 for the SWLS. Since its creation, several studies have validated the unidimensional structure of the SWLS (Arrindell, Meeuwesen, & Huyse, 1991; Neto, 1993; Sachs, 2004; Shelton, Alegre, & Son, 2010). Among LGB samples, the instrument demonstrated a positive correlation with measures of extraversion and agreeableness, as well as a negative association with measures of neuroticism and withdrawal during conflict (Kurdek, 1997). The SWLS is also shown to be associated with a number of sexual minority identity-related variables, including visibility (i.e., outness), involvement with other LGB people, acceptance by family and friends, rejection of negative stereotypes, positivity of LGB identity, and various stages of sexual minority identity development (Halpin & Allen, 2004; Luhtanen, 2003).

Self-stigma.

The 3-item Internalized Homonegativity subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS, Mohr & Kendra, 2011) was used to assess self-stigma among the sample. Participants respond to the subscale items (e.g., "If it were possible, I would choose to be straight") using a 6-point rating scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The Internalized Homonegativity subscale demonstrated high levels of internal consistency with Cronbach's alpha estimates ranging from .86 to .93 among LGB samples within the measure development study (Mohr & Kendra, 2011). The subscale was negatively associated with measures of satisfaction with life and social state self-esteem as well as measures of negative psychosocial functioning, including depression, guilt, fear, sadness, and hostility. The authors also supported the validity of

the Internalized Homonegativity subscale scores by testing its associations with psychometrically sound scales that measure dimensions of LGB identity, yielding predicted correlations with ego-dystonic homosexuality and orientation to LGB ingroup.

Acceptance concerns.

The 3-item Acceptance Concerns subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011) was used to assess respondents' levels of concern with being accepted based on their sexual minority status. Participants responded to the items (e.g., "I often wonder whether others judge me for my sexual orientation") on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Mohr and Kendra (2011) found that the Acceptance Concerns Subscale demonstrated strong internal reliability across a number of tests, with Cronbach's alphas ranging from .74 to .83 among sexual minority populations. The validity of the Acceptance Concerns subscale has been demonstrated by its correlation to satisfaction with life, social state self-esteem, and self-assurance, as well as with measures of a number of LGB identity variables, including public collective self-esteem, outness to world, and ego-dystonic homosexuality (Mohr & Kendra, 2011). The authors also report that the subscale correlates with measures of negative psychosocial functioning, including depression, guilt, fear, hostility, and sadness among various samples of sexual minority respondents.

Membership self-esteem.

A modified version of the 4-item Membership Esteem subscale of the Race-Specific Collective Self-Esteem Scale (CSES; Crocker et al., 1994), was used to assess membership self-esteem. This subscale was designed to assess individuals' judgments of

how worthy they are as members of their social groups. Items were reworded to have them to refer specifically to LGB group membership rather than their racial group membership. Participants responded to the modified Membership Esteem subscale items (e.g., “I am a worthy member of the LGB community”) using a 7-point rating scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The authors reported a coefficient alpha of .75 for the Membership Esteem subscale of the Race-Specific CSES, demonstrating adequate internal reliability. The validity of the Membership Esteem subscale of the Race-Specific CSES has been established through a study including Black, White, and Asian participants, in which Membership Esteem was significantly associated with measures of self-esteem, life satisfaction, depression, and hopelessness among Black respondents, White respondents, and the full sample (Crocker et al., 1994). However, none of these relationships were significant when analyzed specifically among Asian respondents, highlighting a potential limitation of this measure. The validity of the Membership Esteem subscale has also been demonstrated among sexual minorities (Zea, Reisen, & Poppen, 1999) where the measure was shown to be positively related to measures of self-esteem and social support.

Identity strength.

A modified version of the 14-item Ethnic Identity Scale of the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) was used to measure the strength of sexual minority identity among the LGB respondents. The language of the Ethnic Identity Scale was adapted to inquire about an individual’s sexual minority identity (e.g., “I feel a strong attachment towards the LGB community”) rather than their racial/ethnic identity, as has been done in past research measuring LGB identity strength (Mohr & Kendra,

2011). Item responses are rated on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The authors report a Cronbach's alpha coefficient of .90 for the original Ethnic Identity Scale among their college sample, suggesting adequate internal reliability. Researchers who have modified this Ethnic Identity Scale to concern sexual identity have demonstrated strong internal consistency when used with LGB populations, with a Cronbach's alpha coefficient of .91 (Mohr & Kendra, 2011). There is evidence of validity for this modified scale among LGB populations, as it has been shown to have a negative relationship to internalized homonegativity and a positive association to outness and identity centrality (Mohr & Fassinger, 2000; Mohr & Kendra, 2011).

Procedure

To recruit participants, researchers contacted LGB student organization leaders and requested that they distribute a call for study participants to their membership via electronic listservs. The email appeal explained the study and informed readers that participating students were eligible to enter a drawing to either win a \$20 gift card for a national café chain or donate the funds to one of two nonprofit human rights organizations. Interested students were instructed to click on a web link, directing them to the online survey. All surveys began with an informed consent document and contained demographic items in addition to the seven measures of interest. The survey also included additional measures not used in this study.

Survey data were cleaned using a four-step process. First, researchers looked for duplicate surveys by examining date, time, and origin of submission for all responses. No evidence of duplicate entries was found. Second, researchers looked at participants' responses to an item asking them to select the second of five colors listed. This item was

created to preserve the integrity of the data; researchers removed data from five people who responded to this item incorrectly. Third, because some participants discontinued the survey shortly after completing informed consent, researchers removed data from respondents who did not respond to the seven measures relevant to this study. Fourth, 12 respondents identified as exclusively heterosexual. Because this study concerns the management of an indiscernible stigmatized identity, the data from heterosexual study participants were removed. The sample described earlier in this chapter refers to the participants remaining after completing these four steps.

