**IUL School of Social Sciences**

Department of Social and Organizational Psychology

# I Am Because We Are: In-Group Identification and Perceived Social Support as a Social Cure for Sexual Minorities, A Cross-Cultural Comparison

Gustavo Alberto Aybar Camposano

Dissertation submitted as partial requirement for the conferral of

*Erasmus Mundus European Master in the Psychology of Global Mobility, Inclusion and Diversity in Society*

Supervisors:

Dr. Carla Moleiro, Associate Professor,

ISCTE - Lisbon University Institute (ISCTE- IUL)

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Dr. Erik Carlquist, Associate Professor,

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**ABSTRACT**

A growing body of research shows that social identities have a profound impact on health-related outcomes. However, the relationships between identity and health are complex and may be complicated by stigmatization and the social-cultural context. This is the case for sexual minorities, where on one hand their identity can lead to adverse mental health outcomes but on the other, they can unlock psychological resources. The present research examines if an LGBT+ identity can provide a "social cure" to buffer the effects of perceived discrimination against the psychological health of sexual minorities by exploring how (1) in-group identification and perceived social support from the LGBT+ community may mediate this relationship, and (2) these relationships differ across collectivistic and individualistic societies. Participants ($n$ = 441) from collectivistic (the Dominican Republic and Portugal) and individualistic (the United States of America, the Republic of Ireland) countries completed measures of perceived discrimination, LGBT+ in-group identification, LGBT+ perceived social support and psychological health. Serial mediation analysis indicated that the negative relationship between perceived discrimination and psychological health mediated by in-group identification and perceived social support from the LGBT+ community. Subsequent analysis revealed that there was evidence of a combined mediation effect on the collectivistic sample but not in the individualistic one. Findings revealed that the social identity processes in sexual minority individuals may buffer the effects of perceived discrimination through their LGBT+ identity, and the cultural context may influence how sexual minorities relate to the LGBT+ community.

*Keywords:* Social Identity, Social Cure, Sexual Minorities, LGBT, Perceived Discrimination, Psychological Health, Social Support.

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## GLOSSARY OF ACRONYMS

**LGB** – Lesbian, Gay, and Bisexual.

**LGBT+** - Lesbian, Gay, Bisexual, Transgender, plus other sexual and gender identities.

**RIM** – Rejection Identification Model.

**SIA** – Social Identity Approach.

**WEIRD** - Western, Educated, Industrialized, Rich, and Democratic countries.

## INTRODUCTION

Human beings are social beings, meaning that the social relationships that people build with others are not only reflective of who they are as a person, but they may even bring long-lasting benefits to their health. Evidence suggests that the quality and quantity of people's social relationships are associated with an increased 50% likelihood of survival and the magnitude of this effect is equivalent to quitting smoking (Holt-Lunstad, Smith, & Layton, 2010). A word that encompasses the importance of social connections in the lives of humans is the word *ubuntu,* which derives from the South African Xhosa/Zulu culture and Nguni language and roughly translates to "a person is a person through other persons" or better described as "I am because you are" (Gade, 2012). *Ubuntu* is more than just a word, it is a philosophy, that embraces the idea that humans depend on and derive their identities from the connections, bonds, and community they form with others (Oppenheim, 2012), which in turn provides them with the security and sustenance that is needed to develop beyond simple survival needs (Naidoo, 2010). The meaning of the word *ubuntu* captures the core elements of the present study – how social relationships, social networks, social support, and social identities have a profound impact on health-related outcomes – better known as the "social cure" (Jetten, Haslam, & Haslam, 2012).

The social cure framework is based on the social identity approach (SIA), consisting of the social identity theory (Tajfel & Turner, 1979) and the self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). The key idea is that group memberships are internalized and become social identities that contribute to people's sense of self (S. A. Haslam, Jetten, Postmes, & Haslam, 2009). These social identities are profoundly intertwined with people's self-understanding and behaviors and can have important health-related outcomes (Jetten et al., 2017). However, as the body of research in the field of the social cure framework has grown, it has shown both the enhancing and damaging health consequences of social identities (Muldoon et al., 2017).

For instance, social identities can enhance the health of individuals by providing them with positive psychological resources such as self-esteem, belonging, meaning, and a sense of purpose, control, and efficacy in life (e.g., see Bobowik, Martinovic, Basabe, Barsties, & Wachter, 2017; Greenaway et al., 2015; C. Haslam, Cruwys, & Haslam, 2014; C. Haslam et al., 2008; S. A. Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Jetten et al., 2015, 2017) However, when group memberships that define an individual are not associated with positive psychological resources or are compromised by stigma, low status, or failure, the social

identities that derive from these groups may become threatening and potentially harm the health and well-being of group members, also known as the "social curse". The social curse can be present in groups that: (1) promote toxic and unhealthy norms (2) do not provide social support, and (3) are socially devalued (Jetten et al., 2017) (e.g., see Dingle, Stark, Cruwys, & Best, 2015). Therefore, the relationship between health-related outcomes and social identities seem to be influenced not only by the type of group to which one belongs but also to the broader socio-structural context in which these identities are at play, thus making the relationship between social identities and health complex.

The complexity of the relationship between health and social identity increases when referring to stigmatized groups. On one hand, individuals who belong to stigmatized groups find it particularly difficult to derive a positive identity from their group membership, due to it being the basis for threats to their health; on the other hand, when individuals turn to stigmatized groups, they may draw positive psychological resources and social support from others allowing them to counteract those same threats (Jetten, Haslam, Cruwys, & Branscombe, 2018). However, the interplay between social identities, stigma, and health have been understudied in groups such as sexual minorities. In addition to this, psychological research has been mostly conducted on Western, Educated, Industrialized, Rich, and Democratic (WEIRD) countries (Henrich, Heine, & Norenzayan, 2010), and in particular, the LGBT+ literature is still predominantly Anglo-American (Ozeren, Ucar, & Duygulu, 2016). In sum, there seems to be a lack of understanding regarding the impact of culture on the health-related outcomes (Rüdell & Diefenbach, 2008) of sexual minority individuals in different parts of the world.

In order to address some of the aforementioned shortcomings, the present study was developed in an attempt to fill some of the gaps in the literature and generate evidence by expanding on the understanding of the social cure and the role of culture in the health LGB individuals. To do so, this study aims to explore the role of social identity processes such as in-group identification and perceived social support with the LGBT+ community as possible mediators that may help buffer the negative effects of perceived discrimination on the psychological health of sexual minority individuals. Lastly, the influence of different cultural contexts was also taken into consideration as a way to explore if the mediation effect differs across collectivistic (the Dominican Republic and Portugal) and individualistic countries (the United States of America and the Republic and Ireland) based on Hofstede's 2001 cultural dimensions.

# CHAPTER #1: LITERATURE REVIEW

## 1.1 Social Identity, Stigma & Psychological Health

The concept of stigma in the context of the SIA was coined by Crocker, Major, and Steele, (1998) and it is conceptualized as "some attribute or characteristic that conveys a social identity that is devalued in a particular social context" (p. 505). Stigma can arise from any type of group membership such as gender, ethnicity, sexual orientation, ability status, age, and even health condition, and can have negative consequences for members of these groups. As a result, recent research has been making important advances as a means to understand the relationship between stigmatized group membership and health (Jetten et al., 2018).

Considerable evidence has been accumulated emphasizing the adverse effects of stigma on the health and well-being of stigmatized groups and the health discrepancies between minority and non-minority group members (Pascoe & Richman, 2009; Schmitt, Postmes, Branscombe, & Garcia, 2014). Differences between stigmatized and non-stigmatized groups have been attributed to stressors associated with: (1) stigma-related exclusion in important life domains such as education, housing, and employment (Jetten et al., 2018), (2) perceived discrimination (Schmitt et al., 2014), and (3) pervasiveness of the discriminatory treatment across time and contexts (Branscombe, Fernández, Gómez, & Cronin, 2012). Even though the experiences of stigma are associated with poorer health and well-being for stigmatized group members, it is important to distinguish between *objective* encounters from the *subjective* interpretation of stigma and discrimination (Paradies, 2006). Encountering discrimination and perceiving oneself as a target of discrimination may be conceptualized as two different experiences and might also have distinctive consequences for the well-being of stigmatized individuals (Schmitt et al., 2014).

### 1.1.1 Perceived Discrimination.

Perceived discrimination is defined by Schmitt and colleagues (2014) as "the consequences of the subjective perception that one faces discrimination" (p. 1) and has been linked to negative health outcomes in stigmatized groups. For instance, there is evidence that those who perceive themselves as a target of discrimination tend to suffer disproportionality not only from physiological (e.g., cardiovascular diseases, immune disturbances, diabetes, physical disabilities) but also from psychological (e.g., lower self-esteem, depression, anxiety and post-traumatic stress disorder) (Matheson & Anisman, 2012; Pascoe & Richman, 2009; Schmitt et al., 2014) disturbances. The latter seems to be particularly true in a wide variety of

social groups such as (1) women (Klonoff, Landrine, & Campbell, 2000; Schmitt, Branscombe, Kobrynowicz, & Owen, 2002), (2) racial minorities (Branscombe, Schmitt, & Harvey, 1999), and (3) sexual minorities (Herek, Gillis, & Cogan, 1999; Mays & Cochran, 2001). The reasons behind are likely due to the complex and multidimensional nature of social identities, which in the case of minority groups, are often understudied and misunderstood (e.g., Egan & Perry, 2001; Morgan, 2013; Sellers, Smith, Shelton, Rowley, & Chavous, 1998).

Furthermore, important evidence showed that perceived discrimination does not affect the psychological health of all groups to the same extent (Jetten et al., 2018). For instance, the meta-analysis conducted by Schmitt and colleagues (2014) encountered that the negative and significant relationship between perceived discrimination and psychological well-being ($r$ = .23) was significantly larger for disadvantaged groups ($r$ = .24) in comparison to advantaged groups ($r$ = .10). For disadvantaged groups, discrimination is perceived as pervasive, uncontrollable and reflective of generalized exclusion and devaluation towards their stigmatized identity, while for the advantage group is non-pervasive, controllable and attributed to an aspect of the self (Schmitt & Branscombe, 2002). Additionally, the meta-analysis also suggests that the relationship between perceived discrimination and psychological health may be more pronounced depending on which type of minority or stigmatized group one belongs to. For example, stronger relationships were found for individuals such as sexual minorities in comparison to those groups who face discrimination based on gender or race (Schmitt et al., 2014).

The previous findings are important because they highlight that the: (1) psychological health is heavily influenced by the pervasiveness of the perceived discrimination, (2) perceived discrimination is experienced differently for advantaged and disadvantaged groups, and (3) relationship between perceived discrimination and health depends on the type of stigmatized group to which one belongs (Schmitt et al., 2014). The aforementioned prompts the idea that in order to better understand the relationship between stigma and health, researchers need to explore more closely group dynamics, group memberships and the identities that derive from them (Jetten et al., 2018), to comprehend how particular groups, such as sexual minorities, make use of different strategies to cope with perceived discrimination.

### 1.1.2 Sexual Minority Identity.

The concept of sexual minorities can be described as an umbrella term to represent individuals who identify as lesbian, gay or bisexual (LGB). Even though sexual minorities are

quite a diverse group and the experiences of stigma, stress and coping may vary across its members, there is still an important number of similarities drawing them together (Pachankis & Lick, 2018). For instance, the exposure of sexual minorities to unique stigma-related stressors that can have adverse impacts on their health and well-being (Woodell, 2018). The aforementioned has been well documented in the literature, as there are several studies showing that LGB individuals have increased risk for psychiatric morbidity (e.g., Cochran, Mays, & Sullivan, 2003; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; King et al., 2008; Mays & Cochran, 2001; Meyer, 2003; Sandfort, de Graaf, Bijl, & Schnabel, 2001). Compared with their heterosexual counterparts', sexual minorities are at greater risk to suffer from anxiety and mood disorders (Bostwick, Boyd, Hughes, & McCabe, 2010; Cochran et al., 2003), substance abuse disorders (Cochran, Ackerman, Mays, & Ross, 2004; Cochran, Keenan, Schober, & Mays, 2000; K. E. Green & Feinstein, 2012) eating disorders (Koh & Ross, 2006; Russell & Keel, 2002), suicidal ideation and self-harm (King et al., 2008). Even though the previous findings seem consistent across countries (e.g., Kuyper & Fokkema, 2011; Safren et al., 2009), research and cross-cultural works outside of the WEIRD context are very much limited (Kite, Togans, & Schultz, 2019).

Sexual minorities-based inequalities regarding mental health outcomes have commonly been attributed to the stressful social environment elicited by the exposure to stigma, prejudice, discrimination, and violence (Kertzner, Meyer, Frost, & Stirratt, 2009). Based on this premise, theories such as the minority stress model (Meyer, 1995, 2003) have become prominent in the sexual minority health literature. The minority stress model indicates that negative psychological health outcomes are due to LGB individuals being exposed to distal and proximal causes of distress and specific stressors due to their minority position (Kertzner et al., 2009). According to this model, distal causes of stress are objective events of discrimination and violence, while proximal (or subjective) stressors account for the individual perception of the discriminatory treatment (Meyer, 2003). The latest includes (1) expectation and vigilance of the expectation to be rejected and stigmatized (perceived discrimination), (2) internalization of negative social attitudes (internalized homophobia), and (3) concealment of one's sexual orientation (Meyer, 2003). The present study focuses on the distal and subjective consequences outlined by the minority stress model, particularly, on the subjective perceptions and expectations of sexual minorities face for being discriminated against due to their sexual orientation.

In the case of sexual minorities, it can be theorized that at the intersection of perceived discrimination and psychological health is the interplay of social identity processes associated

with the LGBT+ community. Social identity literature suggests that the experiences of stigma-related stressors are profoundly shaped by group membership and identification with the ingroup (S. A. Haslam & Reicher, 2006). Thus, it is within the scope of the present study to explore how sexual minority can unlock the curative powers of group membership (see Jetten et al., 2018) while mounting self-enhancing structures to counteract subjective experiences of minority stress (see Meyer, 2003).

## 1.2 A Social Cure for Sexual Minorities

Sexual minority group membership and status are not only associated with being the target of stress and exclusion (Meyer, 2003) but also, there is evidence suggesting that they may be a great source of psychological resources such as social support, social connectedness, group solidarity and cohesiveness that helps counteract the adverse effects of perceived discrimination (Branscombe et al., 1999; Crocker & Major, 1989; Haslam, Reicher, & Levine, 2012; Jetten et al., 2012, 2018; Levine, Prosser, Evans, & Reicher, 2005; Miller & Kaiser, 2001). These contradicting forces indicate that stigmatized group membership and the social identities derived from them may play an important double-edged role (Seagal, 2001) in the interaction between perceived discrimination and psychological health outcomes. Despite the fact that the aforementioned seems to be paradoxical, it stresses the idea that for stigmatized groups their social identities can be both a threat ("curse") or a solution ("cure") in helping them cope with negative effects of group membership on health and well-being (Jetten et al., 2018, 2017). In other words, for sexual minorities to obtain the benefits of their group membership*,* increased identification with the stigmatized attribute (their LGB identity) and social support from its members seems "the way to go" to unlock the social cure.

### 1.2.1 In-Group Identification.

As early as the 50's, Allport (1954) indicated that members of stigmatized groups tend to respond to stigma with coping and resilience, and sexual minorities are not the exception. LGB individuals seem to employ a variety of coping mechanism and establish alternative structures to buffer the negative psychological outcomes of stigma (Meyer, 2003). However, which coping strategy is employed depends on the individual's level of identification with the disadvantaged group in question (e.g., LGBT+ community) (Branscombe & Ellemers, 1998) and the contextual conditions in which the group is situated (Branscombe et al., 2012). Such conditions refer to the group's (1) stability of its position, (2) legitimacy of its social status, and (3) permeability of its boundaries (Jetten et al., 2017; Verkuyten & Reijerse, 2008). In contexts such as the United States, sexual minority individuals that consider their position as

changeable (instability) and unacceptable (illegitimate) tend to engage in collective and political movements in order to change it. In countries like the Dominican Republic, many LGB individuals perceive their status as legitimate due to the lack of protection from the country's legal framework and the condemnation of religious beliefs, which forces many to "convert" or "pass*"* as heterosexuals (permeability). As illustrated in the previous examples, the context impacts the way sexual minorities relate to their in-group but also how they engage in individual or collective strategies.

Minority or disadvantaged group members use coping strategies such as increasing identification with one's stigmatized group (collective coping strategies) or do exactly the opposite, distancing oneself from the group (individual coping strategies) (Major & O'Brien, 2005). Individual coping strategies emphasize, figuratively or literally, detaching from the devalued group by minimizing, hiding, or overcoming the stigmatizing characteristic as a means to be accepted or "pass*"* as a member of non-stigmatized group with the goal to protect the individual's personal self (also known as social mobility) (Branscombe et al., 2012). An example of individual coping strategies, in the case of sexual minorities, can be depicted when LGB individuals make the effort to try to "pass" as heterosexual in different contexts such as the in the workplace to avoid being identified as LGB. In contrast, collective strategies focus on moving towards and identifying with the stigmatized group as a means to positively redefine the stigmatized attribute, draw social support from it by taking pride in its own group and promoting social justice (Branscombe et al., 2012; Nario-Redmond, Noel, & Fern, 2013). For example, LGB individuals getting involved with LGB community centers and joining support and advocacy groups as a way to cope with discrimination.

Even though both individual and collective coping strategies can be viable means by which minority members protect themselves from social devaluation (Ellemers, Spears, & Doosje, 1997), socio-structural conditions may facilitate the employment of one strategy over the other. For instance, there is evidence suggesting that stigmatized group members may be more inclined to employ individual coping strategies when (1) discrimination is limited to specific contexts or in periods of time in the life of the individual, (2) the discriminatory treatment is seen as legitimate, (3) there is limited contact with other group members who share the stigma, and/or (4) the existing social condition is perceived as unchangeable but the stigma itself can be concealed (Branscombe et al., 2012). On the other hand, when the stigmatized attribute cannot be concealed and the discriminatory treatment is pervasive across context and time, stigmatized groups are more inclined to employ collective coping strategies (Branscombe et al., 2012). Nevertheless, stigmatized groups and identities are not all equal,

therefore suggesting that contextual conditions may impact different groups in various ways. In the case of sexual minorities, the (1) relatively concealable of the LGB identity (Bry, Mustanski, Garofalo, & Burns, 2017), (2) pervasive experiences of discrimination across contexts (e.g., Pizer, Sears, Mallory, & Hunter, 2012), and (3) heterogeneity within the LGB population (Fish, 2006) may lead to distinctive coping strategies such as increasing their identification with the LGBT+ community.

As Muldoon and colleagues (2017) said: "not only does misery loves company but company can militate against misery" (p. 901). The aforementioned is the premise of the rejection-identification model (RIM) (Branscombe et al., 1999), which states that group-based discrimination encountered by stigmatized individuals can be counteracted by increased identification with the minority group in question. According to the RIM, minority group members reject the culture and cycle of stigmatization and decide to identify with other members of the same group rather than the dominant group (Bogart, Lund, & Rottenstein, 2018; Branscombe et al., 1999). In the case of sexual minorities, this may suggest that LGB individuals may be inclined to identify with the LGBT+ community as opposed to heterosexuals. As outlined by the RIM, increased identification with the minority group in question is key to understand the relationship between health, stigma and social identity. Thus, it is through increased identification that the group memberships are internalized as part of the individual's social identity (e.g., LGBT+ identity) which in turn influences people's health-related outcomes and the ways they relate with their in-group (Jetten et al., 2018).

Group membership can impact mental health outcomes in two ways. First, minority members with a stronger sense of connectedness and cohesiveness with their group are more inclined to evaluate themselves in terms of their in-group (e.g. LGB individuals) in opposition to the dominant culture (e.g., heterosexism) (Meyer, 2003). In other words, it is more likely for the in-group of sexual minorities to favor reappraisals of the stressful conditions (Meyer, 2003) and benefit from LGB affirmative values and norms (Meyer & Dean, 1998). Therefore, it is through reappraisal that the in-group validates deviant experiences and feelings of minority individuals (Thoits, 1985) and slowly brings back the power to the stigmatized group. Secondly, it is through increased group identification that the minority group in question may unlock positive psychological resources that make minority individuals feel (1) more connected towards members of their group and (2) supported and responsible for the support of their fellow in-group members (Jetten et al., 2018). The aforementioned seems consistent with research suggesting that increased inclusion and belonging with a group that provides social support has a buffering effect against the negative consequences of out-group

rejection (Ramos, Cassidy, Reicher, & Haslam, 2012) and a positive impact on self-esteem (Bogart et al., 2018; Crabtree, Haslam, Postmes, & Haslam, 2010). In sum, increased identification with the minority group in question may help foster sentiments and positive psychological resources among its members, which in turn will allow minority individuals to provide and receive effective social support from their in-group (Branscombe et al., 1999; S. A. Haslam et al., 2012; Tajfel & Turner, 1979).

**1.2.2 Social Support.**

Social support is an important resource, influential in the successful negotiation of the many forms of stress that people encounter throughout their lives (Thoits, 1995). In the context of LGB individual, social support can help sexual minorities to buffer against the adverse consequences of perceived discrimination (Meyer, Schwartz, & Frost, 2009). For instance, studies have demonstrated the positive impact that social support, provided by shared group membership and identification, has on the well-being of LGB individuals (Domínguez-Fuentes, Hombrados-Mendieta, & García-Leiva, 2012). This effect can be observed across different LGB subpopulation such as youth (Friedman, Koeske, Silvestre, Korr, & Sites, 2006; McConnell, Birkett, & Mustanski, 2015; McDonald, 2018; Williams, Connolly, Pepler, & Craig, 2005), young adults (Snapp, Watson, Russell, Diaz, & Ryan, 2015; Vincke & van Heeringen, 2004), and aging individuals (over the age of 50) (Masini & Barrett, 2008), and across ethnical groups (Frost, Meyer, Schwartz, 2016) such as Black Americans (e.g., Tate, Van Den Berg, Hansen, Kochman, & Sikkema, 2012), Latino Americans (e.g., Rios & Eaton, 2016; Snapp et al., 2015), and Asian Americans (Sung, Szymanski, & Henrichs-Beck, 2015). In addition, research on the effects of LGB social support on the psychological health of sexual minorities have been observed in different countries such as Belgium (Vincke & van Heeringen, 2004), Australia (Morandini, Blaszczynski, Dar-Nimrod, & Ross, 2015), China (Liu et al., 2011) Hong Kong (Chong, Zhang, Mak, & Pang, 2015), Turkey (Toplu-Demirtaş, Kemer, Pope, & Moe, 2018), Germany (Sattler, Wagner, & Christiansen, 2016), Spain (Domínguez-Fuentes et al., 2012) and Croatia (Kamenov, Huić, & Jelić, 2015).