Statistical Considerations

To examine whether the sample size of this data set is adequate for the planned analyses and expected effect sizes in this study, a post hoc analysis of power was conducted using the software package G*Power (Erdfelder, Faul, & Buchner, 1996). Power was calculated for detecting small, medium, and large effects in linear multiple regression for tests of a single regression coefficient ($f^2 = .02, .15, \text{ and } .35$, respectively; Cohen, 1992), given a sample size of 298. An alpha level of .025 was adopted for this study to control the familywise Type I Error Rate. This post hoc analysis demonstrated that the power for the study hypotheses was .58 for a small effect size. For moderate to large effect sizes, the power surpassed .99. The statistical power value of .80 is often used as a threshold by researchers, as a power value above this threshold suggests little risk of a Type II error (Cohen, 1992). Thus, it can be concluded that there is adequate power to detect effect sizes that are at least moderate in size. However, the minimal effect size for which power would be .80 is .03. Thus, the sample size may be inadequate to reveal effects smaller than .03, increasing the risk of Type II errors in this study.

Chapter 5: Results

Preliminary Analyses

Inspection of the data revealed that less than 4% of the scores needed for each of the main analyses were missing. These missing values appeared to be randomly distributed across all measures. Rather than discard cases with missing data points, missing values were imputed using the expectation-maximization (EM) algorithm. This approach, which is considered to be superior to the common practice of mean substitution, begins with regression-based predictions of missing values and uses an iterative process to arrive at maximum likelihood estimates of the covariance matrix (Schafer & Graham, 2002). Although, like all methods of single imputation, the EM algorithm can lead to overly small standard errors, the effects of this bias are believed to be minimal when the amount of missing data is small, as was the case in the present study (Schafer & Graham, 2002).

Correlations, means, standard deviations, observed ranges, and internal consistencies for all study variables are presented in Table 1. The mean score for stigma disclosure was below the scale midpoint, suggesting that, on average, the sexual orientation of the study participants was known about by many people within their respective social environments, but was rarely discussed. In general, the participants reported low levels of LGB concealment over the past two weeks. However, the range of scores represented in the sample was broad for both variables. Regarding the psychological health variables included in the analyses, the mean scores suggest an average-to-high psychological adjustment among the participants. The mean score for depression was just below the midpoint, while life satisfaction scores were, on average,

on the higher end of the response scale. An examination of the means of identity-related variables suggest that, overall, this sample may be well adjusted to their stigmatized identity. For example, the means for identity strength and membership esteem were well above the midpoints of possible scores on the measures, whereas the average score for self-stigma and acceptance concerns were on the lower end of the respective response scales. As reflected in Table 1, the range of scores for both psychological health variables and identity-adjustment variables were quite broad. The full range of possible scores were represented with regard to each of these variables except depression, which fell just short of including the highest portion of the response scale.

Distributions of six of the eight quantitative variables were reasonably normal. However, two variables had skewness coefficients greater than 1.00 in magnitude: stigma concealment and self-stigma. The positive skew for stigma concealment did not lead to a violation of assumptions for the main analyses. However, residuals in the regression of self-stigma scores on stigma concealment and disclosure had a skewness coefficient well over 1.00 in magnitude. A natural logarithm transformation was applied to self-stigma scores, which reduced the skew in residuals to 0.51. A search for outliers did not indicate a need to delete data from participants who had extreme scores.

Are Stigma Concealment and Disclosure Distinct Constructs?

Hypothesis 1 had two components. First, it was posited that stigma concealment would be negatively associated with stigma disclosure. This hypothesis was supported ($r = -.47, p < .001$), and the association can be considered large in magnitude based on conventional benchmarks (Cohen, 1988).

Second, it was hypothesized that the negative association would not be so strong as to suggest that stigma concealment and disclosure are bipolar ends of a unidimensional construct. This hypothesis was tested by determining whether the correlation between stigma concealment and disclosure was significantly less than .80 in magnitude (a value often used in the context of regression analyses to determine whether variables are sufficiently dissimilar to be considered unique predictors; Tabachnick & Fidell, 2007). All values within the computed 95% confidence interval estimate of the correlation were lower than .80 in magnitude (-.58, -.41), indicating that the association between concealment and disclosure was not strong enough to suggest that these variables represent the same construct.

Do Stigma Management Processes Uniquely Predict Psychosocial Outcomes?

Simultaneous multiple regression analyses were conducted to test the hypotheses that levels of stigma concealment and disclosure would each account for unique variance in two psychological health criterion variables (i.e., depression, life satisfaction) and four identity-adjustment criterion variables (i.e., self-stigma, acceptance concerns, membership esteem, identity strength). To control for the inflation of Type I errors in the six multiple regression analyses, a familywise error rate of .10 was adopted (individual test error rate = .017). The results of these analyses are presented in Table 2.

As presented in Table 2, stigma concealment accounted for unique variance in both of the psychological health variables. In alignment with hypotheses, stigma concealment was positively related to depression and negatively associated with life satisfaction, after controlling for stigma disclosure. Also consistent with expectations, stigma concealment predicted the four identity-adjustment variables, after controlling for

stigma disclosure. Specifically, stigma concealment was positively associated with both self-stigma and acceptance concerns and negatively associated with both membership self-esteem and identity strength.

Regarding stigma disclosure, the ability to uniquely predict the six criterion variables was less consistent. Stigma disclosure predicted self-stigma, membership esteem, and identity strength in the expected directions, after controlling for stigma concealment. The associations between stigma disclosure and the remaining criterion variables (i.e., depression, life satisfaction, acceptance concerns) were not significant.