In the same vein, evidence shows that when individuals with concealable stigmas are in the presence of similar others, like someone who shares their stigmatized identity/attribute, their psychological well-being improves (Frable, Platt, & Hoey, 1998). For example, some findings indicate that community and psychological connectedness to the LGB community provides a positive effect on the mental health and well-being of LGB individuals (Kertzner et al., 2009). In addition, participation and engagement within one's local LGB community have

also been found to ameliorate the negative impact of perceived discrimination (Frost & Meyer, 2012; Kertzner et al., 2009). In sum, in order to overcome the adverse effects of stigma, it is important for sexual minorities to establish new social networks, cultivate a positive in-group minority identity, and revise heterosexually-based social norms (Frost & Meyer, 2009; Kertzner et al., 2009; Meyer & Dean, 1998).

Overall, even if minority groups experience individual and collective adversities, such experiences can create the foundations for a group such as sexual minorities to counteract stigma by increasing group identification. By doing so, stigmatized group memberships and identification can protect psychological health outcomes by providing minority members with the opportunity to (1) reappraise the stigmatized condition or attribute and (2) provide psychological resources such as social support that buffer the individual's health when confronted with challenges. However, there is research in cultural and cross-cultural psychology outlining that how individuals relate and seek social support from their in-group may differ depending on the cultural framework (Wang & Lau, 2015).

### 1.3 The Role of Culture: Individualism, Collectivism & Social Identity

The concept of culture has been considered by some authors like Triandis, Villareal, Asai, and Lucca, (1988) as "a fuzzy construct" (p. 323), meaning that there are many ways of understanding and measuring culture. Within social psychology, one of the most successful ways to analyze the relationship between culture and the individual is by determining variation across cultural dimensions (Triandis et al., 1988). Throughout the years there have been various models that have conceptualize and examine cultural dimensions (e.g., Hofstede, 2001; Schwartz, 2004), however, one of the most promising ones have been the individualism and collectivism values (Matsumoto et al., 2008). From the different dimensions and values used to examine culture, individualism and collectivism have been not only one of the most researched (see Oyserman, Coon, & Kemmelmeier, 2002) but also the one (1) with greatest predictive power (Beugelsdijk & Welzel, 2018), (2) relevant for understanding cultural differences in social relationships (Lam et al., 2018), and (3) been found to define the self and emphasize collective or individual aspects (Triandis et al., 1988).

Even though there are countless ways to define individualism and collectivism, the present study focuses on how it was operationalized by Hofstede (2001). Hofstede's (2001) introduction of the individualism and collectivism dimensions has not only been central in the field of cross-cultural research but was well helped triggered an explosion of empirical studies about the impact of culture (Cozma, 2011). In his perspective, culture can be conceptualized as "the collective programming of the mind that distinguishes the members of one group or

category of people from other" (Hofstede, Hofstede, & Minkov, 2010, p. 6). Culture can be manifested in a series of values, beliefs, norms, and patterns of behaviors (Hofstede, 2001) such as the ones described by the construct of individualism and collectivism.

Individualism or individualistic societies (e.g., North America, Western Europe, and Australia) often display a preference of being autonomous, unique, self-reliant, competitive and achievement-oriented (Chen & West, 2008; E. G. T. Green, Deschamps, & Páez, 2005; Oyserman et al., 2002; Triandis, 1995). Therefore, individualistic countries tend to emphasize the importance of "I" by valuing their self as independent of collectives (Markus & Kitayama, 1991, 2010). In contrast, collectivism or collectivistic societies (e.g., South America, Africa, and Asia) emphasize the importance of the "we" by seeing themselves as closely linked or interdependent to one or more collectives (e.g., family) (Markus & Kitayama, 1991, 2010) while valuing social harmony, emotional dependence and following the norms and duties of the in-group (Chen & West, 2008; E. G. T. Green et al., 2005; Oyserman et al., 2002; Triandis, 1995). Individualism and collectivism have been used to explain, describe and even predict cultural differences in various areas of psychological functioning (e.g., self-concept, personality traits, well-being, emotions, group relationship,, among other) (see Oyserman et al., 2002) and have served as the basis of important theories within the field of psychology (e.g., the self-construal theory) (Markus & Kitayama, 1991).

Some authors suggest that how individuals relate with, identify with and seek support from social groups may be embedded in cultural values and therefore may vary across collectivistic and individualistic societies (Brewer & Yuki, 2007). Individuals within individualistic societies tend to develop new relationship easily, they are more "voluntary" and are inclined to form/leave groups according to their personal goals (Lam et al., 2018; Oyserman et al., 2002; Yuki & Takemura, 2014). On the contrary, individuals with collectivistic orientations tend to view their groups as fixed, their relationship are usually more "given" and embedded in mutual obligation and the maintenance of harmony, prompting them to remain with their group(s) (even if they are no longer beneficial to the individual) (Lam et al., 2018; Oyserman et al., 2002; Yuki & Takemura, 2014).

Based on the aforementioned, it can be inferred that collectivistic cultures would form stronger relationships with their in-group through identification and social support, however, research has yield mixed results (Lam et al., 2018). On the one hand, lower identification with one's group is associated with a more "individualistic" attitudes towards the group (e.g., disassociation from the group) while higher identification is linked with a more "collectivistic" ones (Jetten, Postmes, & McAuliffe, 2002). Additionally, evidence suggests

that people in different cultures differ in their willingness to seek social support and how much they benefit from it (Kim, Sherman, Ko, & Taylor, 2006). Research shows that individualistic individuals (European American) benefit more from explicit social support and are more willing to seek help to cope with immediate stressors in comparison to collectivistic ones (Asian American) (Kim et al., 2006; Taylor et al., 2004; Taylor, Welch, Kim, & Sherman, 2007). Other research highlights that Asian American participants benefit more from social support when it was perceived as mutual and when support came from their peers rather than their parents (Wang & Lau, 2015).

Literature regarding the social cure analyzed through the scope of individualism and collectivism cultural orientations is limited. Nevertheless, the few studies that have explored the relationship between group membership, culture and health have also highlighted how social identity processes may differ across cultural contexts. For instance, one study conducted by Muldoon and colleagues (2017) provided empirical evidence of how community identification and collective efficacy work as a social cure for a non-Western sample of survivors of the Nepalese earthquake of 2015. Subsequently, in a cross-cultural study exploring how multiple group memberships impacts the physical health of adult retirees adjusting to retirement across collectivistic and individualistic countries indicated that collectivism did moderate the strength of this association but it was weaker in collectivistic societies in comparison to individualistic ones (Lam et al., 2018). Further research associating the constructs of social identity and culture is still very much needed, especially to understand how stigmatized group relates to their in-group and how such relationships impact their health in different parts of the world.

Although there is evidence supporting variability within the behaviors of individuals from individualistic and collectivistic cultures, it is also important to acknowledge its criticisms. Firstly, some authors (see Fiske, 2002; Nafstad et al., 2013; Schwartz, 1990; Voronov & Singer, 2002) point out that, by classifying entire countries in two dichotomous categories, scholars treat them as homogeneous groups and undermine the complexity and diversity within these societies. Secondly, individualistic and collectivistic values are present within every country. For instance, due to nations being diverse and complex, individuals within them possess both a degree of independence and interdependence (Fiske, 2002). Additionally, by countries possessing unique historical and cultural traditions, societies negotiate their own balance between individual and communal values (Nafstad et al., 2013). Lastly, across the globe, nations have been influenced one way or another by globalization, mass media and capitalistic trends (Nafstad et al., 2013). For instance, the expansion of a

neoliberal globalized world and the increasing capitalist market ideology spreading around the globe strongly endorse and strengthens individualistic values (e.g., personal freedom) (Nafstad et al., 2013; Nafstad, Blakar, Carlquist, Phelps, & Rand-Hendriksen, 2009).

The aforementioned forces are likely to impact the way individuals such as sexual minorities relate to others, especially within the LGBT+ community. However, the question of whether and how the cultural context influences the experiences of sexual minority individuals still remains unanswered. There has been a lack of cultural and cross-cultural psychological research aimed at understanding how do LGB individuals cope with perceived discrimination outside of an Anglo-American context (Ozeren et al., 2016). Furthermore, most cross-cultural studies are conducted by comparing the United States (as the individualistic sample) with Asian countries (as the collectivistic sample) (Gómez, Kirkman, & Shapiro, 2000) instead of Latin American/European participants. Lastly, although the literature on the social cure has focused on examining how perceived socio-structural conditions influence stigmatized individuals (see Jetten et al., 2017), adequate attention has not been paid to the role of culture. Selectively addressing some of the many shortcomings in the literature, the present study aims to examine the interplay between culture, identity, and health of sexual minorities and explore possible differences between collectivistic (Portugal and the Dominican Republic) and individualistic (the United States of America and the Republic of Ireland) societies.

### 1.4 The Present Study

The present study aims to explore the role of social identity process within the relationship between perceived discrimination and psychological health of sexual minority individuals while examining possible differences between collectivistic and individualistic contexts. For this purpose, two hypotheses will be investigated. First, that the negative relationship between perceived discrimination and psychological health will be mediated by increased levels of LGBT+ in-group identification, which in turn unlocks increased levels of LGBT+ perceived social support in the case of sexual minority individuals. ($H_1$). Secondly, the current research explores if this interaction differs between individualistic and collectivistic countries. It is expected that in-group identification and perceived social support will mediate the relationship between perceived discrimination and psychological health in collectivistic countries (Portugal and the Dominican Republic) ($H_{2A}$) but not in individualistic countries (the United States of America and the Republic of Ireland) ($H_{2B}$).

## CHAPTER #2: METHODS

The present study was conducted by collecting the data from lesbian, gay and bisexual individuals across the United States of America, the Republic of Ireland, the Dominican Republic and Portugal.

### 2.1 Participants

A total of 441 sexual minority individuals participated in the current study, of which 204 (57.8%) reported to be females assigned at birth, while 186 (42.2%) reported being male assigned at birth between the ages of 18 and 64 ($M$ = 28.55; $SD$ = 10.12). Of the overall sample, 41.7% reported to identify as male, 46.3% as female, 6.3% as non-binary or "genderfluid", 4.5% as transgender man, and 1.1% as other (e.g., "pangender", "agender", "demigirl", and "transmasculine"). Additionally, from the total sample a 64.4% of the participants reported that they identify themselves as homosexual or gay/lesbian, 31.3% as bisexual, 3.2% identify as other (e.g., "queer", "questioning", "asexual" and "demisexual"), and 1.4% prefer not to disclose their sexual orientation. From the overall sample, a total of 107 indicated that they were nationals or residents of the United States of America, 102 of the Republic of Ireland, 119 of the Dominican Republic, and 113 of Portugal (see Table 2.1 for details).

Table 2.1

*Cross-Cultural Sample Demographic*

| | | Individualistic | | | | | | Collectivistic | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | | United States | | Ireland | | Total | | Dominican Republic | | Portugal | |
| | | ($n$ = 209) | | ($n$ = 107) | | ($n$ = 102) | | ($n$ = 232) | | ($n$ = 119) | | ($n$ = 113) | |
| Sex | Male | 82 | 39.2% | 40 | 42.2% | 42 | 42.2% | 104 | 44.8% | 51 | 42.9% | 53 | 46.9% |
| | Female | 127 | 60.8% | 67 | 57.8% | 60 | 58.8% | 128 | 55.2% | 68 | 57.1% | 60 | 53.1% |
| Gender Identity | Male | 81 | 38.8% | 40 | 37.4% | 41 | 40.2% | 103 | 44,4% | 50 | 42.0% | 53 | 46.9% |
| | Female | 85 | 40.7% | 31 | 29.0% | 54 | 52.9% | 119 | 51.3% | 66 | 55.5% | 53 | 46.9% |
| | Trans Male | 18 | 8,6% | 16 | 15.0% | 2 | 2.0% | 2 | 0.9% | 0 | 0% | 2 | 1.8% |
| | Trans Female | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| | Non-Binary | 21 | 10.0% | 16 | 15.0% | 5 | 4.9% | 7 | 3.0% | 3 | 2.5% | 4 | 3.5% |
| | Other | 4 | 1.9% | 4 | 3.7% | 0 | 0% | 1 | 0.4% | 0 | 0% | 1 | 0.9% |
| Sexual Orientation | Homosexual | 124 | 59.3% | 57 | 53.3% | 67 | 65.7% | 160 | 69.0% | 85 | 71.4% | 75 | 66.4% |
| | Bisexual | 71 | 34.0% | 42 | 39.3% | 29 | 28.4% | 66 | 28.4% | 32 | 26.9% | 34 | 30.1% |
| | Prefer not to answer | 2 | 1.0% | 0 | 0% | 2 | 2.0% | 4 | 1.7% | 2 | 1.7% | 2 | 1.8% |
| | Other | 12 | 5.7% | 8 | 3.2% | 4 | 3.9% | 2 | 0.9% | 0 | 0% | 2 | 1.8% |
| Age | $M$ ($SD$) | 29.4 | (11.1) | 26.6 | (10.7) | 32.4 | (10.8) | 27.7 | (9.06) | 24.6 | (5.38) | 31.1 | (10.8) |

## 2.2 Measures

### 2.2.1 Demographics.

Basic demographics were gathered, including gender identity, sex assigned at birth, age, nationality, and sexual orientation. For the purpose of the present study, sexual orientation, age, and nationality were also used as a pre-screening assessment.

### 2.2.2 Perceived Discrimination.

To measure perceived discrimination within the sexual minority population, an adapted version of the Out-Group Rejection Subscale was used. The Out-Group Rejection Subscale (Postmes & Branscombe, 2002) is a four-item scale that originally was developed to measure the frequency of experiencing racial/ethnic discrimination. However, Bengeny and Huo (2017) adapted the original scale to make reference to the participants' sexual minority group and their experiences. The present scale measures the frequency that participants perceived they were being rejected by the out-group. The items of this scale include “In the past year how often have you felt that (a) “… you were being discriminated against because of your sexual orientation?”, (b) “... you were being treated according to stereotypes associated with your sexual orientation?”, (c) “… you were being viewed negatively because of your sexual orientation?”, and (d) “... you were deprived of opportunities (that were available to others) because of your sexual orientation?”. The scale was rated on a 5-point Likert scale that ranges from *Never* (1) to *Always* (5). The adapted version of this scale has good internal consistency (Cronbach’s $\alpha \geq .84$) (Begeny & Huo, 2017). Reliability analysis was carried out on this subscale showed the questionnaire to reach good reliability, Cronbach's $\alpha = .82$.

### 2.2.3 LGBT+ In-group Identification.

Based on the SIA (Tajfel & Turner, 1979; Turner et al., 1987), one scale was used to measure identification with the LGBT+ community. The instrument used was the Multidimensional Scale of Social Identification (Leach et al., 2008) which is a 14-item (Cronbach’s $\alpha = .87$) scale that measures an individual’s levels of identification with an in-group. The overall scale is composed of five subscales that can be organized in two overarching categories. The first is the self-investment category which is comprised of the Solidarity (Cronbach’s $\alpha = .82$), Satisfaction (Cronbach’s $\alpha = .84$), and Centrality (Cronbach’s $\alpha = .78$) subscales. The second category is titled self-definition, which is made up of the Individual Self-Stereotyping (Cronbach’s $\alpha = .86$) and In-Group Homogeneity (Cronbach’s $\alpha = .66$) subscales. Additionally, the Multidimensional Scale of Social Identification has been found to be reliable across different social identities and has good

construct validity (Cooper, Smith, & Russell, 2017). Therefore, each of the items were adapted to measure the levels of identification of LGB individuals with the LGBT+ community (e.g., "I feel committed to the LGBT+ community", "It is pleasant to be a member of the LGBT+ community", "Being a member of the LGBT+ community is an important part of how I see myself"). The items were rated on a 7-point Likert scale, (1) being *Strongly Disagree* and (7) being *Strongly Agree.*

For this instrument, Spanish and Portuguese versions of the scale were available. The Spanish version of the scale was translated and validated by Bobowik, Wlodarczyk, Zumeta, Basabe, and Telletxea (2013). It shows reliability and structural validity with one common dimension and presents an excellent internal consistency (Cronbach's α = .94 ) (Bobowik, Wlodarczyk, Zumeta, Basabe, & Telletxea, 2013). The Portuguese version of the survey has also been translated and validated (Ramos & Alves, 2011) and its subscales present internal consistencies that range from acceptable and excellent (Solidarity α = .92; Satisfaction α = .82; Centrality α = .87; Individual Self-Stereotyping α = .84, and In-Group Homogeneity α = .76). Reliability analysis indicates that the present scale reaches excellent reliability (α = .90). Furthermore, internal and intercorrelation analysis of the subscales were conducted (see Table 2.2).

Table 2.2

*Means, Standard Deviations, Internal and Intercorrelations of the Multicomponent Scale of In-Group Identification (Leach et al., 2008)*

| | *M* | (*SD*) | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|---|---|
| 1. Solidarity | 5.39 | (1.17) | **.76** | | | | | |
| 2. Satisfaction | 5.47 | (1.05) | .62** | **.85** | | | | |
| 3. Centrality | 5.01 | (1.44) | .65** | .60** | **.86** | | | |
| 4. Individual Self-Stereotyping | 4.19 | (1.25) | .49** | .49** | .54** | **.80** | | |
| 5. In-group Homogeneity | 4.05 | (1.29) | .14** | .28** | .24** | .51** | **.73** | |
| 6. Total | 4.97 | (.94) | .80** | .83** | .84** | .75** | .50** | **.90** |

*Notes.*
Cronbach's alphas are shown in the diagonal and in bold.
Off-diagonal elements are the correlations among the subscales.
** $p < .01$.

### 2.2.4 LGBT+ Perceived Social Support.

The perceived social support from LGBT+ community members was measured using a four-item scale that was adapted from van Dick and Haslam (2012). The scale assesses four distinct aspects of social support (see House, 1981) which are (a) emotional support, (b)

companionship, (c) instrumental support, and (d) informational support. The items were adapted to include the support received from members of the LGBT+ community. The items of this scale include (a) "I get the emotional support I need from other members of the LGBT community", (b) "I get the help I need from other members of the LGBT+ community", (c) "I get the resources I need from members of the LGBT+ community", and (d) "I get the advice I need from members of the LGBT+ community". The items were scored on a scale from (1) *Strongly Disagree* to (7) *Strongly Agrees* and presents an excellent internal consistency (Cronbach's $\alpha = .94$). The reliability analysis conducted indicated excellent reliability, $\alpha = .91$.

**2.2.5 Psychological Health.**

The psychological health of the participants was assessed using the Mental Health Continuum Short Form (MHC-SF) scale (Keyes, 2009). The scale was developed in response to demands for a brief self-rating assessment tool (Perugini, de la Iglesia, Solano, & Keyes, 2017) and it derives from the long form of this scale (the Mental Health Continuum Long Form). The short version poses excellent internal consistency (Cronbach's $\alpha > .80$) and it is comprised of 14 items in total. The 14 items are divided into three components of well-being: (a) emotional, (b) social, and (c) psychological. The emotional component contains three items (e.g., happiness, interest with life, satisfaction with life), the social component is comprised of five items (e.g., social contribution, social integration, social acceptance, social actualization, and social coherence), and the psychological one includes six items (e.g., self-acceptance, environmental mastery, positive relations with others, personal growth, autonomy, and purpose in life). Items are responded on a 6-point Likert scale based on the frequency of experiences participants had had over the last month; therefore (1) being *Never*, (2) *Once or Twice*, (3) *About Once a Week*, (4) *2 or 3 Times a Week*, (5) *Almost Every Day,* and (6) *Every Day*.

The Mental Health Continuum Short Form (MHC-SF) has been validated and translated into Spanish and Portuguese. The Spanish version of this scale was translated and validated for a Latin American sample (Echeverría et al., 2017) showing excellent reliability for the total scale (Cronbach's $\alpha = .94$) and across the emotional (Cronbach's $\alpha = .87$), social (Cronbach's $\alpha = .85$), and psychological (Cronbach's $\alpha = .91$) subscales; therefore making it a valid questionnaire to assess the well-being of the Spanish speaking population (Echeverría et al., 2017). There are studies that have translated and validated the Portuguese version of the survey (Matos et al., 2010). The results seem to be promising, showing good internal reliability (Cronbach's $\alpha = .90$) and across its emotional (Cronbach's $\alpha = .85$), social

(Cronbach's α = .80), and psychological (Cronbach's α = .83) subscales. The Reliability analysis indicates that the present scale reaches excellent reliability (α = .91). Furthermore, internal and intercorrelation analysis of the subscales were conducted (for details see Table 2.3).

Table 2.3

*Means, Standard Deviations, Internal and Intercorrelations of the Mental Health Continuum Short Form (MHC-SF) (Keyes, 2009)*

| | *M* | (*SD*) | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 1. Emotional Well-being | 5.39 | (1.17) | **.89** | | | |
| 2. Social Well-being | 5.47 | (1.05) | .60** | **.76** | | |
| 3. Psychological Well-being | 5.01 | (1.44) | .80** | .68** | **.83** | |
| 4. Total | 4.19 | (1.25) | .87** | .87** | .94** | **.91** |

*Notes.*
Cronbach's alphas are shown in the diagonal and in bold.
Off-diagonal elements are the correlations among the subscales.
** p < .01.