Computing the semipartial correlations of each predictor within the regression analyses offers insight regarding the effect sizes of the above results. The six semipartial correlations of stigma concealment ranged from .18 to .34 in magnitude (depression, $sr = .23$; life satisfaction, $sr = -.20$; self-stigma, $sr = .23$; acceptance concerns, $sr = .34$; membership esteem, $sr = -.18$; identity strength, $sr = -.18$). The semipartial correlations of the three significant regression analyses of stigma disclosure ranged from .15 to .26 in magnitude (self-stigma, $sr = -.15$; membership esteem, $sr = .26$; identity strength, $sr = .26$). Based on Cohen's (1988) effect size standards, this range of semipartial correlations between .15 and .34 can be considered small-to-medium in size.

Is One Stigma Management Process a Better Predictor Than Another?

To investigate whether stigma concealment or disclosure was a significantly better predictor of three dependent variables in this study (i.e., depression, life satisfaction, self-stigma), a series of t-tests of the difference between two dependent correlations were conducted (Meng, Rosenthal, & Rubin, 1992). Again, the familywise error rate was set at .10 (individual test error rate = .033).

Consistent with *Hypothesis 4a*, stigma concealment accounted for significantly more variance in depression than stigma disclosure ($z = -2.26, p = .024$). The finding for *Hypothesis 4b* was the opposite of what was expected: Stigma concealment was found to be a significantly better predictor of life satisfaction ($z = 2.68, p = .007$). In fact, stigma disclosure was not significantly associated with life satisfaction (see Table 1). Finally, the argument that level of stigma concealment would account for significantly more variance in self-stigma than level of stigma disclosure was not supported, as the difference between the associations was not significant ($z = -0.83, p = .41$).

Similar *t* tests were used to investigate research questions concerning whether stigma concealment or disclosure account for significantly more variance in acceptance concerns (*Research Question 1a*), membership self-esteem (*Research Question 1b*), and identity strength (*Research Question 1c*). The familywise error rate was set at .10 to examine these research questions (individual test error rate = .033). Stigma concealment was found to be a significantly better predictor of acceptance concerns than stigma disclosure ($z = -3.06, p = .002$). However, there was no significant difference in the two stigma management variables' respective abilities to predict membership self-esteem ($z = -0.87, p = .38$) or identity strength ($z = -0.85, p = .39$).

Chapter 6: Discussion

In recent decades, research on individuals with indiscernible stigmatized identities has illuminated links between stigma management variables (i.e., stigma concealment, stigma disclosure) and aspects of identity adjustment and psychological health (e.g., Beals et al., 2009; Cole et al., 1996b; Quinn & Chaudoir, 2009; Smart & Wegner, 1999). Despite the value of these contributions, scholarship in this area has often revealed an assumption that stigma concealment and disclosure represent bipolar ends of a unidimensional construct. As a result, little attention has been paid to the relation between these variables or the distinct mechanisms that may uniquely link different stigma management variables to specific psychosocial factors of interest. Developing a clearer understanding of these issues can aid the development of stigma theory and inform clinical interventions for individuals with indiscernible stigmatized identities.

The present study addressed these gaps by testing the relation between two specific types of stigma concealment and disclosure (i.e., context-dependent stigma concealment, global stigma disclosure) among LGB individuals. It also examined the unique and differential relations between these stigma management variables and key aspects of psychological health (i.e., depression, life satisfaction) and identity adjustment (i.e., self-stigma, acceptance concerns, membership esteem, identity strength), which can inform future research on—and clinical interventions with—individuals with indiscernible identities.

The Distinctness of Stigma Concealment and Disclosure Constructs

Results suggest that the facets of stigma concealment and disclosure assessed in this study are related but distinct aspects of identity management. Though moderate in size, the negative association between concealment and disclosure was not strong enough to suggest a unidimensional construct. The moderate negative association between stigma concealment and disclosure demonstrated in this study is consistent with past research on sexual minority identity management (Anderson et al., 2001; Moradi, 2009) and the broader literature on secrecy and emotional disclosure (Larson & Chastain, 1990; Pennebaker et al., 2004; Pennebaker & O’Heeron, 1984).

A series of analyses revealed that stigma concealment and disclosure both uniquely and differentially predicted a number of criterion variables, further evidencing the distinctness between these aspects of stigma management. This builds upon past research (e.g., Anderson et al., 2001; Moradi, 2009), which has shown that criterion variables can be significantly associated to one stigma management variable but not another.

Stigma Management and Psychological Health

Concealment was found to be positively associated with depression and negatively associated with life satisfaction—and these relations remained statistically significant after controlling for disclosure. Positive associations between measures of stigma concealment and depression have been demonstrated among many populations facing social stigma, including older adults (Friedlander et al., 2012), individuals with herpes (Dibble & Swanson, 2000), and HIV-positive individuals (Maas et al., 2012), and sexual minorities (Cole, 2006; Ullrich et al., 2003). The relations between stigma concealment

variables and life satisfaction have not been directly studied in any published empirical studies. Even broadening the scope to include studies that include variables similar to stigma concealment (e.g., secrecy) or proximal to satisfaction with life (e.g., job satisfaction, suicidal behaviors) suggests a relation between concealment and satisfaction that is equivocal at best (e.g., Friedlander et al., 2012; Kahn & Hessling, 2001; Moradi, 2009). These data not only suggests that stigma concealment may be positively related to factors of psychopathology (e.g., depression) and negatively related to aspect of well-being (e.g., life satisfaction), but that these relations remain significant above and beyond that accounted for by stigma disclosure.