### 2.2.6 Individualism & Collectivism.

It was intended to measure individualism and collectivism via the Reduced Version of the Horizontal and Vertical Individualism & Collectivism Scale (Sivadas, Bruvold, & Nelson, 2008). This scale derives from 14 out of the 32 original items a widely used measure of individualism and collectivism developed by Triandis and Gelfand (1998) and it focuses on measuring 4 individual cultural dimensions of (1) Vertical Individualism (VI), (2) Horizontal Individualism (HI), (3) Vertical Collectivism (VC), and (4) Horizontal Collectivism (HC). The scale seemed to have good reliability (ranging from Cronbach's α = .65 to Cronbach's α =. 81). However, after conducting reliability analysis with the sample of the study it showed poor reliability (ranging from Cronbach's α = .44 to Cronbach's α = .62). Internal and intercorrelation analysis of this scale indicated that the removal of any of the items did not significantly improve the alpha of any of the four subscales. Thus, it was decided to exclude the measure from the analysis.

Therefore, it was opted to measure individualism and collectivism based on country scores of the individualism value based on Hofstede's (2001) cultural dimensions. To do so, participants from the United States of America, the Republic of Ireland, the Dominican Republic, and Portugal were grouped into collectivistic or individualistic according to the independent country scores (see Table 2.4 for the breakdown of the scores across countries).

Countries with individualism scores higher than 50 (the United States of America and the Republic of Ireland), were coded as individualistic while those with scores lower than 50 (the Dominican Republic and Portugal) were classified as collectivistic.

Table 2.4

*Hofstede's (2001) Individualism Cultural Dimension Score Across Countries*

| | United States | Ireland | Dominican Republic | Portugal |
|---|---|---|---|---|
| Individualism | 91 | 70 | 30 | 27 |

### 2.2.7 Summary of Measures.

Table 2.5 presents an overall summary of the scales and how they were treated within the scope of the present study.

Table 2.5

*Overview of the Variables, Scales and Languages of the Measures*

| Variable | Scale | | Scale Language | | |
|---|---|---|---|---|---|
| | Measure | Original/ Adapted | English [a] | Spanish | Portuguese |
| Perceived Discrimination | Out-Group Rejection Subscale | Adapted [b] | (Postmes & Branscombe, 2002) | Back Translated | Back Translated |
| LGBT+ In-Group Identification | Multidimensional Scale of Social Identification | Original | (Leach et al., 2008) | (Bobowik et al., 2013) | (Ramos & Alves, 2011) |
| LGBT+ Perceived Social Support | Perceived Social Support | Adapted [c] | (van Dick & Haslam, 2012) | Back Translated | Back Translated |
| Psychological Health | Mental Health Continuum Short Form (MHC-SF) | Original | (Keyes, 2009) | (Echeverría et al., 2017) | (Matos et al., 2010) |
| Individualism & Collectivism 1[d] | Reduced Version of the Horizontal and Vertical Individualism & Collectivism Scale | Original | (Sivadas et al., 2008) | (Soler & Díaz, 2017) [e] | (Torres & Pérez-Nebra, 2015) [e] |
| Individualism & Collectivism 2 | Individualism Country Score | Original | (Hofstede, 2001) | - | - |

*Notes.*

[a] The authors within the section are the original authors of the instruments.

[b] Items were adapted to make reference to the sexual orientation of the participants.

[c] Items were adapted to make reference to the LGBT+ community.

[d] Scale was excluded from the analysis due to poor reliability.

[e] The items for this scale were taken from translated versions of the original scale developed by (Triandis & Gelfand, 1998).

**2.3 Design**

The research used a correlational and cross-sectional design. The variables in this study were (1) perceived discrimination (independent variable), (2) psychological health (dependent variable), (3) LGBT+ in-group Identification (mediator #1), and (4) perceived LGBT+ social support (mediator #2), which were all assessed with self-reported measures. The aforementioned variables were tested across individualistic and collectivistic countries as measured by Hofstede's (2001) individualism country scores, in a between-subject comparison.

**2.4 Procedure**

An online questionnaire in English, Spanish and in Portuguese that was developed using *Qualtrics*, was launched from January 2019 until April 2019. Data were collected from participants who (1) were over the age of 18, (2) identified as lesbians, gay or bisexual, and (3) identified as nationals and/or residents of the United States of America, the Republic of Ireland, the Dominican Republic or Portugal. The selection of the countries assessed in the current study was based on both the individualistic and collectivistic cultural dimensions of Hofstede (2001) and at the convenience of the investigators. The goal was to identify two countries, one more oriented towards individualism and the other oriented towards collectivism, within the continental regions of the Americas (e.g., the United States of America and the Dominican Republic) and Europe (e.g., Ireland and Portugal) that were also accessible to the investigators. To do so, participants were recruited through Internet-based and snowballing sampling methods via social media platforms (e.g., Facebook, Instagram, LinkedIn), email and messaging applications (e.g., Messenger and WhatsApp). Online recruitment was conducted by contacting LGB individuals directly, LGBT+ organizations, persons-in-charge of LGBT social venues and through LGB allies. Electronic recruitment messages for this study written in English, Spanish (Latin American) and Portuguese (European) were posted in the various platforms with a link to the survey. The survey included: (1) pre-screening questions, (2) electronic informed consent, (3) socio-demographic questions, (4) instruments, and (5) end of survey message. To obtain the Spanish (Latin-American) and Portuguese (European) version of the survey, a process of translation and back-translation was used. The translation and back-translation were done by master's students who were native Spanish (Latin American) and Portuguese (European) speakers. The resulting back-translated versions were discussed and piloted with lay native Spanish and Portuguese speakers, which resulted in minor modifications (e.g., grammar and spelling).

The participation was voluntary and has been kept strictly anonymous to protect confidentiality. Additionally, participants who completed the survey were invited to participate in a raffle with the chance to win one out of four 25€ (28.50$) Amazon Gift Cards. To do so, participants were asked to provide their email address, however, this information was in no way linked to their responses of the survey. Ethics approval was obtained from the Ethics Committee from ISCTE - Lisbon University Institute (ISCTE-IUL) (see Appendix A).

**2.5 Statistical Analysis**

Descriptive statistics were calculated (means, standard deviations, and percentages) for the entire sample and later stratified by the sex assigned at birth, gender identity, sexual orientation, country, and collectivistic and individualistic cultural values. Tests of normality were conducted for all major variables and later grouped by culture and across countries (for details see Appendix B). T-tests of independence were also conducted to investigate group difference between individualistic and collectivistic countries. Subsequently, to better understand the difference across the participants from the four countries, a multivariate analysis of variance (MANOVA) was conducted. Pearson correlation coefficients were also estimated to describe the degrees of associations among variables of interest. Lastly, a serial mediation was conducted using the PROCESS macro version 3.3 (Hayes, 2017) for SPSS to determine the relationship between perceived discrimination and the psychological health of sexual minority individuals and whether this interaction was: (1) mediated by LGBT+ in-group identification and LGBT+ perceived social support, and (2) mediated by LGBT in-group identification. Furthermore, the analysis was carried out to determine if the aforementioned relationship will differ across participants from individualistic and collectivistic countries.

# CHAPTER #3: RESULTS

## 3.1 Preliminary Analysis

### 3.1.1 Descriptive Statistics & Correlations

Table 3.1 presents means, standard deviations and zero-order correlations among the major variables from the total sample and later stratified by collectivistic and individualistic countries. Pearson correlations were calculated to assess the relationship between the major variables. The results indicate that all expected correlations across the variables were significant. The aforementioned may suggest that the original hypothesized path model may be a good fit for the data.

Table 3.1

*Descriptive Statistics and Correlation of Major Variables*

| | Total ($N$ = 441) | | Collectivistic ($n$ = 232) | | Individualistic ($n$ = 209) | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *M* | *(SD)* | *M* | *(SD)* | *M* | *(SD)* | 1 | 2 | 3 |
| 1. Perceived Discrimination | 2.14 | (.75) | 2.23 | (.71) | 2.04 | (.77) | - | | |
| 2. LGBT+ In-Group Identification | 4.97 | (.94) | 4.73 | (.85) | 5.23 | (.97) | .13** | - | |
| 3. Perceived Social Support | 4.59 | (1.36) | 4.42 | (1.27) | 4.79 | (1.42) | .02 | .57** | - |
| 4. Psychological Health | 40.51 | (14.04) | 41.05 | (13.25) | 39.90 | (14.89) | -.13** | .25** | .25** |

*Note.* ** $p < .01$

### 3.1.2 Sample Differences

Independent t-tests were conducted to examine differences between the mean scores of the individualistic and collectivistic sample across all major variables. Results from the analysis show that scores of perceived discrimination, ($t(438) = 2.66$, $p = .001$), LGBT+ in-group identification, $t(439) = -5.68$, $p < .001$, and perceived social support ,$t(438) = -2.96$, $p < .001$, differ significantly between the individualistic and collectivistic samples. Participants from collectivistic countries reported higher levels of perceived discrimination compared to their individualistic counterparts. However, participants from individualistic countries reported higher levels of in-group identification and perceived social support from the LGBT+ community than the collectivistic sample. There was no statistical difference in the scores of psychological health ($p > .05$) between participants from individualistic and collectivistic countries. Analysis of the sample differences across the four countries were also

explored. However, given that this comparison was not part of the main study goals, analysis of sample difference across countries is presented in Appendix C.

## 3.2 Main Analysis

### 3.2.1 Hypothesis #1

We were interested in exploring the relationship between perceived discrimination and psychological health in sexual minorities and hypothesized that this interaction might be mediated by the increased LGBT+ in-group Identification and increased LGBT+ perceived social support. A serial mediation analysis revealed (Figure 3.1) that perceived discrimination was negatively related to psychological health, β = -2.46, *SE* = .90, *t*(427) = -2.73, *p* = .007. Subsequently, perceived discrimination was a positive and significant predictor of LGBT+ in-group identification β = .16, *SE* = .06, *t*(427) = 2.71, *p* = .04. In turn, LGBT+ in-group identification was also a positive and significant predictor of perceived social support from the LGBT+ community β = .81, *SE* = .06, *t*(427) = 14.19, *p* < .001.

The serial mediation analysis indicated that the total indirect effect was significant, β = .65, 95% CI = [15, .1.22]. Analysis of the specific indirect effects revealed that the combined mediation effect was significant β = .21, 95% CI = [.02, .94], with perceived discrimination increasing LGBT+ in-group identification, which increased LGBT+ perceived social support, which in turn enhanced psychological health. Additionally, there was evidence of a positive and significant indirect effect through LGBT+ in-group identification, β = .43, 95% CI [.68, .93]. There was also evidence of a significant direct effect of perceived discrimination on psychological health, β = .-2.97, 95% CI = [-4.69, .-1.26] when the mediators were controlled for, suggesting that additional mechanisms may have been at play.

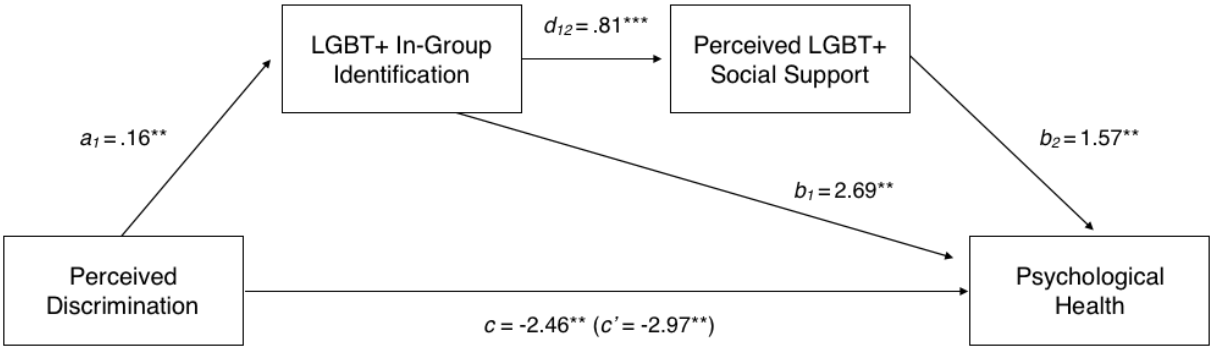


*Figure 3.1.* Serial Mediation of In-Group identification and Perceived Social Support from the LGBT+ Community on the Relationship Between Perceived Discrimination and Psychological Health (Total Sample).

*Notes.* ** *p* < .01; *** *p* < .001.

### 3.2.2 Hypothesis #2

The serial mediation model previously conducted was tested with the participants from collectivistic and individualistic countries in order to explore the possible differences between each group.

#### *3.2.2.1 Collectivistic Countries.*

The sequential analysis in collectivistic countries (Figure 3.2) indicated that perceived discrimination was positively related to LGBT+ in-group identification β = .33, *SE* = .08, *t*(224) = 4.24, *p* < .001. In turn, LGBT+ in-group identification was positively related to LGBT+ perceived social support, β = .85, *SE* = .08, t(224) = 10.29, *p* < .001. Subsequently, LGBT+ perceived social support positively predicted psychological health, β = 2.10, *SE* = .81, *t*(222) = 2.60, *p* < .01. However, there was no significant interaction between LGBT+ in-group-identification and psychological health, *p* > .05.

The total indirect effect of the model in collectivistic countries was positive and significant, β = 1.28, 95% CI = [.44, 2.22]. There was a significant and positive indirect effect via LGBT+ in-group identification and LGBT+ perceived social support, β = .58, 95% CI = [.09, 1.21]. However, the specific indirect effect through LGBT+ in-group identification was not significant, β = .70, 95% CI [-.10, 1.57].

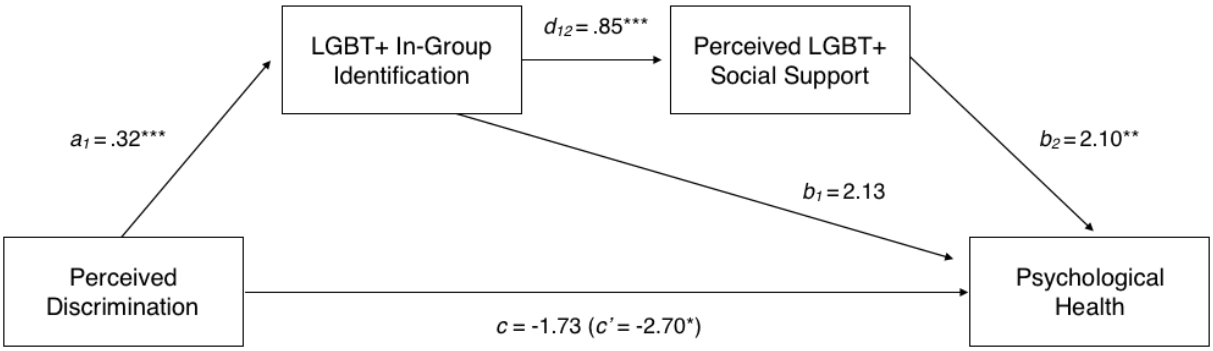


*Figure 3.2.* Serial Mediation of In-Group identification and Perceived Social Support from the LGBT+ Community on the Relationship Between Perceived Discrimination and Psychological Health (Collectivistic Sample)

*Notes.* * *p* < .05; ** *p* < .01; *** *p* < .001.

#### *3.2.2.2 Individualistic Countries.*

The sequential analysis in individualistic countries (Figure 3.3) indicated that LGBT+ in-group identification positively predicted both perceived social support from the LGBT+ community β = .79, *SE* = .09, *t*(201) = 9.19, *p* < .001, and psychological health β = 4.19, *SE* =

1.21, $t(199) = 3.47$, $p = .01$. Additionally, perceived discrimination negatively predicted psychological health, β = -3.82, $SE = 1.26$, $t(199) = 3.47$, $p = .003$, while both mediators were controlled for. However, the analysis revealed that other paths of the model were not statistically significant, $p > .05$. The sequential analysis indicated that the total indirect effect was not significant , β = .46, 95% CI [-.41, 1.40]. The indirect effects through the combined mediators, β = .39, 95% CI [-.36, 1.26], and through LGBT+ in-group identification, β = .11, 95% CI [-.10, 36], were also not significant.

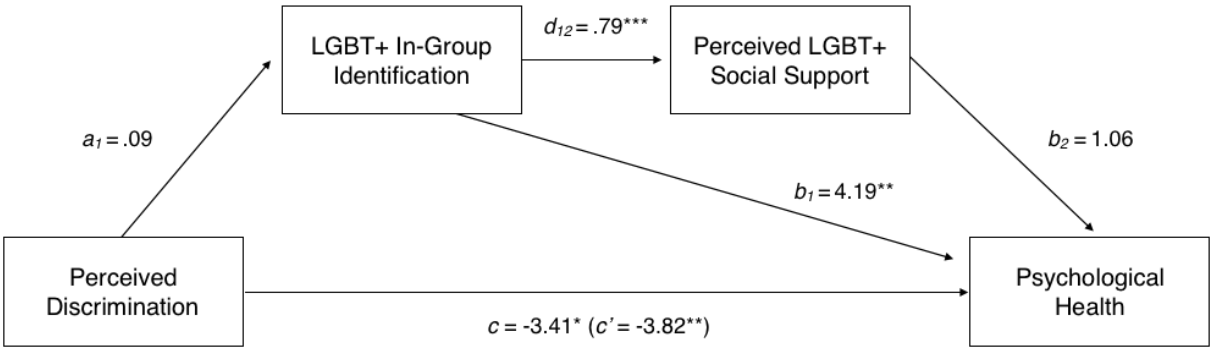


*Figure 3.3*. Serial Mediation of In-Group identification and Perceived Social Support from the LGBT+ Community on the Relationship Between Perceived Discrimination and Psychological Health (Individualistic Sample)

*Notes.* * $p < .05$; ** $p < .01$; *** $p < .001$.

## CHAPTER #4: DISCUSSION

The present study aimed to investigate how the relationship between perceived discrimination and psychological health in sexual minority individuals can be mediated by social identity process associated with being part of the LGBT+ community. It was also explored whether these interactions differ across collectivistic and individualistic cultural contexts. As predicted, higher levels of perceived discrimination hindered the self-reported measures of psychological health of lesbian, gay and bisexual individuals. Based on this result and consistently with the first hypothesis ($H_1$), the aforementioned relationship was mediated by the combined effect of in-group identification, and LGBT+ perceived social support from the LGBT+ community. Additionally, LGBT+ in-group identification also mediated the relationship between perceived discrimination and psychological health. In line with the second hypothesis, the data from the present study suggests that social identity process mediated the regression between perceived discrimination and psychological health in collectivistic countries (the Dominican Republic and Portugal) ($H_{2A}$) but not in individualistic countries (the United States of America and the Republic of Ireland) ($H_{2B}$). The present findings are consistent with social identity literature and furthers the understanding of the intersection between identity, stigma, and health in different parts of the world. Specifically, it highlights not only the double edge role that identity plays for the health of stigmatized individuals but also how LGBT+ identity can act as a social cure for sexual minority individuals. In terms of theoretical contributions, the results of the current research draw attention to five major points.

The first is, that it is not only important to be part of the LGBT+ community but as well how strongly you identify with it. One of the findings suggests that LGBT+ in-group identification was found as a mediator between perceived discrimination and psychological health. It is important to mention this outcome because even though there is significant empirical evidence supporting the relationship between perceived discrimination and psychological health (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Jetten et al., 2017), mixed results have been found, especially in relation to stigmatized groups (see Bobowik et al., 2017; Dingle et al., 2015). On one hand, some authors suggest that group identification exacerbated the effects of perceived discrimination on psychological health while others report evidence of a buffering effect (see Pascoe & Richman, 2009; Schmitt et al., 2014). The data from the study seem to align with the latter line of research. That is, although sexual minority or LGB identity is linked to negative psychological health outcomes, it can also be a

source of strength where the group can collectively cope to buffer against the effects of perceived discrimination.

Second, it is through increased in-group identification with the LGBT+ community that LGB individuals can unlock the positive psychological resources (e.g., social support) outlined by the social cure. Findings from the current study point to the idea that high identifiers with the LGBT+ community are positively and strongly related to increased levels of perceived social support from LGBT+ community members. Evidence from the social cure literature aligns with the notion that increased identification can facilitate the provision and acceptance of social support from in-group members (Jetten et al., 2017). This seems to be the case even for stigmatized or low-status groups, where in-group identification is linked not only to social support (Kearns, Muldoon, Msetfi, & Surgenor, 2018) but also enhanced personal self-esteem and collective efficacy (e.g., Cooper et al., 2017; Muldoon et al., 2017). Therefore, the data from the present study seems to provide further support of the theoretical link between in-group identification and social support and in sexual minority individuals.

Building on the first and second findings, the third point emphasizes how despite their stigmatized identities, LGB individuals seem keen on restoring their positive identity, which in turn allows them to unlock the health-related benefits to the social cure. Theoretically, restoring one's positive identity can be achieved not only by individual coping strategies (distancing from the stigmatized group) but also through collective coping strategies, that is by increasing identification with the group in question and draw social support from it (Branscombe et al., 2012; Major & O'Brien, 2005). Findings from this research provide evidence of collective coping strategies employed by sexual minorities. Consistent with the RIM (Branscombe et al., 1999), LGB individuals seem to (1) reject the culture of stigmatization, (2) increase their identification with their in-group, the LGBT+ community, which in turn (3) allows them to draw support from its members. Therefore, it can be theorized that the processes outlined by the RIM (Branscombe et al., 1999) will create the necessary conditions for sexual minority individuals to unlock positive psychological resources of their social identities that will eventually help protect their psychological health by counteracting perceived experiences of minority stress (see Meyer, 2003).