Stigma disclosure was negatively associated with depression. However, contrary to expectation, this relation was no longer statistically significant after controlling for concealment. Moreover, disclosure was unrelated to life satisfaction. Given these findings, it is not surprising that formal tests indicated that, as compared to stigma disclosure, stigma concealment was a superior predictor of depression and life satisfaction. These findings are notable in light of past studies of these relations, which have been inconclusive at best. For example, regarding the relationship between depression and the disclosure of HIV or sexual minority status, some previous research has demonstrated a negative relationship (e.g., Frost, 2011; Lehavot & Simoni, 2011; Vanable et al., 2006), while others found the association to be insignificant (e.g., Frost & Meyer, 2009) or equivocal in nature (e.g., Legate et al., 2012; Petrak et al., 2001; Talley & Bettencourt, 2011). The results of studies investigating the relation between stigma disclosure and life satisfaction are similarly mixed, with some studies demonstrating a positive correlation (e.g., Beals et al., 2009; Wong & Tang, 2004), some finding no

association (e.g., Huffman et al., 2008; Park et al., 2011), and others suggesting a qualified relationship (e.g., Greeff et al., 2010). However, these studies did not include both stigma concealment and disclosure variables within the same study. This study offers a distinct contribution to the discourse on stigma management and psychological health because it was designed to shed light on the unique and differential associations between these variables.

Multiple takeaways can be gleaned from the data presented on the relations between the respective stigma management processes and psychological health. First, consistent with past research (e.g., Beals et al., 2009; Cole, 2006; Quinn & Chaudoir, 2009; Smart & Wegner, 1999), stigma concealment and disclosure, are both associated with aspects of psychological health. Second, stigma disclosure did not account for variance in either aspect psychological health (i.e., depression, life satisfaction) above and beyond that which is accounted for by stigma concealment. Taken together, these results highlight the fact that not all correlates of stigma management processes are unique. For example, the analyses revealed that although stigma concealment and disclosure were each correlated with depressive symptoms, only stigma concealment accounted for unique variance in this aspect of psychological health. Third, the results suggest that, overall, recent stigma concealment is a significantly better predictor of psychological health than global stigma disclosure.

The results of this study suggest that different mechanisms may explain the relations between stigma concealment and disclosure, respectively, and well-being. Inhibiting processes, such as stigma concealment, are theorized to require some level of cognitive control (Pennebaker et al., 2004; Smart & Wegner, 1999, 2000), while the mere

nondisclosure of stigma does not, by definition, require mental effort. Thus, one possibility is that the relationship between stigma concealment and psychological health is mediated by mental processes that are unique to stigma concealment, such as effortful control, fear of discovery, or cognitive preoccupation (Anderson et al., 2001; Pachankis, 2007; Smart & Wegner, 1999). This conceptualization is supported by literature on secret-keeping, which suggests that there may be a physiological link between active inhibition and both physical and psychological health (Larson & Chastain, 1990; Maas et al., 2012; Pennebaker & O’Heeron, 1984). For example, Maas et al. (2012) found that the relationship between secret keeping and well-being (i.e., depression, quality of life, anxiety) was moderated by cognitive preoccupation. Stigma disclosure, on the other hand, may influence psychological health through a mechanism that is more social in nature. For example, research and theory suggests that stigma disclosure may impact well-being by increasing social support, access to similar others, and identity centrality (Beals et al., 2009; Chaudoir & Quinn, 2010; Frable et al., 1998; Ragins, 2008).

Why might stigma concealment be a better predictor of psychological health? As suggested above, there is reason to believe that the relationship between stigma concealment and well-being is mediated by cognitive strain, whereas stigma disclosure may influence psychological health via social support. Thus, one possible explanation is that the negative impact of stigma concealment (i.e., cognitive burden) outweighs the psychological health benefits of stigma disclosure (i.e., social integration). However, a second explanation is that stigma concealment influences psychological health through both pathways (i.e., cognitive, social). There is some theory and research that posits that, as a result of their secrecy, self-concealing individuals with indiscernible identities may

have decreased options for coping (Larson & Chastain, 1990) and be deprived of essential sources of social support from family, peers, and other members of the stigmatized group (Meyer, 2003). These various types of support have been shown to buffer the health effects of social stigma among individuals with indiscernible identities (Beals et al., 2009; Berger, 1992; Frable et al., 1998; Grossman, Daugelli, & Hershberger, 2000). Therefore, it could be hypothesized that stigma concealment is a better predictor of depression and life satisfaction because it influences both cognitive and social variables in ways known to influence psychological health.

Stigma Management and Identity Adjustment

The study results contribute to the understanding of the relationship between stigma management and the four identity-related variables included in the study: self-stigma, acceptance concerns, membership esteem, and identity strength. Regarding three of these criterion variables—self-stigma, membership esteem, and identity strength—the pattern of findings was similar: Stigma concealment and disclosure were both correlated with these outcomes in expected directions, each uniquely predicted all three variables, and neither was found to be a significantly better predictor than the other. This study is aligned with past research across various types of individuals with indiscernible identities linking stigma disclosure to increased identity adjustment (e.g., Buseh et al., 2006; Law et al., 2011; Szymanski et al., 2008b) and stigma concealment to decreased identity adjustment (e.g., Mohr & Kendra, 2011). Although the effect sizes of some of these results were small in nature (e.g., self-stigma, $sr = -.15$), the effects offer new insight regarding the uniqueness and differential nature of these relations between stigma management and identity adjustment.

The results related to acceptance concerns came in contrast to the above findings. First, although stigma concealment and disclosure were each correlated with acceptance concerns, only stigma concealment was a unique predictor of acceptance concerns. Though a positive relation between acceptance concerns and concealment variables has been demonstrated within past research (e.g., Mohr & Kendra, 2011), the present study goes further, demonstrating that this association is significant after controlling for the variance accounted for by stigma disclosure. Although both stigma concealment and disclosure were associated with acceptance concerns, stigma concealment was shown to be a significantly better predictor of this criterion variable. This result is noteworthy, as previous literature has given little attention to the interrelations between stigma concealment, stigma disclosure, and acceptance concerns.