Fourth, the cultural contexts in which the LGB identities are at play may influence how sexual minorities identify and relate to their in-group, the LGBT+ community. By testing for possible differences across cultures, the findings of the present study suggest that there was a combined mediation effect in collectivistic countries but not in the individualistic ones. Such results seem to be consistent with the differences between how collectivistic and

individualistic societies relate and experience social support from the in-group. In collectivistic samples, there is evidence suggesting the self seems to be more closely knitted with the in-group (Markus & Kitayama, 1991, 2010) and benefit from support when perceived as mutual and when which is coming from peers (Wang & Lau, 2015). In contrast, in individualistic societies, the self is conceptualized as more independent, self-reliant and autonomous (Markus & Kitayama, 1991, 2010) and benefit from explicit social support to cope with immediate stressors (Kim et al., 2006; Taylor et al., 2004, 2007). Based on the findings of the study, it can be theorized that for sexual minority individuals, the underlying mechanism prominent in collectivistic countries (e.g., interdependence, group harmony and increased benefits from peer social support) may enhance the ties of LGB individuals with their local LGBT+ community in comparison to individualistic countries. Since many LGB individuals consider the LGBT+ community as a "family" that is comprised of other peers who have undergone similar experiences and hardships due to their stigmatized identities, individuals from collectivistic countries may build stronger ties with their queer family in comparison to individualistic ones. However, further research is still very much needed in order to question and support this claim. Nevertheless, the present study does answer to the need of research of the effects of culture on health and addresses the gap in the literature by analyzing the consequences of perceived discrimination in sexual minority individuals through a cultural and social identity perspective.

Lastly, by conducting a study of LGB individuals in four different countries some interesting patterns within the data were able to emerge. That is, the experiences of perceived discrimination were pervasive across the four different countries and they significantly and negatively impacted the psychological health of LGB individuals. The present outcome underscores that there is much to be done in the plight of acceptance and inclusion of sexual minorities within the American and European context (e.g., Herek, 2009; Van Der Star & Bränström, 2015). Additionally, even though the experiences and pervasiveness of perceive discrimination were present, the psychological health of the participants did not significantly differ across countries. The aforementioned then highlights that despite the experiences of stigma, LGB individuals still find ways to cope with the adversities related to the social stigma attached to their sexual orientation (e.g., Frost & Meyer, 2012; Kertzner et al., 2009) in different parts of the world.

In terms of practical implications, the findings of the current study suggest that the opportunities to identify and receive support from the LGBT+ community are essential for the psychological health of sexual minority individuals. Additionally, the results also underscore

that the social-cultural conditions could impact sexual minority individuals differently in collectivistic and individualistic societies. Therefore, culturally and socially sensitive strategies that enhance social resources in the form of connectedness, inclusion and social support with the LGBT+ community can be a huge asset to interventions aimed at addressing mental health disparities with sexual minority individuals in different contexts. Such strategies are not only low-cost but can be rewarding with high payoffs by providing LGB individuals with lasting health-related benefits. Lastly, service providers, professionals and organizations working with and for sexual minority individuals could benefit from enhancing supportive networks via social support or advocacy groups. In this way, LGB individuals not only get the chance to connect with their local LGBT+ community but they are also given the opportunity to unlock the positive benefits of their LGB identity.

### 4.1 Limitations

The primary limitations of current research are related to the study design and sampling methods. Firstly, the cross-sectional nature of the study makes it impossible to make causal inferences. Secondly, by recruiting participants through nonprobability sampling methods, the sample can be subjected to bias. In other words, due to the use of convenience, snowball and Internet-based samplings via LGBT+ and LGBT+ friendly internet pages and organization, there is a high chance that the participants in this study not only self-disclosed as LGB but were also strongly connected to the LGBT+ community. Lastly, the analysis conducted was the result of combining different sexual minorities and genders, thus it may overlook the different experiences of the diverse members with intersecting identities that make up for the LGBT+ community.

Another limitation of the present study is related to the measures. Firstly, due to the poor reliability of the cultural orientation instrument, individualism and collectivism could not be measured at the individual level. While the adoption of the Hofstede's (2001) individualism cultural value scores did provide a way to measure individualism and collectivism which entailed a solid theoretical background and plentiful empirical evidence, it also brought its fair share of limitations. As noted in the introduction, measuring individualism and collectivism through country scores not only may undermine the diversity within these societies but also simplify the operationalization of the construct and categorize nations into two dichotomous variables (Fiske, 2002; Nafstad et al., 2013; Schwartz, 1990; Voronov & Singer, 2002).

Secondly, the realities of an increasingly neoliberal globalized and interconnected world must be taken into consideration. The current research measured nationality or

residency status by asking participants to self-identify as U.S. American, Portuguese, Irish or Dominican, but it did not control for variables such as (1) immigration status, (2) length of stay, or (3) biculturality or multiculturality. Taking into account such variables can be of particular significance considering that two out of the five instruments used in this study were retrospective measures assessing the perceived experiences of discrimination and self-reported mental health-related symptoms within the past three months to one year. Within a globalized world, the aforementioned is of special importance because the experiences of U.S. American, Portuguese, Irish or Dominican living outside to their country of origin for over a year can be different to the ones who are still residing there. Subsequently, the experiences of first-generation or even second and third generation immigrants who are residents of the United States of America, the Republic of Ireland, the Dominican Republic or Portugal can also differ from the ones who were born and raised in one of these countries.

Lastly, the present study did not account for nor control for potential confounding variables. There is evidence suggesting that social identity process, cultural orientations and the relationship between perceived discrimination and health can be impacted by factors such as social class (e.g. Cohen & Varnum, 2016; Holt & Griffin, 2005; Jay, Muldoon, & Howarth, 2018; Schmitt et al., 2014). Controlling for social class can be of special importance while conducting research in countries with high levels of inequality. For instance, belonging to the working class (low social status) has been found to be associated more with interdependence, less preference to express uniqueness and a tendency to place emphasis on the role of context and situational influence in comparison to the middle class (high social status) (Cohen & Varnum, 2016). Additionally, the experiences across gender, ethnicity (e.g., Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Diaz, Ayala, Bein, Henne, & Marin, 2001; Eliason & Schope, 2007; Fields, Morgan, & Sanders, 2016; Goode-Cross & Tager, 2011; Parent, DeBlaere, & Moradi, 2013; Parks, Hughes, & Matthews, 2004) and "coming out" status (e.g. Jordan & Deluty, 2005; Vyncke & Julien, 2007) and partnership status (e.g., Frost et al., 2016; Graham & Barnow, 2013; Kornblith, Green, Casey, & Tiet, 2016) also factor in the experiences of LGB individuals. Therefore, highlighting the possibility that the experiences of a high social status, white, partnered and "out" gay male in the Dominican Republic may the more similar to the ones from a high status, partnered and "out" gay man in Ireland than the one from a single and "closeted" low social status black lesbian woman in Portugal or the United States.

Within the present study, the perceived permeability of group boundaries and the perceived stability and legitimacy of the position of the LGBT+ community in each country

were not assessed. This is important to acknowledge, due to the evidence suggesting that socio-structural factors do impact social identity processes within low-status groups (see Jetten et al., 2017). As mentioned before, it is important to recognize that the experiences of LGBT+ individuals may differ according to the cultural and social context. The ways that LGB individuals cope with discrimination may not only be influenced by culture but also how individuals perceive and experience key structural features within their social contexts. For instance, it may be the case that the ways in which LGB individuals from the Dominican Republic (where same-sex marriage is not recognized and there is no legal protection for LGBT+ individuals) come to terms with their LGB identity, experience discrimination and relate with the LGBT+ community may differ significantly from countries such as Portugal (where same-sex marriage is legal and their legal protection to LGBT+ individuals) even though they are both collectivistic.

**4.2 Future Directions**

Future investigations could benefit from changes to the methodology and design of the present study. Firstly, conducting research with probabilistic sampling methods through participants search engines (e.g., Amazon Mechanical Turk, Survey Monkey, among others) may help reduce biases among the sample. Secondly, the inclusion of demographic variables such as perceived social class, ethnicity, immigration status and length of stay, "coming out" status, partnership status and social support networks from non-LGBT+ sources may help complement the analysis and even control for potential confounding variables. Lastly, experimental and longitudinal studies testing processes within the social cure framework with stigmatized groups and sexual minority individuals may further develop and confirm the initial findings of the present research.

It will also be important to consider the potential effects of gender more carefully. Particularly, it would be of great interest to analyze how individuals who do not conform to gender norms may use different strategies to cope with discrimination. For example, how members of the transgender and other gender minorities can unlock the benefits of the social cure through identification with the LGBT+ community. Future research could also explore how the relationship with the LGBT+ community may differ across sexual minority men and women. The aforementioned could prove a noteworthy line of work, especially while taking into consideration that most organizations and venues within the LGBT+ community tend to be dominated by white men (e.g., Han, 2007, 2008; Westbrook, 2009).

Interesting research questions can be derived by further analyzing the social and cultural context of sexual minorities. For example, by assessing cultural orientations at the

individual level it will be possible to explain some of the variances between the behavior of LGB people in collectivistic and individualistic societies. Additionally, measuring the perceived legitimacy, permeability and stability of the LGBT+ identity may help further develop the understanding of the experiences of stigmatized groups from an SIA approach. Exploring the perceived socio-structural conditions of the LGBT+ identity could be of particular interest while conducting cross-cultural research comparing sexual minority individuals in countries where being LGB is considered more socially accepted than others. Lastly, investigating the role of other cultural dimensions (e.g., masculinity/femininity, power distance, etc.) and constructs (e.g., independent and interdependent self-construal) might extend the literature of the relationship between culture, identity, and health.

## CONCLUSION

The present study contributes to social identity, sexual minority, and cross-cultural literature in three ways. First, it highlights that even though perceived discrimination has adverse effects on the psychological health of sexual minority individuals it can also lay the foundations for LGB individuals to unlock positive psychological resources that may help buffer this relationship. Second, it provides evidence that for the stigmatized sexual minority identity to act as a social cure, LGB individuals have to strongly identify with their LGBT+ in-group, which in turn, allows them to perceive social support from its members. Lastly, the ways that sexual minorities relate to their in-group and draw support from it may vary as a function of the cultural context. The findings of the current research emphasize the importance of the LGBT+ community and the role it plays in the identity and health of sexual minority individuals in different parts of the world.

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# APPENDIX A

ISCTE IUL
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**COMISSÃO DE ÉTICA**

**PARECER 28/2018**

***Projeto "I am Because We Are: Cross-Cultural Comparison of Community Identification and Social Support as a Social Cure for the Psychological Health of Sexual Minorities"***

O Projeto "*I am Because We Are: Cross-Cultural Comparison of Community Identification and Social Support as a Social Cure for the Psychological Health of Sexual Minorities*", submetido pelo investigador Gustavo A., Aybar Camposano, foi apreciado pelos membros da Comissão de Ética na reunião do dia 13 de dezembro de 2018.

O projeto apresentado reveste-se de inegável interesse científico e alcance social.

A informação disponibilizada, em conformidade com o *Formulário de Submissão para Aprovação Ética* em uso no ISCTE-IUL, satisfaz os requisitos éticos exigíveis neste tipo de projetos de investigação, contemplando, nomeadamente:

a) O presente estudo visa investigar a complexidade da relação entre identidades sociais e saúde, contemplando, em particular, o modo como os membros de grupos estigmatizados, nomeadamente os da comunidade LGBT+, lidam com a adversidade do estigma e da discriminação, e explorar o impacto que a identificação de grupo e apoio social recebidos desta comunidade terá para a saúde psicológica de lésbicas, *gays* e bissexuais (LGB), procurando esclarecer os fatores de stresse a que estes se encontram expostos em razão do estigma e discriminação em diferentes contextos culturais (Estados Unidos, República Dominicana, Portugal e Irlanda), bem assim como as estratégias de enfrentamento utilizadas pelas pessoas LGB para minorar os efeitos psicológicos negativos associados ao estigma e à discriminação;
b) A metodologia é de natureza quantitativa, correlacional, baseada em questionários disponibilizados *online*, que visam alcançar um conjunto diversificado de indivíduos em várias regiões e permitir que os participantes LGB sintam que o seu anonimato e a confidencialidade das suas respostas se encontram garantidos;
c) O recrutamento de participantes far-se-á através dos vários *media* sociais e de plataformas *online*, nos quais lésbicas, *gays* e bissexuais serão convidados a participar, voluntária e confidencialmente, neste estudo, através de um *hiperlink* que lhes dará acesso a um pacote virtual de questionários contendo: (a) consentimento virtual informado; (b) triagem e questões demográficas; (c) Subescala de Rejeição de Grupo Externo (OGRS); (d) Escala Multidimensional de Identificação (MSSI) e Escala de Apoio Social Percebida; (e) Continuum de Saúde Mental *Short Form* (MHC-SF) (avaliação não clínica), e (f) Versão reduzida do Individualismo Horizontal e Vertical, e Escala de Coletivismo. Este pacote virtual é totalmente digitalizado, e todo o seu conteúdo estará disponível em inglês, espanhol e português. Estes procedimentos estão previstos para: a) serem respondidos uma única vez por cada participante; b) individualmente, e c) com uma duração estimada de 5-8 minutos. Uma vez concluída a recolha de dados *online*, estes serão registados automaticamente no sítio da base de dados *Qualtrics* e, posteriormente, exportados para o software *SPSS*, a fim

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de serem analisados. Toda a informação assim obtida será mantida em formato digital numa base de dados *online*, protegida por senha, apenas acessível aos investigadores;

d) Os participantes deverão satisfazer os seguintes critérios: 1) terem idade superior a 18 anos; 2) identificarem-se como lésbicas, *gays* ou bissexuais, e (3) serem nacionais e / ou residentes nos Estados Unidos da América, República Dominicana, Portugal ou Irlanda. Prevê-se uma amostra de 100 participantes por cada país, ou seja, uma população total de 400 sujeitos. Os participantes serão recrutados através de amostras de conveniência, utilizando o método bola-de-neve, recorrendo às várias plataformas sociais (por exemplo, *Facebook*, *WhatsApp* e *LinkedIn*), com a indicação expressa de que se trata de um projeto de investigação *online*, de natureza confidencial e garantia de anonimato dos participantes;
e) O estudo envolve pessoas pertencentes a grupos minoritários e a populações vulneráveis. Todavia, as medidas propostas pelo investigador afiguram-se adequadas para minimizar eventuais impactos negativos nos participantes;
f) A participação voluntária dos sujeitos, todos de maior idade, será assegurada mediante prévio consentimento informado, livre e esclarecido, apresentado em formato digital;
g) Os formulários de consentimento informado contêm a explicação sumária dos objetivos e procedimentos, a garantia do anonimato e confidencialidade dos resultados obtidos, bem assim como a identificação e o contacto dos investigadores para eventuais esclarecimentos. Toda a documentação pertinente será disponibilizada nas línguas portuguesa, inglesa e castelhana;
h) O estudo não envolve riscos apreciáveis para os participantes e não utiliza o engano experimental (*deception*);
i) O *debriefing* e o armazenamento dos dados, bem assim como a declaração de responsabilidade e de conduta ética do investigador, obedecem às disposições contidas no *Código de Conduta Ética na Investigação – ISCTE-IUL*.

Em suma, assegurados que se encontram o voluntariado da participação, a confidencialidade, a privacidade e o anonimato dos participantes e da informação recolhida, o projeto mereceu o parecer favorável da Comissão, com a recomendação de que deverão ser contemplados mecanismos de proteção de partilha das conclusões do estudo com os participantes que a estas pretendam ter acesso, sem compromisso do anonimato previsto no estudo.

O Presidente da Comissão, *Prof. Doutor Jorge Costa Santos*

O Vogal, *Prof. Doutor Manuel Pita*

A Vogal, *Prof.ª Doutora Sónia Bernardes*

O Vogal, *Prof. Doutor Vítor Basto Fernandes*

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## APPENDIX B

Table A1

*Test of Normality of the Major Variables Across Collectivistic and Individualistic Cultures.*

| | | | Kolmogorov-Smirnov [a] | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|---|---|
| | Skew | Kurt | Statistics | *df* | *p* | Statistics | *df* | *p* |
| Perceived Discrimination | | | | | | | | |
| Collectivism | .15 | -.33 | .09 | 226 | .000 | .97 | 226 | .000 |
| Individualism | 1.08 | 1.15 | .19 | 203 | .000 | .91 | 203 | .000 |
| LGBT+ In-Group Identification | | | | | | | | |
| Collectivism | -.14 | .40 | .06 | 226 | .028 | .99 | 226 | .213 |
| Individualism | -.55 | -.11 | .09 | 203 | .001 | .97 | 203 | .000 |
| LGBT+ Perceived Social Support | | | | | | | | |
| Collectivism | -.52 | .75 | .12 | 226 | .000 | .96 | 226 | .000 |
| Individualism | -.66 | .04 | .12 | 203 | .000 | .95 | 203 | .000 |
| Psychological Health | | | | | | | | |
| Collectivism | -.21 | -.57 | .06 | 226 | .038 | .99 | 226 | .050 |
| Individualism | -.31 | -.76 | .09 | 203 | .000 | .97 | 203 | .001 |

*Notes.* [a] Lilliefors Significance Correction.

Table A2

*Test of Normality of the Major Variables Across Countries*

| | | | Kolmogorov-Smirnov [a] | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|---|---|
| Countries | Skew | Kurt | Statistics | *df* | *p* | Statistics | *df* | *p* |
| Perceived Discrimination | | | | | | | | |
| United States | .85 | .40 | .17 | 107 | .000 | .93 | 107 | .000 |
| Ireland | 1.13 | 1.38 | .18 | 102 | .000 | .91 | 102 | .000 |
| Dominican Republic | .23 | -.15 | .11 | 119 | .002 | .98 | 119 | .050 |
| Portugal | .06 | -.84 | .12 | 112 | .001 | .95 | 112 | .001 |
| LGBT+ In-Group Identification | | | | | | | | |
| United States | .19 | 4.24 | .099 | 106 | .013 | .974 | 106 | .033 |
| Ireland | -.57 | -.39 | .089 | 97 | .058 | .959 | 97 | .004 |
| Dominican Republic | -.14 | .38 | .074 | 117 | .165 | .989 | 117 | .443 |
| Portugal | -.10 | .40 | .065 | 110 | .200* | .993 | 110 | .821 |
| LGBT+ Perceived Social Support | | | | | | | | |
| United States | -.77 | .18 | .134 | 106 | .000 | .941 | 106 | .000 |
| Ireland | -.57 | .09 | .104 | 97 | .012 | .962 | 97 | .006 |
| Dominican Republic | -.48 | .13 | .110 | 117 | .001 | .957 | 117 | .001 |
| Portugal | -.12 | 1.02 | .117 | 110 | .001 | .970 | 110 | .014 |
| Psychological Health | | | | | | | | |
| United States | -.25 | -1.1 | .110 | 106 | .003 | .954 | 106 | .001 |
| Ireland | -.30 | -.32 | .072 | 97 | .200* | .985 | 97 | .324 |
| Dominican Republic | -.36 | -.87 | .103 | 117 | .004 | .965 | 117 | .004 |
| Portugal | -.06 | -.20 | .058 | 110 | .200* | .995 | 110 | .976 |

*Notes.*
[a] Lilliefors Significance Correction.
* This is a lower bound of the true significance.

## APPENDIX C

A MANOVA was conducted to investigate possible group differences between countries. A Bonferroni correction was applied to the follow-up univariate ANOVAs and a new alpha level of .02 was adopted.

Table B1

*ANOVA Results Testing for Differences Between Scales Across Countries*

| Variable | *SS* | *df* | *MS* | *F* | *p* |
|---|---|---|---|---|---|
| Perceived Discrimination | 16.05 | 3 | 5.35 | 10.16 | .000 |
| LGBT+ In-Group Identification | 27.50 | 3 | 9.17 | 11.07 | .000 |
| LGBT+ Perceived Social Support | 24.51 | 3 | 8.17 | 4.58 | .004 |
| Psychological Health | 1214.13 | 3 | 404.71 | 2.06 | .104 |

Table B2

*Means, Standard Deviations, Mean Differences of the Major Variables Across Countries*

| Countries | *M* | (*SD*) | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| Perceived Discrimination [a] | | | | | | |
| 1. United States | 2.21 | (.88) | - | | | |
| 2. Ireland | 1.89 | (.60) | -.32* | - | | |
| 3. Dominican Republic | 2.42 | (.70) | .20 | .52* | - | |
| 4. Portugal | 2.05 | (.68) | -.16 | .16 | -.36* | - |
| LGBT+ In-Group Identification [b] | | | | | | |
| 1. United States | 5.30 | (.93) | - | | | |
| 2. Ireland | 5.15 | (1.00) | -.15 | - | | |
| 3. Dominican Republic | 4.70 | (.90) | -.59* | -.44* | - | |
| 4. Portugal | 4.76 | (.81) | -.54* | -.39* | .06 | - |
| LGBT+ Perceived Social Support [a] | | | | | | |
| 1. United States | 4.89 | (1.40) | - | | | |
| 2. Ireland | 4.65 | (1.41) | -.25 | - | | |
| 3. Dominican Republic | 4.24 | (1.45) | -.66* | -.41 | - | |
| 4. Portugal | 4.58 | (1.04) | -.31 | -.07 | .34 | - |
| Psychological Health [c] | | | | | | |
| 1. United States | 38.03 | (15.64) | - | | | |
| 2. Ireland | 41.95 | (13.80) | 3.92 | - | | |
| 3. Dominican Republic | 42.15 | (15.07) | 4.13 | .21 | - | |
| 4. Portugal | 39.87 | (10.99) | 1.84 | -2.08 | -2.28 | - |

*Notes.*

* Significant Mean Differences at the .05 level.

[a] Scale ranges from 1 to 5.

[b] Scale ranges from 1 to 7.

[c] Scale ranges from 0 to 70.