Why might stigma concealment be a better predictor of acceptance concerns, as compared to stigma disclosure? There are reasons to believe that the fear and negative affect associated with hiding a stigmatized identity, may mediate the relationship between stigma concealment and acceptance concerns. Regarding fear, people with acceptance concerns, by definition, experience a fear being rejected because of their stigmatized identity. Also, the most widely accepted motivation for concealment is fear of negative judgment from others (Hill et al., 1993; Rodriguez & Kelly, 2006; Vrij et al., 2002). For instance, in a study by Pachankis and Goldfried (2006), seventy-five percent of gay students reported attempting to modify their behavior out of fear of being rejected or harassed due to their sexual minority status. This pathway is distinct from the theorized link between stigma disclosure and fear, within which the type of fear characterized is typically less situational and more global and chronic in nature (e.g., Chaudoir & Quinn,

2010). A second possibility is that stigma concealment and acceptance concerns are both influenced by negative affect. For example, in the present study, depression and life satisfaction each had a stronger relationship to acceptance concerns than they did to the other identity-adjustment factors. These results are supported by findings by Balsam and Mohr (2007), who found that, as compared to self-stigma and stigma disclosure, acceptance concerns was a better predictor of overall well-being.

Whether fear or depression is the unique mechanism between stigma concealment and acceptance concerns, Pachankis' (2007) Cognitive–Affective–Behavioral Process Model can be applied to connect the variables. This framework suggests that stressful stigma–related cognitions (e.g., acceptance concerns) have affective consequences (e.g., fear, depression) and that both affective and cognitive processes influence behavior (e.g., concealment). Completing the loop of interrelated variables, vigilant concealment may lower one's chances of receiving supportive feedback or coming into meaningful contact with similar others, both of which are theorized to ameliorate negative cognitions (e.g., acceptance concerns). Although stigma disclosure is also linked to social support (Beals et al., 2009), it may be that stigma concealment restricts social connections in such a way (or to such a magnitude) that it more greatly undermines acceptance concerns. Thus, acceptance concerns may be a better predictor of stigma concealment than it is of stigma disclosure because (a) acceptance concerns may impact concealment behavior directly and via multiple affective processes (e.g., situational fear, depressive mood) and (b) the relation between stigma concealment and acceptance concerns seems to be bi-directional in nature.

Implications for Clinical Intervention

Despite the fact that this investigation does not focus on a clinical population, the results may inform counselors working with individuals with indiscernible identities. Specifically, this study offers insight into the way that stigma management behaviors may relate to aspects of psychological health and well-being. As noted previously, results suggest that both stigma concealment and disclosure are related to aspects of psychological health. Thus, although this study cannot make causal claims, practitioners interested in decreasing depression and bolstering identity-adjustment among clients with indiscernible stigmatized identities may consider attending to the client's recent experiences with stigma concealment or exploring their overall tendency to disclose their stigmatized identity. However, there is little evidence that attending to both concealment and disclosure has any added benefit in the prediction of depression and life satisfaction. Based on the results of this study, situational concealment behavior (e.g., altering one's appearance, verbally denying one's stigmatized identity, avoiding contact with similarly stigmatized individuals) may be more directly related to health outcomes, as compared to disclosure (e.g., outness to family, outness to similar others, outness at work) among individuals with indiscernible identities.

These findings contradict clinical theory, which has disproportionately focused on increasing disclosure as the path towards well-being, especially among LGB individuals (Cain, 1991). Future clinical guidelines may focus less on encouraging disclosure and more towards educating the client about the cognitive, affective, and behavioral consequences of actively hiding a stigmatized identity. Because this study cannot confirm the direction of the relations between stigma management and the various outcomes

assessed, practitioners may also want to consider the ways in which increasing psychological health and identity adjustment may help a client who wishes to decrease stigma concealment or increase stigma disclosure.

Increasing research has linked identity adjustment variables (e.g., self-stigma) to mental and physical health issues (e.g., minority stress, suicidality, substance abuse, depression, cardiovascular health; King et al, 2008; Williams & Mohammed, 2009). This may explain why mental health professionals have increasingly framed bolstering identity-related adjustment and coping as therapeutic goals, especially among LGB clients (e.g., Bieschke, Perez, & DeBord, 2007; Hershberger & D'Augelli, 2000; Pachankis & Goldfried, 2004). As noted previously, results from this study suggest that both stigma concealment and disclosure account for unique variance in multiple aspects of identity-adjustment (i.e., self-stigma, membership esteem, identity strength). Thus, practitioners interested in bolstering identity-adjustment among clients with indiscernible stigmatized identities may want to attend to both the client's experiences with stigma concealment as well as their overall tendency to disclose their stigmatized identity. Based on these study findings, clinicians working with individuals with indiscernible identities who experience elevated acceptance concerns, may want to consider how this variable influences (or is influenced by) stigma concealment and psychological health.

Contributions and Limitations of the Study

This study contributes new insight to the understanding of stigma management variables. One advantage over past studies of stigma management is that this investigation evaluated the relationship between two stigma management strategies in a number of different ways (i.e., correlation, unique prediction, differential prediction),

which provides a more nuanced understanding the relationship between these constructs. Second, although mechanisms were not directly studied in this investigation, inferences drawn from the study findings can be used to inform theory about the mechanisms through which psychosocial variables may relate to stigma concealment and disclosure. Although theorists have long been developing distinct frameworks to link self-concealment with negative outcomes and self-disclosure with well-being (e.g., Larson & Chastain, 1990; Pennebaker, 1989, 2003), similar theoretical frameworks aiming to differentiate the mechanisms triggered by stigma concealment and disclosure processes have not been posited. The results of this study also help bridge the gap between stigma management scholarship and the larger secret-keeping and disclosure literature.

Although the study contributes to the existing literature on the management of indiscernible stigmatized identities, it has several limitations. The reliance on cross-sectional data does not allow one to draw conclusions regarding the direction of influence between stigma management processes and psychosocial outcomes. For instance, the relationship between stigma concealment and stigma disclosure can be interpreted in multiple ways. On the one hand, self-stigma may increase self-concealment, as a person with a negative opinion of their sexual orientation may feel more uncomfortable, ashamed, or fearful of sharing an identity that feels negatively valenced in society (Hill et al., 1993; Meyer, 2003). However, another interpretation is that self-concealment increases self-stigma by (a) isolating the concealing individual from the ameliorative experiences of meeting similar others or gaining social support from significant people in their life (Frable et al., 1998; Meyer, 2003) and (b) sending an implicit message to the concealer that, because this aspect of identity is worthy of hiding, it is inherently

shameful (Pachankis, 2007). Longitudinal or experimental research is needed to determine the direction of influence.

An additional limitation of this investigation relates to characteristics of the sample. This study relied upon empirical data concerning a single identity type (i.e., sexual minority status) to draw theoretical conclusions about the larger population of individuals with indiscernible stigmatized identities. Although this approach has been adopted in the past (e.g., Smart & Wegner, 1999), it raises questions about the generalizability of the study results. Because the study did not include individuals with other types of potentially invisible minority statuses (e.g., people living with HIV, undocumented immigrants, people with a mental illness, religious minorities), one is unable to confirm that the study results are generalizable to the larger population of individuals with indiscernible stigmatized identities. For example, distinct types of indiscernible stigmatized identities differ in numerous ways, including level of stigmatization in society, whether they are permanent or temporary, or whether they are likely to be known by (or present among) family members. Could these differences interfere with the generalizability of the study results? Although past research has not produced a theoretical framework to suggest differences in stigma management processes between various indiscernible identity groups, more research is necessary to understand if and how the association between stigma concealment and disclosure—as well as their respective relations to various psychosocial outcomes—may differ among individuals with different types of indiscernible identities.

A final limitation relates to potential biases in sampling. First, to recruit sexual minority participants for this study, researchers contacted LGB student organization

leaders and requested that they distribute a call for study participants to their membership via electronic listservs. Though this is a common practice in the recruitment of an LGB sample (e.g., Mohr & Kendra, 2011; Pachankis & Goldfried, 2010; Wright & Wegner, 2012), it may have skewed the distribution of stigma concealers and disclosers in the sample—characteristics that are of utmost centrality to the study. For example, it is likely that the sexual minority individuals that belong to LGB listservs are disproportionately comfortable with their sexual orientation, and therefore may be more likely to disclose (and less likely to conceal) their sexual minority status as compared to the larger LGB population. This recruitment bias may have been compounded by a response bias in which, of the LGB individuals who received the study announcement, those who were more comfortable with their sexual orientation identity were more likely to be interested in completing the survey. Outreach via electronic listservs make it nearly impossible to calculate a return rate. However, the study participants did, on average, demonstrate positive identity adjustment (e.g., low self-stigma, high membership esteem) in this study, which could serve as evidence of this response bias.

Implications for Future Research

The results of this study can help guide scholarship on stigma management among individuals with indiscernible identities in a number of ways. Take, for instance, the data that suggests stigma concealment and disclosure—as assessed in this study—were found to be negatively related but distinct constructs. These results may caution researchers against using stigma concealment and disclosure variables as proxies for one another, both in the measurement of stigma management processes or in the scientific discourse on these constructs. Relatedly, if interested in studying both concealing and disclosing

processes, researchers may want to avoid mixing concealment and disclosure items within a single instrument without differentiating these concepts into distinct subscales.

Based on these findings, researchers should rely upon a theory-driven rationale to decide whether it is most sensible to include a stigma concealment variable, a stigma disclosure variable, or both, within a given study. For example, this study suggests that both stigma concealment and disclosure variables may both uniquely predict identity adjustment outcomes (e.g., membership esteem, identity strength), suggesting that, at times, there is utility in considering multiple aspects of stigma management when attempting to predict these variables. That being said, as compared to stigma disclosure, this study also showed that a subset of criterion variables were (a) only predicted by stigma concealment (e.g., life satisfaction), (b) uniquely predicted by stigma concealment but not stigma disclosure (e.g., self-stigma), and (c) were better predicted by stigma concealment than stigma disclosure (e.g., depression). These findings can guide future researchers in selecting the strongest predictors of specific psychosocial outcomes. For example, based on the results presented in this study, researchers interested in predicting psychological health variables via a single stigma management strategy may be wise to focus on recent concealment behaviors rather than broader disclosure tendencies. Also, the fact that many of the identity-related criterion variables in the study were uniquely predicted by both stigma concealment and disclosure variables may encourage more researchers to include measures of both hiding and revealing processes in their studies of identity adjustment.

The aforementioned limitations of the study also highlight a number of additional directions for future research. First, studies that assess changes in stigma management

and psychosocial outcomes across time or via an experimental design can help clarify the directionality of relations between these variables. Also, studies that replicate the tests of these hypotheses among social groups based in identities other than sexual orientation may help determine how relations between stigma management and psychosocial outcomes vary among different populations of individuals with indiscernible identities. Finally, recruitment methods that reach individuals who are less adjusted to their stigmatized status and which allow for the tracking of a response rate is warranted.

Research is needed to determine whether the present results would have differed if other facets of stigma concealment and disclosure had been studied. Though this study selected two popular conceptualizations of stigma management, there are other dimensions of both identity concealment and disclosure that can be measured. Within future analyses, it would be useful to examine the relations between and among different conceptualizations of stigma concealment (e.g., general tendency to hide one's stigmatized status, concealment behaviors among family members) and disclosure variables (e.g., disclosure behaviors over the past two weeks, timing of first disclosure experience). It is important that researchers continue to explore how these variables uniquely or differentially predict psychosocial outcomes. Relatedly, another area for potential expansion relates to the outcomes studied. Future investigations should include criterion variables related to physical health, as past studies have illuminated relations between physical symptoms and stigma management processes (e.g., Cole et al., 1996b; Quinn & Chaudoir, 2009). It may be that stigma management processes link to factors of health (e.g., physical symptoms, HIV progression) in ways similar to the psychological health outcomes included in this study (e.g., depression), such that stigma concealment

and disclosure are inversely related to physical well-being, with stigma concealment being a significantly better predictor.

Finally, the idea that aspects of identity can be neatly categorized as discernible and indiscernible is misleading, as visibility likely exists on a continuum (Downie et al., 2006; Ginsberg, 1996; Shippee, 2011). Forms of identity traditionally assumed to be invisible (e.g., sexual orientation, social class, religion) can be more conspicuous depending on the personal (e.g., friend group, mannerisms), contextual (e.g., presence at identity-relevant establishments), and cultural factors (e.g., style of dress, wearing an identity-relevant signifier). Thus, future research concerning individuals with indiscernible stigmatized identities should assess the level of identity discernibility at the participant-level. Doing so may help yield greater understanding of how stigma management strategies are used differentially within groups traditionally understood to be indiscernible. It is also true that many social identity categories typically considered easily detectable (e.g., race, gender) are sometimes ambiguous, mutable, or invisible (a) among select group members or (b) during communications that do not occur in person, such as those that transpire via email, job applications, or online chat. The inclusion of less common indiscernible stigmatized identities (e.g., multi-racial people, transgender individuals) or among virtual communications may clarify if and how stigma management strategies are utilized differently among populations and in environments typically excluded from the literature of individuals with indiscernible identities.

Conclusion

Previous incarnations of stigma theory (e.g., Goffman, 1963; Jones et al., 1984) suggest that individuals with indiscernible stigmatized identities were able to dodge the

consequences of social stigma by managing the visibility of their membership within marginalized populations. However, a wealth of recent scholarship (e.g., Cain, 1991; Frable et al., 1998; Pachankis, 2007; Quinn, 2006) has highlighted that stigma management decisions may be rife with complex and interrelated benefits and consequences for individuals with indiscernible identities. A review of relevant literature on the consequences of stigma concealment and disclosure reveals that both stigma management strategies relate to factors of psychological health and identity adjustment. Despite these advances, a number of questions remained unanswered: Are stigma concealment and disclosure the mere opposites thing? Can either be used in the prediction of psychological health and identity adjustment? If not, which is better, and in the prediction of which variables? The present study offers a substantive contribution to the literature on individuals with indiscernible stigmatized identities by exploring how two specific stigma concealment and disclosure variables relate to each other and to various aspects of psychosocial functioning.

Tables

Table 1

Descriptive Statistic for Main Variables

Variable	<i>M</i>	<i>SD</i>	Possible range	Observed range	1	2	3	4	5	6	7	8
1. Stigma concealment	1.57	0.63	[1.00, 5.00]	[1.00, 5.00]	.90							
2. Stigma disclosure	1.91	0.54	[1.00, 4.00]	[1.00, 3.25]	-.47**	.79						
3. Depression	1.89	0.61	[1.00, 4.00]	[1.00, 3.80]	.27**	-.16*	.93					
4. Life satisfaction	4.69	1.41	[1.00, 7.00]	[1.00, 7.00]	-.20**	.024	-.56**	.89				
5. Self-stigma	1.97	1.18	[1.00, 6.00]	[1.00, 6.00]	.36**	-.28**	.20**	-.18**	.87			
6. Acceptance concerns	3.30	1.26	[1.00, 6.00]	[1.00, 6.00]	.42**	-.26**	.39**	-.27**	.36**	.78		
7. Membership esteem	4.71	1.02	[1.00, 6.00]	[1.00, 6.00]	-.36**	.40**	-.19**	.09	-.37**	-.21**	.80	
8. Identity strength	4.54	0.95	[1.00, 6.00]	[1.21, 6.00]	-.36**	.37**	-.07	.08	-.47**	-.14*	.75**	.92

Note. Means, standard deviations, and ranges are based on untransformed scales. Correlations are based on the transformed scales used in the main analyses. Scale internal consistency reliability estimates appear in the diagonal.

* $p < .05$. ** $p < .01$.

Table 2

Multiple Regression Models Predicting Psychological Health and Identify Adjustment From Stigma Management Processes

Variable	β	SE	$t(298)$	sr^2
Depression ($R^2 = .073$)				
1. Stigma concealment	.26	.06	4.11*	.05
2. Stigma disclosure	-.01	.07	-.16	-.00
Life satisfaction ($R^2 = .043$)				
1. Stigma concealment	-.53	.15	-3.59*	.04
2. Stigma disclosure	-.19	.17	-1.11	.00
Self-stigma ($R^2 = .15$)				
1. Stigma concealment	.22	.05	4.33*	.05
2. Stigma disclosure	-.18	.06	-2.89*	.02
Acceptance concerns ($R^2 = .18$)				
1. Stigma concealment	.78	.12	6.39*	.11
2. Stigma disclosure	-.14	.14	-.98	.00
Membership self-esteem ($R^2 = .20$)				
1. Stigma concealment	-.34	.10	-3.50*	.03
2. Stigma disclosure	.57	.11	5.03*	.07
Identity strength ($R^2 = .19$)				
1. Stigma concealment	-.31	.09	-3.45*	.03
2. Stigma disclosure	.53	.11	4.95*	.07

Note. $N = 298$.

* $p < .017$.

Appendices

Appendix A: Sexual Orientation Concealment Scale (SOCS; Blair, 2006)

The following six items concern behaviors LGB people sometimes use to hide their sexual orientation. Please rate each item to complete the following phrase:

In the last 2 weeks, I have...

Not at all	A little bit	Somewhat	Very much	All the time
<input type="checkbox"/>				

1. ...concealed my sexual orientation by telling someone that I was straight or denying that I was LGB.
2. ...concealed my sexual orientation by avoiding contact with other LGB individuals.
3. ...avoided the subjects of sex, love, attraction, or relationships to conceal my sexual orientation.
4. ...allowed others to assume I am straight without correcting them.
5. ...altered my appearance, mannerisms, or activities in an attempt to “pass” as straight.
6. ...remained silent while witnessing anti-gay remarks, jokes, or activities because I did not want to be labeled as LGB by those involved.

Appendix B: Outness Inventory (OI; Mohr & Fassinger, 2000)

Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below.

1 =	person <u>definitely</u> does NOT know about your sexual orientation status
2 =	person <u>might</u> know about your sexual orientation status, but it is NEVER talked about
3 =	person <u>probably</u> knows about your sexual orientation status, but it is NEVER talked about
4 =	person <u>probably</u> knows about your sexual orientation status, but it is RARELY talked about
5 =	person <u>definitely</u> knows about your sexual orientation status, but it is RARELY talked about
6 =	person <u>definitely</u> knows about your sexual orientation status, and it is SOMETIMES talked about
7 =	person <u>definitely</u> knows about your sexual orientation status, and it is OPENLY talked about
0 =	not applicable to your situation; there is no such person or group of people in your life

1. mother	1	2	3	4	5	6	7	0
2. father	1	2	3	4	5	6	7	0
3. siblings (sisters, brothers)	1	2	3	4	5	6	7	0
4. extended family/relatives	1	2	3	4	5	6	7	0
5. my <u>new</u> straight friends	1	2	3	4	5	6	7	0
6. my work peers	1	2	3	4	5	6	7	0
7. my work supervisor(s)	1	2	3	4	5	6	7	0
8. members of my religious community (e.g., church, temple)	1	2	3	4	5	6	7	0
9. leaders of my religious community (e.g., church, temple)	1	2	3	4	5	6	7	0
10. strangers, new acquaintances	1	2	3	4	5	6	7	0
11. my <u>old</u> heterosexual friends	1	2	3	4	5	6	7	0

Appendix C: Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977)

Below is a list of the ways you might have felt or behaved. Please check off how often you have felt this way during the past week.

Rarely or none of the time (less than 1 day this week)	Some or a little of the time (1-2 days this week)	Occasionally or a moderate amount of the time (3-4 days this week)	Most or all of the time (5-7 days this week)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. I was bothered by things that usually don't bother me.
2. I felt that I could not shake off the blues even with help from my family or friends.
3. I had trouble keeping my mind on what I was doing.
4. I felt depressed.
5. I felt hopeful about the future.
6. I felt that people dislike me.
7. I felt lonely.
8. People were unfriendly.
9. I was happy.
10. I enjoyed life.
11. I did not feel like eating; my appetite was poor.
12. I felt that everything I did was an effort.
13. I talked less than usual.
14. I felt fearful.
15. I could not get "going."
16. I had crying spells.
17. I felt that people disliked me.
18. I felt sad.
19. My sleep was restless.
20. I felt that I was just as good as other people.

Appendix D: Satisfaction With Life Scale (SWLS; Diener et al., 1985)

Please indicate how much you agree or disagree with each of the following statements.

Strongly Disagree	Disagree	Disagree Somewhat	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. In most ways, my life is close to my ideal
2. The conditions of my life are excellent
3. I am satisfied with my life
4. So far I have gotten the important things I want in life
5. If I could live my life over, I would change almost nothing

Appendix E: Internalized Homonegativity Subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS, Mohr & Kendra, 2011)

For each of the following statements, mark the response that best indicates your experience as a lesbian, gay, or bisexual (LGB) person. Please be as honest as possible in your responses.

Disagree Strongly <input type="checkbox"/>	Disagree <input type="checkbox"/>	Disagree Somewhat <input type="checkbox"/>	Agree Somewhat <input type="checkbox"/>	Agree <input type="checkbox"/>	Agree Strongly <input type="checkbox"/>
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1. If it were possible, I would choose to be straight.
2. I wish I were heterosexual.
3. I believe it is unfair that I am attracted to people of the same sex.

Appendix F: Acceptance Concerns Subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011)

For each of the following statements, mark the response that best indicates your experience as a lesbian, gay, or bisexual (LGB) person. Please be as honest as possible in your responses.

Disagree Strongly <input type="checkbox"/>	Disagree <input type="checkbox"/>	Disagree Somewhat <input type="checkbox"/>	Agree Somewhat <input type="checkbox"/>	Agree <input type="checkbox"/>	Agree Strongly <input type="checkbox"/>
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1. I often wonder whether others judge me for my sexual orientation.
2. I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
3. I think a lot about how my sexual orientation affects the way people see me.

Appendix G: Membership Esteem Subscale of the Race-Specific Collective Self-Esteem Scale (CSES; Crocker et al., 1994)

The following items concern your identity as an LGB person. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions.

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
<input type="checkbox"/>					

1. I am a worthy member of the LGB community.
2. I feel I don't have much to offer the LGB community.
3. I am a cooperative member in the activities of LGB communities.
4. I often feel I'm useless as compared to other LGB people.

Appendix H: Modified Sexual Identity Version of the Ethnic Identity Scale of the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992)

Please respond to the following items related to your connection to LGB communities.

Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Strongly Agree
<input type="checkbox"/>					

1. I have spent time trying to find out more about the LGB community.
2. I am active in organizations or social groups that include mostly LGB people.
3. I have a clear sense of my sexual orientation and what it means for me.
4. I think a lot about how my life will be affected by my sexual orientation.
5. I am happy that I am a member of the LGB community.
6. I am not very clear about the role of my sexual orientation in my life.
7. I really have not spent much time trying to learn more about the culture and history of the LGB community.
8. I have a strong sense of belonging to the LGB community.
9. I understand pretty well what being a part of the LGB community means to me, in terms of how to relate to LGB people and straight people.
10. In order to learn more about LGB culture, I have often talked to other people about LGB culture.
11. I have a lot of pride in the LGB community and its accomplishments.
12. I participate in LGB cultural practices, such as pride events, benefits, or marches.
13. I feel a strong attachment towards the LGB community.
14. I feel good about being a part of the LGB community.

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